AMA
AMERICAN MEDICAL ASSOCIATION

JAMES L. MADARA, MD
EXECUTIVE VICE PRESIDENT, CEO

ama-assn.org
t (312) 464-5000

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Marilyn B. Tavenner
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: **Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models & Other Revisions to Part B for CY 2015** [CMS-1612-P]

Dear Administrator Tavenner:

On behalf of its physician and medical student members, the American Medical Association (AMA) appreciates the opportunity to offer comments to the Centers for Medicare & Medicaid Services (CMS) regarding the Proposed Rule entitled *Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models & Other Revisions to Part B for CY 2015* [CMS-1612-P]. We believe this Proposed Rule has very important implications for physicians, as well as for patients.

This letter includes the AMA's recommendations, comments, and questions regarding the following provisions of the Proposed Rule:

- Removal of Employment Requirements for Services Furnished "Incident to" Rural Health Clinic and Federally Qualified Health Center Visits *(Page 28)*
- Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models *(Page 30)*
- Private Contracting Opt-Out *(Page 30)*
- Payment Policy for Substitute Physician Billing Arrangements *(Page 30)*
- Reports of Payments or Other Transfers of Value to Covered Recipients *(Page 32)*
- Physician Compare Website *(Page 33)*
- Physician Payment, Efficiency, and Quality Improvements—Physician Quality Reporting System *(Page 36)*
- Electronic Health Record Incentive Program *(Page 50)*
- Medicare Shared Savings Program *(Page 51)*
- Value-Based Payment Modifier and Physician Feedback Program *(Page 58)*

I. Resource-Based Practice Expense (PE) Relative Value Units (RVUs)

A. Practice Expense Relative Value Methodology

In 2010, CMS completed a transition to a "bottom-up" practice expense RVU methodology. According to the CMS PE formula in Table 4,[1] to obtain the direct PE RVU, the actual labor, supply, and equipment costs accepted by CMS are first multiplied by a direct budget neutrality adjustment resulting in adjusted labor, adjusted supplies, and adjusted equipment costs, which are then converted into RVUs by dividing them by the current conversion factor. The AMA/Specialty Society Relative Value System/RVS Update Committee (RUC) has repeatedly expressed concern that this method means that CMS is only paying a percentage of the actual PE direct costs to provide a service. CMS has responded that the purpose of the resource-based PE methodology is to develop RVUs within the overall Medicare Physician Payment Schedule budget neutrality requirements, and prefers to refer to the direct adjustment in their methodology as a scaling factor. The AMA echoes the RUC's concern, while acknowledging that the percent of direct PE costs covered has improved since 2010. In 2009, the direct costs covered were 62.5 percent and then dropped to 50.8 percent in 2010, under the new "bottom-up" PE RVU methodology. In 2011, that percentage dropped further to 50 percent, then in 2012 increased to 55 percent and increased again in 2013 to 60 percent before dropping to less than 55 percent in 2014. **Although the AMA is pleased that the percentage of direct costs covered by CMS has increased to a proposed 59 percent for 2015, we believe that CMS should revise its method to pay the actual direct PE costs to provide a service.**

B. Changes to Direct PE Inputs for Specific Services

The AMA greatly appreciates CMS' review and agreement with many of the RUC recommendations, including the specific RUC recommendations with respect to:

- Changes to monitoring time following moderate sedation;
- Adding a stretcher to the standard moderate sedation package;

[1] 79 Fed. Reg. 40,327.

- Adding supply items to the cleaning and disinfecting endoscope pack and the IV starter kit;
- A new standard supply package for contrast imaging; and
- Direct PE inputs for Stereotactic Radiosurgery (SRS) services.

We also strongly urge CMS to adopt the recommendations of the RUC regarding the following PE issues, as set forth in the Committee's separate comment letter on this Proposed Rule:

- PE inputs for the migration from film to digital technology;
- Inputs for digital mammography services;
- Updates to price for existing direct inputs;
- Inclusion of capnography for pediatric polysomnography services; and
- PE equipment item change and reaffirmation of RUC recommendations for CPT code 88375.

II. Using OPPS and ASC Rates in Developing PE RVUs

In the 2014 Physician Fee Schedule Final Rule, CMS withdrew its proposal to place a cap on non-facility (office-based) PE RVUs for 211 physician services at either Hospital Outpatient Prospective Payment System (OPPS) or Ambulatory Surgical Center (ASC) rates. In the 2015 Proposed Rule, CMS admits that the vast majority of comments it received urged withdrawal of the proposal. Nonetheless, CMS continues to express "serious concerns regarding the accuracy of some of the information we use in developing PE RVUs**."** [2] **The AMA remains adamantly opposed to capping physicians' services at OPPS or ASC rates, for the litany of reasons expressed in AMA and multi-specialty sign-on letters previously submitted to CMS.**[3] For example, the proposal would have: 1) cut payments for some services by 50 percent or more; 2) encouraged moving services to more costly facilities; 3) inconvenienced many patients; 4) failed to cover costly supplies, equipment, and/or clinical labor integral to many services; 5) employed ASC caps for services rarely performed there; and 6) ignored the fundamental difference between the service-specific, cost-based valuation of PE under the PFS and the averaging of a basket of items and services to arrive at the ambulatory payment classifications (APCs) for OPPS and ASC services. **Rather than resurrect this inherently flawed and misguided proposal (opposed by a majority of public commenters), we urge CMS to concentrate on supporting the good-faith efforts and substantial resources that specialty societies devote to developing accurate and complete PE data.**

In order to understand trends in hospital acquisitions of physician practices, CMS proposes to create a Healthcare Common Procedure Coding System (HCPCS) modifier to be reported with every code for physician and hospital services furnished in an off-campus provider-based department of a hospital. The

[2] 79 Fed. Reg. 40,332.
[3] AMA OPPS/ASC Comment Letter, September 6, 2013, https://download.ama-assn.org/resources/doc/washington/x-pub/medicare-hospital-outpatient-prospective-payment-system-ambulatory-surgical-centers-comment-letter-06sept2013.pdf;
AMA MPFS Comment Letter, September 6, 2013, https://download.ama-assn.org/resources/doc/washington/x-pub/2014-physician-fee-schedule-comment-letter-06sept2013.pdf; and
Sign-On Letter to CMS, August 29, 2013, https://download.ama-assn.org/resources/doc/washington/x-pub/outpatient-prospective-payment-system-sign-on-letter-29august2013.pdf.

modifier would be reported on both the CMS–1500 claim form for physicians' services and the UB–04 (CMS form 1450) for hospital outpatient claims.

We have serious concerns about the administrative burden that this proposal would impose on physician practices, and strongly urge CMS to rescind this proposal and instead engage with stakeholders to develop alternative methodologies for understanding trends in hospital acquisitions of physician practices. Requiring inclusion of a modifier for each code for services furnished in an off-campus provider-based hospital department would be a significant, unwarranted encumbrance on administrative workflow. There is not sufficient merit for CMS to impose this requirement simply to study hospital acquisitions of physician practices, a trend that is complex and unlikely to be fully understood by the collection of these data. The AMA would be happy to work with CMS as it evaluates physician practice trends. The AMA has conducted extensive research on this topic, which CMS may find helpful.[4]

III. Potentially Misvalued Services under the Physician Fee Schedule

A. Potentially Misvalued Services

The AMA appreciates the recognition from CMS that the RUC is a vital part of the agency's valuation process of Medicare services. Since the inception of the RUC Relativity Assessment Workgroup, the RUC and CMS have identified over 1,700 services through 15 different screening criteria for further review by the RUC. Most recently, the RUC has identified 010-day and 090-day global period services which appear as outliers with regard to the number of post-operative office visits included in the global period. The RUC will review and submit recommendations for these services for the 2016 Medicare Physician Payment Schedule. The RUC has also recommended reductions and deletions for 935 services, more than half of the services identified, leading to redistribution of more than $3 billion. The RUC will continue working with CMS in a concerted effort to address potentially misvalued services. A detailed report of this progress is appended to the RUC's separate comment letter.

At the September 2014 RUC meeting, the RUC Relativity Workgroup plans to review and discuss next steps for two groups of codes that were identified as potentially misvalued, by the public or by CMS. The public nominated three services as potentially misvalued, CPT codes 37250, 37251, and 41530, largely due to questions regarding the direct practice expense inputs. CMS identified six families of services for further examination of interim values or requiring specific review: Epidural Injection and Fluoroscopic Guidance, Neurostimulator Implantation, Mammography, Abdominal Aortic Aneurysm Ultrasound Screening, Prostate Biopsy Codes, and Obesity Behavioral Group Counseling.

CMS identified 64 high expenditure services as potentially misvalued. CPT codes 36475, 36478, 76700, 76770, 76775, and 93978 were recently reviewed and the RUC submitted recommendations for the CPT 2015 cycle. CPT codes 11750, 65855, 73560, 73562 and 73564 have been identified through other screens or are part of a family of an identified service and are scheduled to be reviewed. The RUC will submit recommendations for these five services for the CPT 2016 cycle. CPT codes 97032, 97035, 97110, 97112, 97113, 97116, 97140, 97530, and G0283 are all currently referred to the CPT Editorial

[4] Kane, C.K., Emmons, D.W. "New Data on Physician Practice Arrangements: Private Practice Remains Strong Despite Shifts Toward Hospital Employment." 2013, American Medical Association. https://download.ama-assn.org/resources/doc/health-policy/x-pub/prp-physician-practice-arrangements.pdf.

Panel as the entire Physical Medicine and Rehabilitation section is undergoing revision. The RUC Relativity Assessment Workgroup plans to discuss the remaining 44 identified services at the September 2014 RUC meeting to determine next steps.

CPT Code	**RUC Review Status**
11750	On Sept 2014 RUC agenda, to submit RUC recommendation for CPT 2016.
36475	RUC Recommendation Submitted for CPT 2015.
36478	RUC Recommendation Submitted for CPT 2015.
65855	Previously identified via 010-Day Global Post-Operative Visits and scheduled to be surveyed and reviewed at April 2015 RUC meeting. RUC recommendations to be submitted for CPT 2016.
73560	Surveying for September 2014 with other x-ray services. RUC recommendations to be submitted for CPT 2016.
73562	Surveying for September 2014 with other x-ray services. RUC recommendations to be submitted for CPT 2016.
73564	Surveying for September 2014 with other x-ray services. RUC recommendations to be submitted for CPT 2016.
76700	RUC Recommendation Submitted for CPT 2015.
76770	RUC Recommendation Submitted for CPT 2015.
76775	RUC Recommendation Submitted for CPT 2015.
93978	RUC Recommendation Submitted for CPT 2015.
97032	Referred to CPT Editorial Panel, part of revision to entire Physical Medicine and Rehabilitation CPT book section.
97035	Referred to CPT Editorial Panel, part of revision to entire Physical Medicine and Rehabilitation CPT book section.
97110	Referred to CPT Editorial Panel, part of revision to entire Physical Medicine and Rehabilitation CPT book section.
97112	Referred to CPT Editorial Panel, part of revision to entire Physical Medicine and Rehabilitation CPT book section.
97113	Referred to CPT Editorial Panel, part of revision to entire Physical Medicine and Rehabilitation CPT book section.
97116	Referred to CPT Editorial Panel, part of revision to entire Physical Medicine and Rehabilitation CPT book section.
97140	Referred to CPT Editorial Panel, part of revision to entire Physical Medicine and Rehabilitation CPT book section.
97530	Referred to CPT Editorial Panel, part of revision to entire Physical Medicine and Rehabilitation CPT book section.
G0283	Referred to CPT Editorial Panel, part of revision to entire Physical Medicine and Rehabilitation CPT book section.

B. Improving the Valuation & Coding of the Global Service Package

The AMA generally supports increasing the accuracy of physician payment and commends CMS for investigating methods to more accurately pay Medicare practitioners for the services they provide. However, we have serious concerns that the current proposal would not accurately account for physician work, practice expense, and malpractice risk for services performed within the current surgical global period. CMS proposes to transition all 010-day and 090-day global codes to 000-day global codes by 2017 and 2018, respectively. As support for this proposal, CMS references challenges it has experienced in obtaining available data to verify the number, level, and relative costs of post-operative visits included in global packages. CMS also expresses concern that 010-day and 090-day global packages may, in some cases, no longer accurately reflect the post-operative care provided to the typical patient. We highlight below several logistical hurdles and other major consequences, which CMS may have not yet fully taken into account. We recommend that CMS work jointly with the RUC Relativity Assessment Workgroup to collect and review existing, objective data in order to validate bundled post-operative visits. **Given the complications that may arise from these logistical difficulties, we believe that the proposed timeline is simply unrealistic.**

1. Unbundling Global Service Packages Would Require Separate Reporting (New Codes & Valuation) of Non-E/M Post-Operative Physician Work

Before finalizing any proposal, CMS should work with the RUC and the CPT Editorial Panel to ensure physicians are accurately paid for vital, routine patient care services that currently have no separate coding or reimbursement. In addition to hospital visits, office visits, critical care visits and discharge day management, there are many other post-operative care services that are also bundled into the 010-day and 090-day global packages. If CMS's proposal is implemented, these other physician services would also need to have their physician work, practice expense, and malpractice risk separately compensated—using either new or existing CPT/HCPCS codes. The Medicare Claims Processing Manual (Chapter 12, Section 40.1) provides several examples of services which are currently bundled into the global surgical package. If post-operative care is unbundled, examples of services that would need to be separately reported include:

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

2. Problems with Practice Expense

As CMS pointed out in the Proposed Rule, there is a different mix of post-operative direct practice expense (PE) inputs for global period Evaluation and Management (E/M) services and separately-reported E/M services. **These differences are warranted, and if unbundling does occur, CMS should still**

account for these additional direct PE inputs for the post-operative period of surgical procedures via new and/or existing CPT/HCPCS codes.

- In the Proposed Rule, CMS notes that the clinical labor time for separately-reportable E/M codes includes a staff blend listed as "RN/LPN/MTA" (L037D) priced at $0.37 per minute, whereas some codes with post-operative visits include the staff type "RN" (L051A) priced at a higher rate of $0.51 per minute. CMS' sole example is not representative and does not justify the inappropriate non-payment of thousands of direct PE supply inputs and hundreds of direct PE equipment inputs. The RUC conducted an analysis of the 3,329 facility-only 010-day and 090-day global codes, which took into account volume and only examined clinical labor minutes in the post-operative period. The post-operative clinical labor time for these codes was paid 61 percent of the time at $0.37 per minute (L037D), 36 percent of the time at $0.38 per minute (L038A), and only three percent of the time at $0.51 per minute (L051A).

- Another critical distinction is that E/M services performed in a surgical global period often include additional and justifiably more expensive supplies and equipment relative to standard, separately-billed E/M services. Addenda A and B to the RUC comments list direct PE inputs for supplies and equipment when facility-only services are performed.

- Certain surgical E/M services also include additional clinical staff time relative to the clinical staff time for separately-reported E/M visits. Examples include the additional clinical labor time required to care for stomas or for the setup and cleaning of scope equipment required at a post-operative visit. The post-operative clinical staff type and time are both carefully considered by the RUC, and are directly related to the typical patient condition and type of service performed for the specific CPT code that has been valued.

- CMS must also consider the effects of this proposal on the *indirect* practice expense payment, derived from the weighted average of the specialty mix that performs each service. Currently, the indirect PE related to the post-operative work for surgical services is correctly derived from the costs associated with the surgical specialties performing the service. Under the CMS proposal, this post-operative work would be inappropriately diluted due to the broad mix of specialties which perform separately reported E/M services. The main input for indirect PE in the PE RVU formula, indirect PE percentage, is higher for many of the surgical specialties relative than for the many separately-reported hospital and office visits. For example, the indirect PE percentage for CPT code 99213 is 75 percent, while the indirect PE percentage for Neurosurgery is 87 percent. The unbundling of post-operative E/M visits would thus result in a decline in indirect PE payment for many specialties which does not accurately reflect the actual indirect PE resources for post-operative services.

We fail to see how a potential discrepancy exists under the current resource-based Medicare Physician Payment System, which requires more expensive resources and additional clinical labor time to be paid at correspondingly higher amounts and rates. **CMS has a statutory obligation to reimburse services and procedures based on the actual resource costs expended. These direct and indirect PE inputs would need to be accounted for in any unbundled reporting system.**

3. Medicare Payment for PLI

The risk of potentially severe complications that may result during the post-operative period of a complex procedure will be substantially undervalued if there is a transition away from 010- day- and 090-day global periods. Another consequence of this proposal that needs to be addressed would be the large redistribution of the Professional Liability Insurance (PLI) payment from the primary providers of surgical procedures to a more diverse group of providers. The PLI RVU for each service is calculated by multiplying the work RVU by the specialty risk factor of the particular specialties which perform the service. Currently the work RVUs of the proxy E/M services contained in the global period for 010-day and 090-d

ay surgical codes are part of the PLI calculation. This is appropriate because the liability costs of a specific service should be derived from those of the performing specialties. However, under the CMS proposal, the liability costs associated with the post-operative work would be removed from the primary service and would be artificially diluted by the wide mix of specialties performing all types of E/M services. For instance, the liability associated with thoracic surgeons is significant, with a surgical risk factor of 7.27. Therefore, all the work RVUs associated with the physician's work in the post-operative period are assigned to this risk factor. CMS' proposal would reduce the work RVUs associated with the post-operative work, due to the wide range of provider specialties who perform E/M services, many with significantly lower risk factors (e.g., the Family Practice risk factor is 4.18, and the Internal Medicine risk factor is 2.07).

If CMS goes forward with its plan to unbundle surgical global periods, there should be a separate mechanism to account for this disparity. Without global periods, a one-size-fits-all approach to PLI will be unsustainable and result in great disparities between the actual and realized malpractice costs for many physician specialties.

4. Level of Office and Hospital Visits

Given the vast majority of 010-day and 090-day global codes have post-operative visits that are typically coded at relatively lower levels, CMS should take into account the upward shift in the level of post-operative E/M reporting that would likely occur when assessing both the viability and impact of this proposal. On average, the global surgical packages have much lower levels of office and hospital visits than separately-reported E/M visits. The median established office visit in a global surgical package is a 99212, whereas the median level for separately-reported visits is a 99213. Only one percent of all established patient office visits in 010-day and 090-day global surgery packages have a visit level above a 99213, whereas 43 percent of all separately-reported E/M visits are reported as a 99214 or 99215.

CPT Code	2013 Surgical Global E/M Utilization Percentage (010-day and 090-day)	2013 Separately Reported E/M Utilization Percentage
99211	0.39%	2.84%
99212	56.83%	7.70%
99213	41.52%	45.70%
99214	1.23%	39.58%
99215	0.03%	4.19%
TOTALS	100.00%	100.00%

The median hospital visit in a global surgical package is a 99231, whereas the median level for separately-reported hospital visit is a 99232. Fifty-seven percent of hospital visits in a global package have a hospital visit level of 99231, whereas only 12 percent of all separately-reported hospital visits are reported as a 99231.

CPT Code	2013 Global Surgical E/M Utilization Percentage	2013 Non-Global E/M Utilization Percentage
99231	57.25%	12.31%
99232	29.73%	56.89%
99233	9.99%	24.82%
99291	3.03%	5.98%
TOTALS	100.00%	100.00%

5. Administrative Burden

The separate submission, processing, and payment of post-operative E/M codes and other miscellaneous post-operative services and supplies would place an additional and substantial administrative burden on Medicare providers, Medicare Administrative Contractors (MACs), and CMS. Under the CMS proposal, there would be a significant increase in the total number of Medicare claims per year. These would include millions of separate claims for post-operative E/M services (62.7 million in 2013), as well as the many miscellaneous post-operative services and supplies which are currently bundled. Individual private payers would make their own decisions as to whether to retain the current 010-day and 090-day surgical global packages, or to adopt a transition at a later date. The resulting heterogeneous reporting mechanisms between payers would create additional administrative burden and confusion for all involved stakeholders, including patients. When conducting future cost-benefit analyses, CMS should not only factor in the necessary budget neutrality implications of this

proposal, but also the additional administrative burdens for all stakeholders and the additional expense for CMS to pay A/B Medicare MACs for processing the large amount of additional claims.

6. Impact on CMS Multiple Surgery, Bilateral Surgery, Co-Surgeons Reduction Policies

If the proposal is implemented, all CMS payment reduction policies that impact 010-day and 090-day global codes would need to be analyzed in detail and the reduction percentages would need to be lowered by a substantial amount. CMS has several payment reduction policies that impact 010-day and 090-day global procedures. These include the multiple surgeries reduction, bilateral payment reduction, co-surgeons and team surgeon payment reductions, and the assistant-at-surgery reduction. These reductions are largely based upon, and justified by, the redundancy of bundled post-operative E/M visits between multiple services, or when multiple surgeons are performing the same surgery.

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

7. Current RUC Review of 010-Day and 090-Day Global Period Services

The RUC is currently engaged in reviewing 010-day and 090-day global period services through two different screens identified by the Relativity Assessment Workgroup. In January 2014, the RUC separately reviewed all 010-day and 090-day global codes to search for potentially misvalued codes. When screening codes with higher than 1,000 Medicare utilization, the RUC Relativity Assessment Workgroup identified 19 services with 010-day global periods that had more than 1.5 office visits, and 10 services with 090-day global periods that had more than six office visits. The RUC expanded the services identified in the 090-day global screen to 18 to also incorporate codes from the same code families.

The RUC submitted recommendations for two 010-day services for the 2015 Medicare Physician Payment Schedule and reaffirmed the post-operative visits for five others. The RUC also submitted recommendations for one 090-day service for the 2015 Medicare Physician Payment Schedule, reaffirmed the post-operative visits for one other, and referred two more to CPT for deletion. The RUC will submit recommendations to CMS for the remaining 12 services with 010-day global periods, and 14 services with 090-day global periods, for the 2016 Medicare Physician Payment Schedule.

8. Data Collection and Post-Operative Period Validation

The AMA agrees with the RUC and CMS that it is crucial to collect data on post-operative visits furnished by the practitioners reporting current 010-day and 090-day global codes. The RUC strongly recommends that CMS collect and examine existing post-operative visit data in order to validate current surgical bundles and to facilitate informed decision-making on how to proceed with current and future proposals. One potential method for data capture would be to collect and examine large group practice data for CPT code 99024 *Post-operative follow-up visit, normally included in the surgical package, to indicate that an evaluation and management service was performed during a post-operative period for a reason(s) related to the original procedure* on all post-operative follow-up visits. This service is currently status "B" (bundled) in the Medicare physician payment schedule and is therefore not paid.

The RUC has identified several large hospital-based physician group practices that internally use CPT code 99024 to report each bundled post-operative visit, and therefore data is already being captured for many Medicare providers. CMS may also have denied-claims data available for CPT code 99024 via the Medicare claims processing system. We recommend that CMS work with the RUC to explore the availability, usefulness, and appropriateness of the group practice data and the CMS denied-claims dataset in validating the number of post-operative visits. The RUC and CMS should work in concert to gather existing, objective data in order to validate the actual number of post-operative visits for 010-day and 090-day procedures.

Current capabilities and data allow for alternatives to achieve CMS' goals via less onerous means. CMS could review current Medicare Part A claims data in order to determine the length of stay of surgical services performed in the hospital facility setting. Matching the average length of stay with the post-operative visits in the physician time file would give CMS and other stakeholders the opportunity to identify anomalies within the data set that could be reviewed further. The RUC Relativity Assessment Workgroup, working with CMS, could review the post-operative visit and length of stay data for outliers.

This suggested approach is advantageous for several reasons. It would build upon, rather than completely undo, the enormous amount of work and resources that went into the proper valuation of surgical services in a bundled global period, since the inception of the Resource-Based Relative Value System. Maintaining the current global period structure would avoid the myriad of unintended consequences likely to follow its dissolution. This approach also provides objective data across a large sample to determine if a service is currently valued with anomalous visit data. This allows for only the targeted review of services with anomalous data, not a blanket review of all services, with varying degrees of Medicare volume and physician work.

Gathering objective data on the number of post-operative visits and the length of stay would give the RUC and CMS useful mechanisms to better determine appropriate levels of post-operative visits. Using the data would allow the RUC and CMS to accurately and efficiently prioritize and identify anomalies that most impact the Medicare Physician payment schedule.

9. Proposed Timeline Unachievable Without Inappropriate Shortcuts

The proposed timeline to transition codes from 010-day and 090-day global periods to 000-day global periods is not achievable unless several inappropriate shortcuts are taken. Any systemic transition of values would be seriously flawed and would result in payment that would no longer be resource-based or appropriately relative. There is no solution to systematically, accurately, and efficiently transition codes from 010-day and 090-day global periods to 000-day global periods.

Since its inception, the RUC has worked under the prevailing assumption that magnitude estimation is the standard for valuation of all physician services, including those with global surgical packages. Consequently, the work values associated with E/M services in a code's global period are not necessarily added to the physician work value to determine the final work RVU. These services are proxies representing a physician's typical case. Therefore, even if accurate claims data were available for post-operative E/M visits, simply using a reverse building block methodology to systematically convert all 010-day and 090-day global codes to 000-day global codes by backing out the bundled E/M services would be highly inappropriate. To preserve appropriate relativity, these codes would need to be transitioned to a 000-day global period on a code-by-code basis, taking into consideration all the issues discussed above regarding practice expense and liability insurance.

CMS emphasizes that the RUC recommendations are an essential element that it considers when valuing a code. Yet CMS must allow sufficient time for the RUC review process if unbundling were to take place. If the proposal is finalized without modification in the CY 2015 Final Rule, the RUC would only have four meetings prior to implementation of the CY 2017 proposed conversion of the 473 010-day global surgical codes and only three meetings after that for the CY 2018 proposed conversion of 3,773 090-day global surgical codes. It would be virtually impossible to review that many codes over that short of a time frame.

If CMS proceeds with implementing some version of this proposal, the RUC highly recommends a staggered rollout over the span of several years to provide the necessary time for the full RUC review process and the creation of the many new CPT codes that would be needed to cover unbundled miscellaneous post-operative services. A staggered rollout would also give CMS sufficient time to decide and vet the accurate resource costs for over 4,200 codes.

10. Scope of the Proposal

We would like to clarify that there are over 4,200 services on the Medicare Physician Payment Schedule with a 010-day or 090-day global period, not 3,000 as the Proposed Rule had incorrectly stated. Therefore, the scope of this proposal is actually larger than it appears in the Proposed Rule, and would likely take substantially more effort to implement than was anticipated. Yet its impact, in terms of potential cost savings, is questionable. Only 268 of these services, or six percent, were performed more than 10,000 times accordingly to 2013 Medicare claims data. We would also like to point out that:

- Only nine percent of all 010-day global codes have more than one post-operative office visit;
- 85 percent of all established patient office visits in 010-day surgical packages are a relatively low level office visit, 99212;

- Only four percent of all 090-day global codes have more than five post-operative office visits; and
- 98 percent of all established patient office visits in 090-day surgical packages are a 99213 or lower.

11. Adverse Impact on Patient Access and Compliance Issues

We have serious concerns regarding the impact the current proposal would have on patient compliance and access to care. Unbundling post-operative E/M services would result in patients having to pay co-payments separately for each visit, instead of upfront as a single bundled payment. Medicare beneficiaries are often on a tight fixed income. An additional co-payment per visit would incentivize many patients to consider not showing up for follow-up visits in order to save money. In spreading these payments out, the physician's ability to properly manage their patients' status would be seriously mitigated due to the potential for the patient not to return for post-operative services.

Most private insurers would follow CMS' lead and unbundle global periods. Some of these private payers do not charge a co-payment for surgery, but would likely require co-payments for separately-reported office visits. Patients covered by certain private payers would have to pay more out of pocket, adversely impacting them financially. This proposal has the potential to disproportionally impact chronically ill and low-income patients who will have the highest amount of return visits and therefore the most co-pays.

There is also a valid concern that the CMS proposal may itself pose an obstacle for some Medicare beneficiaries and other patients to obtain post-operative visits. Currently, some surgeons and facilities have an open-door policy, allowing patients to come in for post-operative visits on particular days at their convenience, without requiring the beneficiary to make a formal appointment through the often burdensome and overloaded appointment system. CMS' proposal would end that informal option, increasing the burden for patients to make and obtain formal appointments, and potentially decreasing the availability and convenience of appointments for follow-up visits.

Given the unintended consequences and logistical challenges of the CMS proposal highlighted above, the AMA has severe reservations that the perceived benefits outweigh the time, expense, and risk necessary to properly implement this proposal. Thanks in large part to the shift from a five-year review for potentially misvalued codes to an annual rolling review by CMS and the RUC Relativity Assessment Workgroup, the AMA and the RUC are confident that the vast majority of 010-day and 090-day global period services include few post-operative visit outliers. Eliminating the surgical global period is an inefficient, overly broad policy that is unlikely to accomplish the agency's limited, focused concerns. The RUC has worked in partnership with CMS, at a grueling pace over the last several years, to ensure that the vast majority of services are accurately valued, based upon their typical resource costs. CMS' concerns would be better addressed by working jointly with the RUC Relativity Assessment Workgroup to gather and examine existing data, validate post-operative visits, and identify anomalies.

C. Valuing Services That Include Moderate Sedation as an Inherent Part of Furnishing the Procedure

CMS is proposing to add separate codes for moderate sedation and then review the codes currently listed in Appendix G of the CPT book. Currently, CMS assumes that "to the extent moderate sedation is typically furnished as part of the diagnostic or therapeutic service, the inclusion of moderate sedation in the valuation of the procedure is appropriate." However, CMS notes that practice patterns for endoscopic procedures are changing, and anesthesia is increasingly being separately reported for these services. Additionally, CMS reports that data clearly indicate that moderate sedation is no longer typical for all of the procedures listed in Appendix G. Therefore, CMS will no longer assume that moderate sedation is inherent in these codes.

The AMA supports the intention of CMS to establish a uniform approach for valuing Appendix G services for which moderate sedation is no longer inherent. We also agree that it is important to value moderate sedation accurately so that duplicate payments will not occur. In anticipation of developing a more consistent approach to valuation of these services, the RUC in conjunction with the CPT Editorial Panel established the Joint CPT/RUC Moderate Sedation Workgroup. This Workgroup has already started work on this issue and will now focus on the "blueprint" set forth by CMS in the Proposed Rule. The Workgroup will develop separate codes to describe moderate sedation for consideration by the CPT Editorial Panel. Finally, the AMA appreciates that CMS will not change existing policies associated with valuing moderate sedation as inherent in the procedures listed in Appendix G, until there is an opportunity to consider overall valuation of these codes.

IV. Professional Liability Insurance Relative Value Units

CMS has again proposed improvements under its statutory obligations for the Five-Year Review of the Professional Liability Insurance (PLI) RVUs. We are pleased with several of the proposals introduced in this review cycle, but remain concerned over those that maintain the current, flawed status quo.

A. Annual Review of PLI RVUs

Over the past several years, CMS has made concerted efforts to ensure that services are accurately paid on the Medicare Resource-Based Relative Value System (RBRVS). Removing the five-year review of potentially misvalued services has streamlined the review process and provided stakeholders an opportunity to provide comments to CMS in a timely fashion, on services that may be misvalued. In addition, practice expense inputs are updated frequently, with direct PE inputs updated within the RUC recommendations for specific services, and indirect inputs updated each year based on shifting PE percentages for each physician specialty. Given that CMS has modernized its process for updating these two components to reflect the most accurate information available, it seems logical that the third component of physician payment, PLI, should also be updated annually. Instituting a yearly collection of PLI premium data would provide two clear advantages. First, it would base PLI RVUs on the most current PLI premium data available, increasing the reliability and accuracy of PLI payments. Second, it would provide additional transparency for stakeholder comments. Under the current five-year review process, stakeholders have only one opportunity every five years to identify potential problems and/or improvements to a service's PLI RVU. If problems are not addressed in the final rule, then they must wait five years. An annual review would eliminate this problem and allow PLI RVUs to be treated

identically to physician work and PE RVUs. **The AMA supports the RUC's recommendation that CMS implement an annual collection and review of PLI premium data.**

B. Dominant Specialty for Low Volume Codes

We are pleased that CMS is again proposing to use the risk factor of the dominant performing specialty for each procedure which is performed less than 100 times based on 2013 Medicare claims data. We agree that the current methodology works for most codes, since using a weighted average of the specialty mix for such low volume services would often inappropriately lower the risk factor due to a few instances per year reported by a non-dominant specialty. While this approach works in most cases, the RUC remains concerned about this method since it does not adequately cover the PLI premium costs for a subset of low volume services. In the Medicare claims data for any given year, some services have low enough volume that the dominant provider does not accurately reflect the associated PLI premiums and risk involved. While these services are low volume, it is important that within an RBRVS construct, services should reasonably reflect the typical costs associated with performing them. Many third-party payers use the Medicare Physician Payment Schedule as the basis for their own payment schedules. Therefore, many of these low volume Medicare services realize undue year-to-year volatility in payment due to inconsistent reporting on Medicare claims. Here is an example of the impact of having an inappropriate dominant specialty listed:

	Specialty in Medicare Utilization	Work	PE	PLI
61575	Neurosurgery	36.56	22.55	14.74
61576	Otolaryngology	55.31	35.54	7.64

In this case, the RUC has previously recommended that CPT code 61576 should have the PLI risk factor of neurosurgery rather than otolaryngology. The comparison to a similar code in the same family, 61575, with less work RVUs, is stark.

The AMA shares the RUC's concern about existing codes with no Medicare volume reported for any given year. According to the contractor report, CPT codes lacking utilization received a crosswalk created by CMS that assigns the same risk factor to codes with a similar specialty mix. In contrast, an existing service receives the average risk factor for all physician specialties. The crosswalks are clear when related to new CPT codes reviewed by the RUC, as the RUC provides, and CMS uses, specified crosswalks for each code which are reviewed to ensure the providing specialties are analogous. However, it is inappropriate for a service to have fluctuating PLI risk factors simply due to whether it is reported in Medicare claims data for a given year. According to 2013 Medicare claims data, there are 120 codes which have inaccurate PLI risk and premium data due to the effects of applying the average risk factor for all physician specialties.

To stem this volatility and provide PLI RVUs that more accurately reflect the actual premiums paid and inherent risks involved in low volume services, the RUC reached out to specialty societies and obtained recommendations for a list of 1,911 codes where volume is less than 100 claims per year. Of these 1,911 codes, 511 codes include an inappropriate dominant specialty—in terms of PLI—or had no utilization listed in the 2013 Medicare claims data. The AMA supports the RUC recommendation to use an alternative specialty for these codes, as detailed in the list attached to the RUC comment letter. **We implore CMS to reconsider the RUC's list of appropriate PLI crosswalks for use in the PLI risk**

factor calculations for these low volume services. In addition, we request that CMS publish the list of specialty crosswalk for all codes with no Medicare utilization, not just new codes.

C. Non-MD Risk Factor / Premium Crosswalk

CMS has again chosen to crosswalk the PLI premiums of non-MD specialties to the lowest MD risk factor, Allergy Immunology (risk factor = 1, non-surgical premium rate = $8,198). Per the *Draft Report on the CY 2015 Updated of the PLI RVUs for Medicare Payment*, we appreciate the difficulty the CMS contractor had in obtaining comprehensive, accurate premium data across the large majority of states. In these circumstances, for similar physician specialties, it is reasonable to assume that crosswalking a more robust premium rate data set to a less robust set is appropriate. However, in many cases, crosswalking non-MD specialties to even the lowest MD specialty would overstate the PLI premiums and risks associated with these non-physician services. The RUC has reviewed data on non-physician specialties that participate in the RUC Health Care Professionals Advisory Committee (HCPAC) and has previously submitted these premium rates to CMS. These data were collected through the AMA Physician Practice Information (PPI) survey process. While these premium rates reflect 2006 payments and do not represent every non-physician specialty, these data still provide a reasonable comparison to suggest that a direct crosswalk to Allergy Immunology, with a rate of $8,198, is simply unrealistic.

Specialty Code	Specialty Name	Risk Factor	Non-surgical Normalized Premium Rate	PPI 2006 PLI Premium Rate	Proposed- Risk Factors Assigned Via Crosswalk:
64	Audiology	1	$8,198	$1,506	Reclassified to Allergy Immunology
35	Chiropractic	1	$8,198	$4,742	Reclassified to Allergy Immunology
68	Clinical Psychologist	1	$8,198	$1,466	Reclassified to Allergy Immunology
80	Clinical Social Worker	1	$8,198	$1,115	Reclassified to Allergy Immunology
67	Occupational Therapist	1	$8,198	$1,821	Reclassified to Allergy Immunology
41	Optometry	1	$8,198	$8,109	Reclassified to Allergy Immunology
65	Physical Therapist	1	$8,198	$1,821	Reclassified to Allergy Immunology
62	Psychologist	1	$8,198	$1,466	Reclassified to Allergy Immunology

The RUC also strongly opposes this crosswalk methodology because the use of Allergy Immunology as the comparator is simply illogical. This specialty was not chosen due to its close association with PLI

premium costs to non-physician services, but instead because it represents the lowest premium rates for a specialty in which adequate data, as defined by the contractor, were collected. **The AMA requests that CMS use the PPI survey data provided above, or some other measure of central tendency within the existing collected premium data, to determine accurate PLI premium rates for non-physician specialties.**

D. Proposed Crosswalks

For the CY 2015 PLI update, CMS has chosen to crosswalk the Gynecological/Oncology specialty to Obstetrics Gynecology. Over the past several updates, the RUC has consistently recommended, and CMS has agreed, that Gynecological/Oncology should be directly crosswalked to General Surgery. If this is finalized, the resulting PLI risk factor would see a large decrease from the current (5.91 currently to 3.80). The PLI risk for procedures provided under Gynecological/Oncology is more akin to General Surgery procedures rather than non-surgical OBGYN procedures. **We recommend that CMS again crosswalk Gynecological/Oncology to General Surgery.**

We are pleased with the CMS decision to partially blend the surgical risk factors for Neurology and Neurosurgery, and agree that it would not be appropriate to simply crosswalk Neurosurgery directly to Neurology due to the incompatibility of the two specialties' rate filing premium data. Therefore, the blended approach, as proposed by CMS, offers the most reasonable approach to adequately account for the PLI premiums and risk associated with surgical services performed by these two specialties.

E. Cardiac Catheterization and Angioplasty Exception

We are pleased that CMS proposes to classify cardiac catheterization and angioplasty services as surgical procedures for the purpose of establishing PLI premium rates and risk factors. The RUC also agrees with the CMS decision to include the injection procedures used in conjunction with these services. The AMA discussed the appropriateness of the codes on the exclusion list with relevant stakeholders, and concurred with the other stakeholders that there are several additional codes in the family that have PLI premiums and risks that should instead be classified as surgical rather than non-surgical services.

CPT Code	Long Descriptor
92961	Cardioversion, elective, electrical conversion of arrhythmia; internal (separate procedure)
92986	Percutaneous balloon valvuloplasty; aortic valve
92987	Percutaneous balloon valvuloplasty; mitral valve
92990	Percutaneous balloon valvuloplasty; pulmonary valve
92992	Atrial septectomy or septostomy; transvenous method, balloon (e.g., Rashkind type) (includes cardiac catheterization)
92993	Atrial septectomy or septostomy; blade method (Park septostomy) (includes cardiac catheterization)
92997	Percutaneous transluminal pulmonary artery balloon angioplasty; single vessel
92998	Percutaneous transluminal pulmonary artery balloon angioplasty; each additional vessel (List separately in addition to code for primary procedure)

The AMA supports the RUC recommendation that CMS consider adding the above list of services to the list of invasive cardiology procedures classified in the "Surgery" risk factor category.

V. Medicare Telehealth Services

CMS has proposed further expansion of covered telemedicine services. The AMA is generally supportive of the agency's proposed inclusion of the following services via telemedicine: psychotherapy services (CPT codes 90845-7); prolonged services (CPT codes 99354-5); and annual wellness visit (HCPCS G0438-9). The AMA has consistently supported Medicare's proposals to expand access to a telemedicine option for Medicare covered services including last year's proposal to broaden the definition of "originating sites" to include more geographic locations. The AMA would welcome the opportunity to collaborate with CMS and other major stakeholders to identify strategies to increase access to telemedicine services while ensuring quality and standards of care consistent with newly adopted AMA policy.

In June of this year, the AMA's House of Delegates adopted a report entitled, "Coverage and Payment for Telemedicine," which contains the most comprehensive and expansive AMA policy statements on telemedicine to date. The report was the culmination of discussions and deliberations by a diverse cross-section of practicing physicians. As part of a comprehensive top to bottom initial review of the various telemedicine issues considered prior to the preparation of the report, leading telemedicine innovators provided expert guidance, early-adopter physicians provided recommendations concerning the benefits, risks, and best practices, and a number of environmental scans were completed.

Consistent with current Medicare practice and regulation, the AMA supports physicians and other health practitioners delivering telemedicine services abiding by state licensure laws and state medical practice laws and requirements in the state in which the patient receives services. The AMA advocates that physicians delivering telemedicine services must be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by that state's medical board.

AMA policy outlines the conditions and factors applicable to establishing a valid physician-patient relationship. In addition, the AMA urges CMS to consider other factors that should apply to telemedicine services. For example, the AMA urges CMS to prioritize coverage of telemedicine services that include care coordination with the patient's medical home and/or existing treating physicians. This includes at a minimum identifying the patient's existing medical home and treating physician(s) and providing to the latter a copy of the medical record. AMA policy also provides that:

- Telemedicine services must be delivered in a transparent manner, to include but not be limited to, the identification of the patient and physician in advance of the delivery of the service, as well as patient cost-sharing responsibilities and any limitations in drugs that can be prescribed via telemedicine;
- Patients seeking care delivered via telemedicine must have a choice of provider, as required for all medical services;
- Patients receiving telemedicine services must have access to the licensure and board certification qualifications of the health care practitioners who are providing the care in advance of their visit;
- The patient's medical history must be collected as part of the provision of any telemedicine service;

- The provision of telemedicine services must be properly documented and should include providing a visit summary to the patient;
- Telemedicine services must abide by laws addressing the privacy and security of patients' medical information;
- The standards and scope of telemedicine services should be consistent with related in-person services; and
- The delivery of telemedicine services must follow evidence-based practice guidelines, to the degree they are available, to ensure patient safety, quality of care and positive health outcomes.

The AMA strongly supports the agency's effort to increase the evidence base. To that end, the AMA supports Medicare expanding pilot programs to enable coverage of telemedicine services, including, but not limited to, store-and-forward telemedicine as well as demonstration projects under the auspices of the Center for Medicare and Medicaid Innovation (CMMI) to address how telemedicine can be integrated into new payment and delivery models. As adoption of new telecommunication technologies increases, the AMA continues to carefully consider and evaluate the impact on patient clinical care and welcomes the opportunity to work with CMS.

VI. Valuing New, Revised and Potentially Misvalued Codes

A. Initiation Year

The AMA agrees that the timeline for reviewing potentially misvalued codes should be better aligned with the regulatory process, as we expressed many times in conversations and correspondence with CMS over the past year. However, we strongly urge CMS to begin implementing the new timeline and procedures for the CPT 2017 cycle and the 2017 Medicare Physician Payment Schedule. In an effort to respond promptly to the call for greater transparency in the valuation process, CMS proposes to shift the consideration of all new, revised, and potentially misvalued services to the Proposed Rule (rather than an Interim Final Rule) for implementation in the 2016 Medicare Physician Payment Schedule. Unfortunately, the 2016 implementation date is premature, as it would have a serious impact on the development of new technology and new code bundles which is already underway for the CPT 2016 code set. The cycle for the CPT 2016 code set began with code change applications for the May 2014 CPT Editorial Panel Meeting submitted by February 14, 2014, and will conclude on February 7, 2015. We believe that it would be highly inappropriate for CMS to implement this proposal in the November 1, 2014 Final Rule because the CPT Editorial Panel process for the 2016 cycle will already be nearly complete by that date. Requiring publication in a proposed rule next summer will delay their implementation in Medicare by another year. Those that have solicited new and/or revised CPT codes deserve timely consideration of their applications. They also deserve fair notice of the implementation date. If CMS were to announce a 2017 implementation date on November 1, 2014, it would provide appropriate notification to those submitting code change applications by the first CPT 2017 deadline of February 13, 2015.

B. CPT/RUC Timeline

We strongly urge CMS to adopt the AMA proposal for modifications in CPT/RUC workflow to accommodate publication in the Proposed Rule, while ensuring that new technology may be described and valued in an efficient and timely manner. The AMA proposal would eliminate the

need for CMS to create G codes, which essentially duplicate the CPT codes. We believe that the G code proposal is entirely unworkable and should not be considered in finalizing the new process.

The CPT Editorial Panel and the RUC each meet three times per year. Historically, the May CPT/October RUC meetings have been the first meetings of each coding cycle, followed by the October CPT/January RUC meetings, and finally the February CPT/April RUC meetings. Following the last set of meetings, the CPT code set is finalized for the next calendar year, and the RUC submits recommendations to CMS for consideration and implementation. The RUC submits all recommendations no later than May 31 each year for consideration for the next payment schedule. As stated earlier, a CPT code originates with a code change application and the first applications of each cycle are due in February, followed by application deadlines in July and November. The current time required to generate a code/relative value ranges from 14 to 22 months from the time of application.

In order to accommodate the publication of proposed valuation of new, revised, and potentially misvalued services, CMS proposes to require that all RUC recommendations be submitted by January 15 of each year. For 2016, this would mean that the May 2014 CPT/September RUC meeting would be the only opportunity for the medical community to offer description and recommended valuation of new technology and code bundles, since the RUC will not have the opportunity to consider codes from the October CPT Editorial Panel meeting until January 29, 2015. This is not just a matter of convenience or reluctance to reschedule a meeting, but rather it is due to the significant amount of survey work and data analyses that must be conducted prior to the RUC meeting—work that cannot begin until the code changes have been finalized.

In addition, this proposal would extend the time required to generate a code/relative value to 22 to 30 months for each subsequent CPT code set cycle at a time when CMS, the CPT Editorial Panel and the RUC are being asked to reduce the amount of time needed to accommodate changes.

The AMA offered a detailed and reasonable proposal to expedite the review processes for new, revised, and potentially misvalued services.[5] This proposal would retain the current meeting infrastructure for both CPT and the RUC, while shifting the workflow to accommodate the review of commonly performed services to the May CPT/October RUC and October CPT/January RUC meetings. This would allow recommendations for the most significant fee schedule changes to be reviewed, modified, and published by CMS in the proposed rule the following year. Under this proposal, the February CPT meeting would predominantly address editorial changes, clinical lab payment schedule services, and new technology services, with expected low volume. The April RUC meeting would replace the formerly lighter September RUC meeting agenda and would be utilized to review the low volume new technology services and discuss methodological and process issues. We believe that CMS should be able to publish consideration of the low volume new technology codes in the Final Rule as interim values, as these changes would have minimal impact on the other services on the Medicare Physician Payment Schedule. The AMA proposes to submit RUC recommendations to CMS within one month of each meeting (each

[5]This proposal was initially discussed in the AMA letter to CMS dated June 3, 2014, and more recently in a joint letter to CMS dated August 12, 2014, on behalf of the AMA and 70 medical specialty societies representing physicians and non-physicians. The June 3, 2014 letter and related CPT-RUC schedule and timeline were enclosed as attachments to the RUC's August 22, 2014 comment letter on this Proposed Rule. The August 12, 2014 letter was submitted as a separate comment on this Proposed Rule, and is available online at: https://download.ama-assn.org/resources/doc/washington/x-pub/medicare-program-sign-on-letter-13aug2014.pdf.

November and February for new, revised, and potentially misvalued; and each May for low volume new technology).

The creation and adoption of temporary G codes would unnecessarily add to the administrative burden of physicians, non-physician practitioners, and providers who would be tasked with having to learn and implement new codes to be replaced within a relatively short period. When this applies to large families of codes, the burden is even greater, as is the risk for coding errors. Moreover, this threatens to create a situation of parallel but distinct coding between Medicare and private payers, as private payers are likely to implement new CPT codes as soon as they are published.

C. Refinement Process/Appeals Process

We recommend that CMS consider these issues and create a fair, objective, and consistently applied appeals process that would be open to any commenting organization. CMS proposes to eliminate the Refinement Panel process currently utilized by the agency to consider comments on interim relative values. For nearly two decades, the CMS Refinement Panel Process was considered by stakeholders to be an appeals process. The Refinement Panel was organized and composed by CMS and consisted of members from the primary care organizations, contractor medical directors, a specialty related to the commenter, and the commenting specialty. For many years, CMS deferred to the vote conducted by the Refinement Panel in finalizing values. Most often, the Refinement Panel would support the original RUC recommendations. CMS states that the Refinement Panel was not convened for the former Five-Year Review processes, as this process always involved proposed rulemaking. However, this is not accurate. CMS even convened multi-day face-to-face Refinement Panel meetings during the first two Five-Year Review processes.

Most recently, CMS modified the process to only consider codes for which new clinical information was provided in the comment letter. CMS also began to independently review each of the Refinement Panel decisions in determining which values to actually finalize. In many cases, the Refinement Panel supported the original RUC recommendation and the commenter's request, yet CMS chose instead to implement their original proposed value. The complete elimination of the Refinement Panel indicates that CMS will no longer seek the independent advice of contractor medical officers and practicing physicians and will solely rely on agency staff to determine if the comment is persuasive in modifying a proposed value. The lack of any perceived organized appeal process will likely lead to a fragmented lobbying effort, rather than an objective review process. Those organizations with limited resources are disadvantaged in comparison to those vendors or organizations that will spend significant resources to overturn a CMS proposed value. This runs contrary to the sort of transparency that CMS says it is trying to achieve through the revised regulatory procedure.

VII. Chronic Care Management (CCM)

The AMA supports payment for chronic care management (CCM) services. The RUC has worked with the CPT Editorial Panel and the CPT/RUC Complex Chronic Care Workgroup ("C3W") to describe and estimate resource costs associated with these important non face-to-face services. The C3W has advocated for separate payment for other non face-to-face services that are critical components of care management, including team conferences, patient education, telephone calls, and anticoagulant management. In 2013, CMS implemented payment for transitional care management services (TCM)

based on the work of CPT and the RUC. In 2015, CMS will begin payment for CCM services for patients with two or more complex chronic conditions that are expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. We appreciate the CMS decision to pay for TCM and CCM services and urge CMS to continue consideration of payment for other non face-to-face services.

In the Proposed Rule, CMS discusses nomenclature for a G code originally proposed in July 2013. **The CPT Editorial Panel has created a new code 99490X for 2015 intended to address the CMS proposal, and we urge that CMS use this new CPT code, rather than the G code.** The CPT code does describe the service "per calendar month," rather than the G code description of "per 30 days." The CPT Editorial Panel agreed with the recommendations of specialty societies who perform these services that the "calendar month" verbiage will be easier to implement than the "30 day" timeframe. Given the variance in the number of days per month and the unique start date of services for each patient, keeping track of the constantly shifting 30-day timeframe unique to each individual patient would be a tremendous (and unnecessary) burden. Consequently, we strongly urge CMS to recognize this improvement in their recognition of the new CPT code 99490X.

The RUC reviewed survey data from 338 respondents in April 2014, and these data were presented to CMS in late May. The RUC recommendation of 1.00 is based on a median physician time of 30 minutes (the 25th percentile was 20 minutes). We understand that CMS may not have yet had the opportunity to consider the RUC recommendations as the Proposed Rule was drafted prior to the submission of the RUC recommendations. CMS should now consider these survey data and the RUC recommendations to finalize physician work for 2015. Additionally, the RUC recommended that typically 60 minutes of an RN's time would be expended each month for these complex patients. CMS proposed 20 minutes of clinical labor time. We urge CMS to adopt the RUC clinical staff recommendations. **In addition to implementing the RUC recommendations for 99490X, CMS should also continue to publish, and ideally pay and recognize, the RUC recommended relative values and direct practice expenses for CPT codes 99487 and 99489, *Complex chronic care coordination services*.**

VIII. Definition of Colorectal Cancer Screening Tests

As a response to recent articles in the *Journal of the American Medical Association* and *Gastrointestinal Endoscopy* on the growing practice of anesthesia professionals participating in screening colonoscopies provided to detect colorectal cancer, CMS proposes to waive the deductible and copayment for anesthesia services furnished with screening colonoscopy. Previously, the Medicare screening colonoscopy services included moderate sedation, but if an anesthesiologist was involved then the patient would have been charged cost-sharing for the anesthesia service even though there is no cost-sharing for the screening colonoscopy itself. The Affordable Care Act (ACA) provided for patient cost-sharing for Medicare preventive services to be waived, with the Medicare program paying 100 percent of the Medicare payment schedule amount. As the use of separate anesthesia services is becoming more common than moderate sedation provided intravenously by the gastroenterologist, the anesthesia service will now be included in the definition of the Medicare preventive service and the cost-sharing will be waived.

Colorectal cancer—cancer of the large intestine or rectum—is the second leading cause of cancer deaths and the third most common cancer in men and women in the United States. While it is almost totally preventable through the use of recommended screening tests, thousands of people in the United States die

each year from this cancer. While Medicare pays for several types of colorectal screening tests, including colonoscopy, less than two-thirds of people age 65 and older had this screening in 2008. Colonoscopy, which allows for the removal of polyps and lesions during the procedure that could later turn into deadly cancers, is considered to be the best test for early detection and prevention of colorectal cancer.

The AMA supports the CMS proposal to waive cost-sharing for anesthesia services furnished in conjunction with screening colonoscopy. Nonetheless, we remain concerned that other barriers to greater use of the colorectal cancer screening benefit are not addressed in the current proposal. Specifically, when a polyp or abnormal growth is removed during the colonoscopy, or when a biopsy is done of suspicious-looking tissue, the Medicare Part B deductible is waived but patients are billed co-insurance of 20 percent of the cost of the procedure. This situation has led to a great deal of patient confusion and consternation, because patients think they are going in for a "free" screening colonoscopy and then are shocked to later receive a bill for a portion of the costs. In contrast, under regulations issued to implement the ACA provisions on preventive screenings covered by private insurance plans, polyp removal and tissue biopsy are considered to be an integral part of a colonoscopy and therefore patients incur no cost-sharing. Medicare coverage of colonoscopies should be defined in the same fashion, which would remove a significant cost barrier discouraging Medicare patients from undergoing preventive colorectal cancer screenings.

We also urge CMS to give careful consideration to comments on this proposal submitted by the specialty societies representing those who furnish these services.

IX. Payment of Secondary Interpretation of Images

The AMA advocates for fair payment of the secondary interpretation of images, to support the efficient use of resources and patient safety. CMS is required by statute to pay physicians and other health professionals for the relative value of their work, practice expenses, and PLI for rendering covered health services to Medicare beneficiaries. Medicare currently pays for secondary image interpretation for emergency room patients only under "unusual circumstances," and within the payment for E/M services is part of the review of previous documentation. We believe that physicians should be paid fairly for the time and effort they devote to interpreting existing images, when such review is necessary and appropriate. This allows them to hone in on particular aspects of imaging, confirm diagnoses, develop a treatment plan, and determine the need for subsequent imaging or other diagnostic procedures. It also promotes the efficient care and use of resources by preventing unnecessary imaging studies, which can pose a small, but potentially consequential risk of harm for certain patients. In addition, as imaging studies are subject to individual interpretation, and affected by the reviewer's own knowledge and experience, this second layer of review can also serve to prevent unnecessary surgeries and procedures.

These examples illustrate the value of subsequent interpretation of imaging studies, in various health care settings.

- The radiologist at a mammography center or clinic initially reviews and evaluates a patient's mammogram(s). When problems appear, the patient is referred to another physician with special expertise and experience in diagnosing and treating breast cancer. This physician carefully reviews the existing images, compares anomalies with the underlying tissue characteristics, takes into account

the patient's overall health and specific symptoms, and determines whether to perform or recommend performing additional studies, needle biopsy, lumpectomy, etc.

- In another scenario, existing images are an invaluable resource for a physician who sees a new patient with multiple and/or longstanding conditions (such as scoliosis, neurogenic bladder, degenerative orthopedic conditions) which require frequent imaging studies, sometimes at regular intervals. The patient may be transitioning to a new locale, phase of life, health plan, or provider, or presenting to the emergency department. Having existing images to review helps set a baseline for current or future issues, and avoids unnecessary studies. For many patients with debilitating conditions or developmental or mental health issues, the very process of performing imaging studies can in itself pose a particular risk or challenge. The very avoidance of unnecessary studies is advantageous to the health and well-being of such patients.

Fair payment to physicians for the time and effort they spend in reviewing existing studies not only compensates their professional services, it also creates an incentive for optimal performance of precise studies, and maximum utilization of each image. We defer to the relevant medical specialty societies in their responses to the specific questions that the agency has posed in the Proposed Rule.

X. Clinical Laboratory Fee Schedule: PAMA Implementation, Pricing, and Coverage

The AMA shares CMS' goals of achieving better care for patients, better health for our communities, and lower costs through improvement of our health care system. Given the impact that testing services already have on patient care, and are expected to have on patient treatment in the future—particularly in the area of genetic and next generation and whole genome testing services—it is critical that the regulatory framework for coding, pricing, coverage, and payment for laboratory developed testing services as well as Food and Drug Administration (FDA) approved/cleared commercialized testing kits supports these goals.

Specific to personalized medicine testing services, the AMA concurs with the statement of Patrick Conway, MD, during a Personalized Medicine Coalition (PMC) keynote address that CMS should promote policies directed at removing "barriers to personalized medicine and catalyz[ing] transformation focused on patient-centered care." While agency leadership has articulated this broad aspiration, the last three years have presented significant challenges for patients and physicians in need of medically necessary and reasonable testing services. The challenges have included new, inadequately communicated, rapidly evolving, and ad hoc coverage processes implemented through the Palmetto GBA Molecular Diagnostic Program pilot ("MolDX"). The foregoing has compounded the difficulties associated with unusually high number of codes in this area subject to the lengthy and resource intensive gap-fill method of pricing. Moving forward, the AMA would strongly support an agency initiative to convene a cross-section of major stakeholders and interested public to discuss the continuum of opportunities and challenged that lay ahead.

We have included preliminary recommendations below concerning the implementation of section 216 of the Protecting Access to Medicare Act of 2014 (PAMA), given the impact on the Medicare Clinical Laboratory Fee Schedule (CLFS). Among other provisions outlined below, section 216 revises the pricing method for clinical laboratory tests paid on the CLFS by requiring new reporting of private payer payments, and setting rates based upon the weighted median payment for most tests, but not all. Section

216 also contains other provisions that have broad implications for access to medically necessary and reasonable testing services.

A. Medicare Administrative Contractors (MACs)

PAMA authorizes CMS to designate one or more (not to exceed four) MACs to either establish coverage policies or establish coverage policies and process claims for payment for clinical diagnostic laboratory testing services, as determined appropriate by the Secretary of the U.S. Department of Health and Human Services (HHS). **The AMA strongly urges CMS to retain the maximum allowable MACs—four—to establish coverage policies and process claims**. Consolidation of the MACs to less than four would confer undue influence on an extremely small number of individuals over testing services and would undermine the quality and quantity of comparative information that CMS would need to evaluate the performance of MACs in this critical space. **While consolidation to four MACs will improve the ability of the agency to provide oversight, the AMA strongly opposes consolidation of coverage policies or coverage and processing claims within a single MAC. This would undermine the use of the local coverage determination process and have a negative impact on patient access to medically necessary and reasonable medical care**.

B. Coding

The AMA urges CMS to consider that CPT Category I codes are for "procedures that are consistent with contemporary medical practice and are typically widely performed" subject to additional criteria for molecular pathology diagnostic testing services, including those testing procedures used for rare diseases. The process used by the CPT Editorial Panel to develop and approve the creation of CPT codes is transparent, rigorous, evidence-based, and includes deliberations and input from a cross-section of stakeholders, including national clinical experts in relevant areas covered in code applications, for example, in the field of molecular pathology for genetic, next generation, and whole genome sequencing. As a result, given the CPT Editorial Panel process, we strongly urge CMS to ensure that MACs cover new CPT Category I codes until the Local Coverage Determination (LCD) process is utilized to modify coverage or issue non-coverage determinations. Additional recommendations related to the PAMA coding provisions will be forthcoming after full engagement of the array of health care stakeholders and adherence to CPT Editorial Panel processes.

C. Essential Role of Laboratory Developed Test Services (LDTs) and Patient Centered Care

The AMA strongly urges CMS to consider that LDTs play an essential role in protecting the public health when there is an infectious disease outbreak, ensure the availability of testing tools for rare diseases where a commercial market for FDA approved/cleared kits does not exist, and serve as the source and means of relevant clinical innovation and rapid application into medical practice. LDTs also promote value and competition. Personalized medicine, including the use of genetic and next generation testing services and gene-based treatment modalities, constitutes the practice of medicine. Given the training of physicians and their direct relationship to patients, physicians have a central role to play in the development of laws, regulations, and policies that impact the clinical implementation of personalized medicine, which includes testing services, the interpretation of testing within the clinical context, and identification of targeted therapies. Testing alone will not dictate patient treatment. Rather, a physician's

clinical expertise in identifying the most appropriate test and the subsequent analysis required to obtain results, and the physician's interpretation of test results in the context of the patient's clinical situation, along with the patient's preferences, are what guide treatment options.

D. Federal Advisory Committee Act (FACA Committee)

No later than July 1, 2015, HHS is required to consult with an expert outside advisory panel, comprised of an appropriate selection of individuals with expertise in issues related to clinical laboratory tests, which may include the development, validation, performance, and application of such tests. We strongly urge CMS to ensure that this FACA Committee includes individuals well-versed in clinical practice, the majority of whom are practicing physicians regularly providing clinical laboratory testing services.

E. Laboratories Excluded from Reporting

The AMA strongly urges CMS to exclude physician-office based laboratory testing services from the reporting requirement. It is essential that low volume exclusion apply as the burden associated with reporting would be substantial and the data reported would not be statistically significant. However, the AMA strongly urges CMS to exercise its discretion to undertake targeted sampling in order to evaluate pricing differentials, to the extent that these exist, between data reported by laboratories subject to PAMA reporting and those in a statistically relevant sample of physician-office based laboratories.

F. Process for Pricing Next Generation Sequencing Codes

In addition to the above PAMA-related considerations, the AMA strongly urges the agency to implement a framework for pricing new codes that minimizes interruption in payment to medically necessary services. We are particularly concerned with the confusion created in 2013 as a result of the gap-fill process utilized by the MACs for the molecular pathology diagnostic testing codes. We urge CMS to evaluate carefully the flexibilities available to obtain data quickly in order to price the next generation sequencing codes and minimize the disruption to patients. The consequences of the disruptions are far-reaching outside of the Medicare program and undermine efforts to accelerate the application of new genomic knowledge with an established clinical evidence base into medical practice.

G. Local Coverage Determination Process for Clinical Laboratory Testing

CMS proposes to revise the LCD process when used for clinical laboratory tests. While CMS cites PAMA as the basis for "streamlining" the coverage process, the LCD provisions of PAMA were enacted by Congress to ensure that MACs, in particular the MolDX pilot program, would not continue to sidestep the applicable statutory and regulatory LCD requirements. PAMA actually does not make any reference to streamlining the LCD process. Instead, PAMA provides that MACs are only permitted to issue a coverage policy with respect to a clinical diagnostic laboratory testing service in accordance with the process for making a LCD (as defined in statute and consistent with the appeals and review process for LCDs under 42 CFR Part 426). Citing section 216 of PAMA as the basis to expedite and streamline the LCD process and address certain limitations within the existing LCD process, CMS proposes a revised process that would apply only to clinical laboratory tests, including molecular tests.

We are concerned that the agency has acknowledged that the pilot MolDX program referenced in the Proposed Rule issued a blanket proposal of non-coverage over a wide category of testing services. This action did not provide adequate specificity to provide public and reasonable notice, and the final coverage decisions were contrary to the weight of clinical evidence, including established clinical practice guidelines. Waiving MAC compliance with the LCD process deprives physicians and other stakeholders with clinical expertise the opportunity to provide comment, and challenge incorrect and erroneous determinations. **The AMA strongly urges CMS to issue a public report on the scope, charge, metrics, and assessment of the overall performance of the MolDX pilot prior to utilizing it as a model for expansion of its coverage practices to the clinical laboratory fee schedule—which was not implemented in compliance with current LCD statutory and regulatory requirements**. **The agency regularly emphasizes the importance of transparency, and this is an area where stakeholder engagement is needed.** Our concern is amplified by reports that large commercial interests have met regularly with Palmetto GBA and advisors from the FDA, and CMS, without engagement of a wide array of physician organizations as part of invitation-only meetings. These closed door discussions with regulators, payers, and those with a pecuniary interest in structural regulatory modifications that reduce patient and physician diagnostic options have largely excluded those who represent physicians and raise serious transparency questions. The AMA would welcome the opportunity to work with the agencies to facilitate Open Door discussions with all stakeholders.

In its proposal, CMS encourages the MACs to collaborate across jurisdictions on policies contained in LCDs. We also urge CMS to clarify that <u>each</u> MAC is required to use the LCD process so that patients, physicians, and other stakeholders in their jurisdiction have a means to appeal adverse coverage determinations. MACs should be clearly informed that collaboration does not entail adopting the LCD of another contractor without providing impacted parties, including physicians and patient groups, the opportunity to provide comment and appeal the determination.

CMS is proposing significant changes to the LCD process for clinical lab testing services. In short, the current process would be dismantled and replaced with a process that: 1) shortens the public comment period for physicians and others to respond to changes in coverage from 45 days to 30 days; 2) makes Carrier Advisory Committee (CAC) meetings optional at the MAC's discretion with no requirement for open stakeholder meetings; and 3) would require MACs to respond to all comments and publish a final LCD within 45 days with the LCD becoming effective immediately as opposed to allowing 45 days before it became effective. The new process would not apply to LCDs that are being revised for the purpose of liberalizing the coverage or issued for a "compelling reason," non-substantive changes, changes in diagnosis coding that do not make policy more restrictive, or changes stemming from Administrative Law Judge rules.

The agency proposal to modify the process by restricting, and in some instances precluding altogether the input of subject matter experts will undermine necessary and meaningful input. The LCD proposal seeks to build upon a highly controversial pilot that has been the subject of widespread criticism and resulted in access barriers to clinically and analytically valid testing services that continue to be medically necessary and reasonable for individual patients. **The AMA strongly opposes the reduction in time to comment on proposed coverage policies, modifying the CAC meeting structure, and rescinding the 45 day grace period before LCDs become effective.** These proposals will restrict stakeholder input and limit the quality of relevant clinical information. Based upon the pilot program performance, the proposal is modelled on restricting access to tests which represent the standard of care. We are equally concerned

that this process will be applied to other services, which will further restrict physician's ability to meaningfully impact coverage policies and limit access to CACs which has already been eroded over the past several years.

As we move to alternative payment and delivery reform models, it is essential that physicians, and the medical teams whose members are accountable and responsible for treating individual patients, have the ability to exercise their clinical judgment vis-à-vis the appropriate method and/or technology platforms when conducting patient-specific testing. The AMA does not agree that insurance companies (as opposed to a patient's treating physician)—such as MACs—are best positioned to ascertain the difference in performance characteristics among available testing options nor are insurance companies and their employees medically liable or accountable for the quality of care delivered or the patient's health outcome. The clinical expertise of these physicians and medical team members—who boast specialized and sub-specialty clinical training, regularly provide medical care to individual patients, and most importantly, have knowledge of the patient's conditions and medical history—strongly dictates that treating physicians and the patient's medical team are the best qualified and positioned to make the most informed decisions concerning which testing methods and technology options to utilize.

In order to facilitate the foregoing, physicians should not have their clinical decision-making undermined through highly restrictive and prescriptive insurance coverage policies that dictate how medicine should be practiced—employing, ironically, a one-size-fits-all approach to testing services. This is particularly problematic in the area of coverage where the MolDX pilot program evinces a preference for technologies and testing methods that represent the lowest common denominator in testing methodologies—commercial kits that can be performed by any laboratory, but are the least likely to reflect the most up-to-date clinically and analytically validated testing methods. This is not consistent with, as referenced by Dr. Conway in his PMC address, consideration of and access to new therapeutic technologies. The coverage conclusions of the MolDX program have been characterized as unduly restrictive and many of the clinical findings roundly rejected by the College of American Pathologists, the Association of Molecular Pathologists, and the American College of Medical Genetics—the leading national and international subject matter clinical experts.

XI. Removal of Employment Requirements for Services Furnished "Incident to" Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Visits

In May 2014, CMS amended the regulations for RHCs to allow nurse practitioners (NPs), physician assistants (PAs), certified-nurse midwives, clinical social workers, and clinical psychologists to furnish their services under contract, so long as at least one NP or PA is employed by the RHC (as required by section 1861(aa)(2)(iii) of the Social Security Act). In similar fashion, CMS is now proposing to allow billing for services "incident to" an RHC or FQHC visit that are furnished by nurses, medical assistants, and other auxiliary personnel who work under contract with the clinic or center, as well as by those who are employees. These changes are designed to provide RHCs and FQHCs with greater flexibility.

The AMA supports this proposal, provided that RHC and FQHC auxiliary personnel are held to the same high professional standards for the quality of their care, regardless of whether they are working under contract or as employees. The AMA believes that all members of a physician-led health care team should be enabled to perform medical interventions that they are capable of performing according to their education, training, licensure, and experience to most effectively provide quality patient care. In June

2014, the AMA House of Delegates adopted guidelines for physician-led medical health care teams. Many of the guidelines are quite relevant to the team approach integral to many RHCs and FQHCs:

Patient-Centered:

a. The patient is an integral member of the team;
b. A relationship is established between the patient and the team at the onset of care, and the role of each team member is explained to the patient;
c. Patient and family-centered care is prioritized by the team and approved by the physician team leader;
d. Team members are expected to adhere to agreed upon practice protocols;
e. Improving health outcomes is emphasized by focusing on health as well as medical care;
f. Patients' access to the team, or coverage as designated by the physician-led team, is available twenty-four hours a day, seven days a week; and
g. Safety protocols are developed and followed by all team members.

Teamwork:

a. Medical teams are led by physicians who have ultimate responsibility and authority to carry out final decisions about the composition of the team;
b. All practitioners commit to working in a team-based care model;
c. The number and variety of practitioners reflects the needs of the practice;
d. Practitioners are trained according to their unique function in the team;
e. Interdependence among team members is expected and relied upon;
f. Communication about patient care between team members is a routine practice; and
g. Team members complete tasks according to the agreed upon protocols as directed by the physician leader.

Clinical Roles and Responsibilities:

a. Physician leaders are focused on individualized patient care and the development of treatment plans;
b. Non-physician practitioners are focused on providing treatment within their scope of practice consistent with their education and training as outlined in the agreed upon treatment plan or as delegated under the supervision of the physician leader; and
c. Care coordination and case management are integral to the team's practice.

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Practice Management:

a. Electronic medical records are used to the fullest capacity; and
b. Quality improvement processes are used and continuously evolve according to physician-led team-based practice assessments.

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d. Prior authorization and precertification processes are streamlined through the adoption of electronic transactions.

XII. Access to Identifiable Data for the Center for Medicare and Medicaid Innovation (CMMI) Models

The AMA recognizes the need for CMS to monitor and evaluate the models being tested under the CMMI. However, we ask that the agency not impose overly burdensome requirements on physicians to collect and report data from these programs. Before requesting data, CMS should estimate and publish the potential burden and cost on physicians and other providers. Physicians should have the right to opt-out of producing information that may not be available due to cost limitations or other administrative barriers. CMS should also consider the potentially major barriers in producing data that are stored in electronic health records. Producing these data can be problematic given concerns with data lock-in, the current lack of interoperability, and other problems with these systems. We appreciate that, wherever possible, CMS will make use of existing administrative systems to receive this data, but caution that CMS should provide clear instructions and other educational resources to ensure that collection and reporting of the data complies with the HIPAA Privacy and Security rules.

XIII. Private Contracting/Opt-Out

We strongly urge CMS to amend its current opt-out policy by allowing physicians to opt-out of the Medicare program indefinitely, and by ending the required submission of an affidavit every two years, in perpetuity. The AMA supports CMS' clarification that the physicians who have validly opted-out of the Medicare program are nevertheless still permitted to write orders and referrals for Medicare beneficiaries. This will assist beneficiaries in receiving the care they need. The AMA House of Delegates has also called for changes in another troublesome requirement for physicians who choose to opt-out of the Medicare program. The AMA fully supports those changes, which would allow physicians to opt-out of Medicare without a requirement to reaffirm their opt-out status; and create a safe-harbor period for a physician to remain opted-out of the Medicare program, without penalty or possibility of recoupment, when a physician has mistakenly not reaffirmed his or her intention to be opted-out. The current requirement—that every physician who opts-out of Medicare must re-file an affidavit every two years in order to maintain his or her opt-out status—is unnecessary, is not required by law, and seems completely illogical. No other government program comes to mind, where one has to file a legal document in order to continue not to participate. Most important, this creates an unnecessary burden for these physicians to needlessly submit documentation every two years, and has the potential to catch some physicians unaware, at great peril. Failing to submit such documentation may expose physicians to significant penalties. After the two-year minimum that is required by law, the opt-out period should be effective indefinitely, unless and until the physician chooses to terminate his or her opt-out status.

XIV. Solicitation of Comments on the Payment Policy for Substitute Physician Billing Arrangements

We urge CMS to not limit or impose additional requirements on substitute physician billing arrangements given that these arrangements facilitate and guarantee patient access to care. Substitute billing arrangements, whether they are reciprocal billing or locum tenens arrangements, have been a staple in the health care delivery system for many years. These arrangements have developed as an essential, short-term solution to ensure patients' continuous access to care when their physician is temporarily unavailable due to continuing medical education, family medical leave, sabbatical, pregnancy, accident, disability, or leaving his or her medical group or other employer. These

arrangements are often necessary to ensure that patients in rural areas do not experience gaps in their treatments or delays in receiving physician services.

Because of the key role that substitute billing arrangements serve and the fact that the Proposed Rule does not cite any evidence that those arrangements pose a real threat to program integrity, CMS should not limit the ability of physicians, medical groups, or other physician employers to utilize substitute billing arrangements to protect patient access to care. In the Proposed Rule, CMS identified a program integrity concern that *could* arise if a medical group continued to use a departed physician's National Provider Identifier (NPI) to bill for services.[6] But, as noted in the Proposed Rule, Medicare regulations already require the former employer and the departing physician to promptly notify the Medicare program of the departure. Nothing prohibits CMS from taking remedial action with respect to an employer or a physician who has failed to comply with these requirements. CMS has also not indicated that the continued use of a departing physician's NPI is a real threat to program integrity. Consequently, continued education and, if necessary, enforcement of existing Medicare requirements, should adequately address this concern.

Accordingly, we strongly urge that substitute billing arrangements <u>not</u> be limited to reciprocal arrangements between two individual physicians, and we support retaining the current ability of medical groups and other physician employers to utilize such arrangements.[7] We also do not believe that any valid reason exists that would support either restricting substitute billing arrangements in the Medicare Shared Savings Program, or placing limits on the amount of time that an individual physician may provide services to replace or substitute for a particular departed physician.[8] Finally, we oppose any limitations on the role that locum tenens arrangements have in determining when physicians are members of a group practice under the physician self-referral law. Such limitations could have a significant, negative impact on many physician practices that may rely on such arrangements when complying with that law's highly technical group practice requirements.

We also disagree with the imposition of additional requirements suggested in the Proposed Rule. For example, the Proposed Rule suggests that the departing physician be made a party to the substitute billing arrangement. Contractually obligating a departing physician's former employer (or vice versa) to monitor or otherwise be responsible for the billing activities of the physician (or former employer) is not a practical proposal. In most cases, neither the former employer nor the departing physician will have access to each other's billing activities. Regardless of monitoring or other obligations that may be created by adding the departing physician to a locum tenens arrangement, neither the former employer nor the departing physician will be in a position to enforce such provisions. This will only add to the already substantial administrative burden for physicians and unnecessarily increase the potential for regulatory liability. Similarly, requiring medical groups and other former employers of departing physicians to demonstrate a staffing need as a prerequisite to entering into a locum tenens arrangement would place a wholly unnecessary burden on entering into such arrangements. Physician employers often engage in locum tenens arrangements at considerable expense and as a temporary solution. Mandating that locum tenens arrangements must be justified by a demonstrated staffing need would, therefore, be superfluous and unnecessarily burdensome.

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[6] 79 Fed. Reg. 40,383.
[7] Ibid.
[8] <u>Id</u>.

Instead, we believe that it may be appropriate for CMS to increase the flexibility that physicians and other parties have, in some circumstances, to enter into substitute billing arrangements. Increased flexibility may be particularly important given the expected U.S. physician shortage—predicted at 45,000 primary care and 46,000 specialty physicians by 2020. Recognizing this shortage, it is likely that the need for substitute billing arrangements will not only increase, but that physician employers will need greater latitude with respect to those arrangements. Depending on demographic and geographic considerations, and other factors such as the duration of a physician's absence or recruitment challenges, physician employers may need to engage in the sequential use of multiple substitute physicians beyond the current 60-day continuous day limit.[9]

XV. Reports of Payments or Other Transfers of Value to Covered Recipients

CMS has proposed removing the explicit Open Payments Program regulatory exclusion for continuing medical education (CME) that is applicable to certified and accredited CME activities that meet certain criteria for independence. Instead, CMS proposes to apply another regulatory exclusion to certified and accredited CME when manufacturers are "unaware of" or "do not know" the identity of the covered recipient(s) during the reporting year or by the end of the second quarter of the following reporting year. While the AMA appreciates that CMS would like to expand the number of entities offering independent continuing education (CE) that would be eligible for exclusion, the agency's proposal will chill physician participation in independent CE programs. The agency's proposal is unworkable as industry can and does learn the identities of speakers/faculty and potentially participants after the funds have been transferred through brochures, programs, and other publications, or through their physician-employees' participation in CE activities (either as speakers/faculty or attendees). This is a pronounced problem for CE activities that are offered online and can exist on the World Wide Web for an extended period of time. Ironically, this provision would diminish the likelihood that physicians—particularly those without any ties to industry—would be willing to participate in independent CE. CE providers offering independent CE will either have to forgo all industry funding of the independent educational activity or lose the ability to recruit a fairly large number of physician participants—either as speakers or attendees—to participate in such events.

The AMA strongly urges the agency to modify the proposal so that independent CE remains excluded from reporting. The agency should allow this exclusion where independence is established when an applicable manufacturer:

- Does not pay covered recipient speakers or attendees directly;
- Does not select covered recipient speakers or provide a third party (such as a continuing education vendor) with a distinct, identifiable set of individuals to be considered as speakers or attendees for the CE program; and
- Does not control the program content.

In order to strike a balance that acknowledges CMS' concerns while also safeguarding independent CE, the AMA strongly urges modification of the agency's proposal to exclude from the Open Payments Program reporting where the above criteria are met. Alternatively, CMS could exclude CE activities where the industry donor is unaware of the speakers and other participants before committing to fund the activity. This could create administrative reporting burdens for CE providers, applicable manufacturers,

[9] Id.

and the agency, but accomplishes CMS' goal while reducing the potential for negatively impacting CE. To allow CE providers adequate time to ensure that their processes comply with the modified exclusion, we urge CMS to make this change effective six months after the final rule is issued.

When evaluating the various options, the AMA strongly urges CMS to consider and acknowledge that there is a fundamental distinction between promotional education activities (which not infrequently are called CME as well) and independent CE. There are many, including the Institute of Medicine (IOM), who have pointed to the inordinate length of time that it takes for clinically relevant medical breakthroughs to become part of clinical practice. Independent CE represents an important mechanism for providing physicians with this information and sharing clinical insights with other physicians about medical practice. Independent CE also provides an important forum to conduct inter-professional educational activities that enhance care coordination and effective communication among the continuum of health care providers including physicians, nurses, and pharmacists, for example. We are at an unprecedented stage of medical discovery in areas such as telemedicine, connected health, and personalized (genetic and genomic) medicine, and the need for independent CE is as compelling and as important as ever.

In addition to the issues raised in the Proposed Rule, the AMA strongly urges CMS to engage with manufacturers/group purchasing organizations, physicians/teaching hospitals, patients, and other interested stakeholders to develop contextual information that will enhance public understanding of these relationships. The AMA remains very concerned with how the Open Payments data will be presented and explained to the public. In some cases and particularly with respect to indirect transfers of value, an individual physician may not even appreciate how the reporting provision impacts them. Transfers of value to support research grants may falsely create the impression of a relationship between individual physicians and companies that have no real association.[10] It is critical that CMS preface the data release with appropriate context so that the public can make educated judgments on the benefits of various transfers of value, such as medical journal reprints and industry-funded clinical research, in the practice of medicine.

XVI. Physician Compare Website

CMS is proposing a significant number of changes and additions to the Physician Compare website, starting in 2015 or 2016, including plans to:

- In early 2015, publicly report on Physician Compare 20 2014 PQRS measures for individual EPs, collected via registry, electronic health records (EHRs), or claims.
- Perform concept testing to test consumers' understanding of each measure under consideration.
- In 2016, make available for public reporting all 2015 PQRS Group Practice Reporting Option (GPRO) measure sets across group reporting mechanisms (GPRO web interface, registry, and EHR), for groups of two or more eligible professionals (EPs). All measures reported by Shared Savings Program ACOs would also be available for public reporting on Physician Compare. CMS would select some of these to include on the profile pages, based upon consumer testing

[10] Ratain, Mark J. "Forecasting Unanticipated Consequences of 'The Sunshine Act:' Mostly Cloudy." *Clinical Oncology*, Vol. 32, No. 22, Aug, 1, 2014.

and stakeholder input, as too much information can negatively impact consumers' ability to make informed decisions.

- In 2016, publish composite scores by grouping measures according to the PQRS GPRO measures groups, e.g., care coordination, coronary artery disease, diabetes, and preventive care.
- In 2016, include benchmarks for 2015 PQRS GPRO data, using the Shared Savings ACO benchmark methodology. Benchmarks would be calculated using data at the group practice TIN (tax identification number) for all EPs who have at least 20 cases in the denominator, for each percentile from the 30th through the 90th percentiles. A group practice would earn quality points on a sliding scale, with a level of performance based on an average of their scores for each measure group.
- In 2016, begin reporting patient experience data for group practices of two or more EPs who meet sample size requirements and collected 2015 data via a CMS-specified certified CAHPS (Consumer Assessment of Health Providers and Systems) vendor.
- In late 2016, make available for reporting all individual EP-level PQRS measures collected via registry, EHR, or claims. Some would be published on the profile pages, based upon consumer input, and CMS would set benchmarks and calculate composite scores for individual EPs.

The AMA adamantly opposes the multiple proposals to extensively expand the Physician Compare website, as serious and fundamental flaws and errors remain unaddressed. While we appreciate CMS taking a phased approach to expanding Physician Compare, the website continues to be riddled with problems. Until CMS can make timely updates to the demographic data for individual EPs and group practices, we have little confidence in CMS' ability to accurately report performance scores, benchmarks, and composites. It is vitally important that quality information is utilized to improve care and support new delivery and payment models. But this must be done in a manner that is transparent and fair, so that providers and consumers can have confidence in the information that is posted. Recent efforts by CMS to publicly post individual physician data (i.e., the Medicare Physician Data Release and the Sunshine Open Payments Website Data) have been far from ideal and riddled with problems. This has soured the faith of many physicians in CMS' ability to accurately post information regarding the quality of their care.

There are also regular issues regarding the appropriate sample size to allow for correct inferences to be made about an individual physician. The AMA recommends against posting individual performance information, and supports continuing to post only group practice performance information for successful reporters. AMA policy adopted at the June 2014 House of Delegates meeting states that "Consistent with the Medicare Improvements for Patients and Providers Act of 2008, the public reporting of quality and outcomes data for team-based care should be done at the group/system/facility level, and not at the level of the individual physician . . ."

CMS must consider the current state of data collection and aggregation accuracy. The agency has yet to put in place a formal appeals process for contesting Physician Compare information and only provides 30 days for an EP to review their information. **The AMA urges CMS to expand the preview period to 90 days at a minimum. And if an EP or group practice files an appeal and flags their demographic data or quality information as problematic, CMS should postpone posting their information until the issues are resolved.** It often takes medical practices several weeks and sometimes months to register and obtain their PQRS reports and Quality and Resource Use Reports (QRURs). It is also unclear how CMS plans to notify EPs of the preview period for reviewing their pubic ratings. We anticipate problems

and backlogs with obtaining reports, as CMS greatly expands all of its quality programs and moves to profile all EPs.

The AMA supports efforts to make medical standards more comprehensible to patients. However, star rankings or similar systems that display disparate quality scores in a simplified graphic result in distorted, inappropriate distinctions of quality for physicians whose performance scores are not statistically different. **Since the overwhelming majority of physicians would likely fall within a small range of average quality, the only information that accurately identifies what is truly valuable to a patient, considering the evolving state of quality measurement, is whether a physician is an outlier.**

CMS also proposes to report measures that meet a minimum sample of 20 patients. However, we are concerned with the accuracy of this sample size and the possibility of incorrect inferences. Acumen, on behalf of CMS, tested measures at the group practice rate using at least 25 measure-eligible cases for a select set of GPRO web-interface measures. Therefore, the results may vary if CMS moves to a sample of 20 patients and reports measures at the individual level. **We request that CMS test measures and composites with a 20 patient attribution and provide an opportunity for public review and comment on the results.** The Physician Compare Technical Expert Panel (TEP) reports highlight the value in maintaining a consistent measure set for public reporting over time, which is more evidence as to why it is premature to move to reporting benchmarks and composites and reducing the sample size." This is especially confusing if CMS moves forward with its truncated list of measures for 2015 due to the proposal to remove a significant number of measures from the 2015 PQRS program. The information from 2013 and 2014 will be very different from the information based upon 2015 quality measures.

While we are supportive of composite measures, the composites, both as a whole and those newly proposed, have not been tested. Only individual measures have been reviewed and tested. It is inappropriate to simply assemble individual measures into a composite, and then assume they remain valid and measure practices accurately. There are also existing limitations in the evolving methodologies for risk-adjustment, attribution, and aggregation which greatly affect the performance score of a group and/or EP. Acumen specifically highlights in its testing of the Diabetes Mellitus (DM) composite results that when risk adjustment is expanded to include race, income, and region type, that predicted performance rates differed from actual performance rates on the group practice level. TEP members also highlight that case-mix adjustment will be critical when reporting at the individual EP level.

We urge CMS to move forward with expanding its risk adjustment methodology to incorporate race, income, and region type. The lack of adjustment can lead to inaccurate and misleading conclusions about quality and performance measurement. This could, in turn, lead to increases in disparities in health care. A simple examination of performance scores without adjustment for patients' socioeconomic and/or sociodemographic situation ignores a number of factors that are believed to influence quality and cost of care. For example, economic and cultural status can affect health status, impede ideal communication between the patient and the physician, and hamper the patient's desire and/or ability to follow a given treatment plan. Ignoring these factors could lead to the conclusion that physicians and practices that serve low income patients provide lower quality care than those serving high income patients, when the difference in scores could actually be due to differences in patient mix rather than differences in quality of care provided. To hold physicians accountable if outcomes differ for these patients without accounting for the factors that contribute to that difference would unfairly penalize

physicians for factors outside of their control. This also runs the risk of unfairly penalizing those physicians who treat a number of socio-disadvantaged patients.

We also advocate for enhancing the transparency of the process by providing the opportunity for the public to comment on the deliberations of the Physician Compare TEP and to regularly engage with interested stakeholders, especially medical specialty societies. Currently, the public has no opportunity to participate and comment on the TEP's recommendations. With Hospital Compare, CMS conducts monthly to quarterly calls with the affected stakeholders, engages in discussion with them regarding plans for expansion, and informs them of the latest release of information. The AMA would be happy to convene something similar with the specialty societies and CMS.

CMS also seeks comment on whether to post specialty society measures on Physician Compare, or link to the websites of societies with non-PQRS measures and proposes to post QCDR (qualified clinical data registry) measure data from 2015. We defer to the specialties to determine how specialty society measures and QCDR measures are best suited for reporting. We also provide more detailed information on publicly reporting QCDR measures in the following section of our comments.

XVII. Physician Payment, Efficiency, and Quality Improvements—Physician Quality Reporting System (PQRS)

CMS is proposing changes in several key areas of PQRS, particularly the requirements for the 2017 PQRS payment adjustment. By statute, CY 2015 is the first year when no PQRS incentives are available under the program. The year 2015 also serves as the performance year for the 2017 payment adjustment of two percent, which will apply to eligible professionals (EPs) who do not satisfactorily report data on quality measures. CMS continues to maintain a two-year look-back period for satisfactorily reporting data on quality measures to avoid a penalty. CMS also proposes to remove a significant number of measures from the PQRS program due to CMS considering the measures as "topped out;" having no identified measure steward; or due to changes in recommended guidelines. CMS, however, maintains all of the reporting options for 2015 (claims, registry, qualified clinical data registry, group practice reporting option, GPRO web interface, and EHR), which we support.

We agree with CMS' decision to maintain the claims-based reporting option for 2015 and urge CMS to maintain the option for future years as it continues to be the most popular reporting option and one that small physician practices depend upon. As CMS considers alterations to try to meet the varying needs of newly electing participating EPs, it is imperative that CMS take into consideration the simultaneous and compounding demands of rapid changes in health care delivery systems and the effects upon physicians, as CMS develops requirements for its programs. We continue to remain concerned that the growing complexity of PQRS and yearly program changes pose a significant barrier to participation for many physicians and successful participation for physicians who have experience in the program. Monitoring the yearly changes to the PQRS reporting options, measures, measures groups, and physician group participation options requires an overwhelming layer of administrative burden that is extremely costly and resource intensive. For some physicians, this is simply not feasible and probably leads to the continually low PQRS participation rate. According to the last year of data that CMS has provided the public on PQRS participation rates, only 36 percent of eligible professionals participated in PQRS for 2012.

If physicians are not considered to successfully report in PQRS, Meaningful Use (MU), and the Value Based Payment Modifier (VM), in 2015 for 2017 penalties, they are potentially subject to a two percent PQRS adjustment, a three percent MU adjustment, and a four percent VM adjustment, plus an additional two percent adjustment due to sequestration, for a total 11 percent cut in reimbursement in 2017. The maximum cumulative penalties (with sequestration) in 2015 total five and a half percent, increase to eight percent in 2016; 11 percent in 2017; and 12 to 13 percent (or greater) in 2018 and 2019. These penalties far exceed the maximum penalties that hospitals can receive under the hospital quality and value based purchasing programs. At the same time, physicians must transition to ICD-10 by October 1, 2015, which could have serious repercussions for successful reporting and CMS' ability to accurately process claims. **Therefore, we urge CMS to institute stability into these programs by not changing requirements on a yearly basis and by scaling back on reporting requirements.**

At a minimum, PQRS requirements should stay the same for three years. We believe three years constitute an appropriate timeline as physicians are not provided a PQRS Feedback Report until six months after the close of the previous reporting period. For example, a physician who participated in 2013 PQRS is not provided a PQRS Feedback Report until approximately September of 2014. At that point, the physician or practice is well into the next reporting cycle when they learn of potential errors, and whether they will receive a payment adjustment for 2015. Based on this timeline, the first opportunity EPs may have to correct their mistakes and successfully report is 2015. An additional year of stability is necessary so that physicians can have the opportunity to learn and follow standard quality improvement protocols, such as the Plan, Do, Study, Act (PDSA) method. Furthermore, multiple studies and editorials have seriously questioned the ability of pay-per-performance programs to improve quality of care in the long term.[11]

A. Proposed 2015 PQRS Reporting Changes

CMS proposes to increase the number of measures that must be reported via the claims and registry-based reporting mechanisms to avoid a payment adjustment, from three to nine measures, as well as the number of measures in a measure group. These nine measures must cover at least three of the National Quality Strategy (NQS) domains and must include two measures from the newly proposed cross-cutting measure list. CMS indicates that these changes are necessary to further the goal of aligning CMS' various quality reporting programs.

Increasing the current reporting requirements threefold and requiring the reporting of two cross-cutting measures when physicians have still not seen their data for successful participation in 2013 or 2014 is an unreasonable leap and disregards the realities of the existing PQRS measure portfolio. The availability of measures to meet the needs of varying specialties and subspecialties becomes even more problematic as CMS proposes to remove a significant number of measures for 2015. Many specialties, particularly those that are procedure-based, continue to struggle in identifying meaningful clinical quality measures to

[11] Caroll, A.E. "The Problem with 'Pay for Performance' in Medicine." *New York Times*, July 28, 2014.
Jha, A.K, Joynt, K.E., Orav, E.J., and Epstein, A.M. "The Long-Term Effect of Premier Pay for Performance on Patient Outcomes." *New England Journal of Medicine*, Vol. 366, No. 17, April 26, 2012.
Serumaga, B., et al. "Effect of Pay for Performance on the Management and Outcomes of Hypertension in the United Kingdom: Interrupted Time Series Study. " *British Medicine Journal,* Vol. 342, No. 108 (2011).
Werner, R. M., Kostad, J.T., Stuart, E.A. and Polsky, D. "The Effect of Pay-For-Performance in Hospitals: Lessons for Quality Improvement." *Health Affairs,* Vol. 30, No. 4 (2011); 690-698.

report, e.g., pathologists, urologists, neurosurgeons, and other subspecialists. **Therefore, the AMA opposes the increase from three to nine measures due to the unavailability of meaningful measures relevant to every specialty and the dramatic reduction of measures available to report.** Until there is a clinically significant number of measures that are relevant to every individual specialty, it is contrary to the intent of the PQRS program to require every EP to report on nine measures, of which two must be from the cross-cutting measure list. For instance, CMS proposes to remove several ophthalmology measures, leaving only six eye care measures in the program, and only four non-cataract eye care measures. Due to sub-specialization within ophthalmology, it will be nearly impossible for ophthalmologists to find nine measures to report on. This dramatic change and reduction in available measures will create an undue burden on a physician's ability to report on meaningful measures that actually improve care.

It is imperative that CMS maintain the options of reporting three measures or electing reporting via administrative claims to avoid the 2017 PQRS penalty. Since 2015 is the first year the VM will apply to all physicians, regardless of practice size, it behooves CMS to give physicians more flexibility in avoiding the penalty, as CMS works to fix methodological issues with the VM program and physicians work to better evaluate the PQRS measure portfolio and reporting options, as well as work on developing clinically relevant measures available through EHR and registry reporting modalities. Reinstating the administrative claims option will provide an additional gateway for physicians and other EPs to participate in and achieve PQRS and VM penalty avoidance.

While we very much support CMS maintaining the claims-based reporting option and understand CMS' goal to move away from claims-based reporting, we are concerned with the number of measures eliminated for reporting through claims. The sudden elimination of reporting specific measures through claims will leave a significant gap in the measure portfolio. We are aware of certain specialties now left without any measures through the claims reporting option. This proposal will disproportionately affect certain specialties and physicians who are unable to participate through a registry and/or adopt certified electronic health record technology (CEHRT). Many specialties also are unable to participate through the Group Practice Reporting Option (GPRO) web-interface, since the measures are focused on internal medicine, and reporting is required on every measure on the GPRO list.

Based upon what has been published in the Proposed Rule, the AMA would like to provide additional comments related to the AMA-PCPI measures which CMS has proposed as "cross-cutting," as well as the proposed addition, domain change, removal, and changes in reporting modalities for PQRS 2015. These comments have been broken down into relevant tables and can be found at Appendices A-E.

B. Program Alignment

The AMA appreciates the agency's efforts to further align CMS quality programs, but we continue to believe the effort falls short, and the vast majority of physicians must report multiple times to avoid payment adjustments. In order for MU quality reporting to count towards PQRS, a physician must take into consideration the following detailed rules and requirements:

- PQRS quality measures must be reported for a full year, as opposed to 90 days, so first year MU participants must report twice;

- Regardless of calendar year, the first year of participation in MU only requires 90 days of reporting;
- In 2015, MU requires reporting through Version 2014 Certified Software;
- Some of the MU electronic clinical quality measures (eCQMs) include "look back" or "look forward" periods requiring data outside of the PQRS and VM reporting periods. If CMS cannot calculate a performance rate for that eCQM, a physician would be subject to both PQRS and VM penalties;
- Measures reported through the PQRS Qualified Clinical Data Registry (QCDR) option must be part of the MU program;
- The QCDR must be certified by ONC; and
- For MU, it is acceptable to report zeroes on measures (including not having any denominator-eligible patients for any of the measures for which their EHR is certified). This is not permissible for the PQRS EHR reporting option or any other option under PQRS. If a physician does not have any data on Medicare patients (i.e., none of their Medicare patients fall into the denominator of any of the quality measures for which their EHR is certified), then the physician needs to report separately for PQRS.

To truly streamline reporting, physicians who successfully participate in PQRS, regardless of the reporting mechanism, should be deemed as successfully meeting the MU quality measure requirements, and vice-versa. **We also urge CMS to reduce the number of quality measures required to report until there are enough eCQMs that work for all physician specialties.** As stated above, we recommend that CMS only require physicians to report on three measures to be considered successful and avoid a payment adjustment. This also resolves part of the alignment problem due to physicians currently having to report on measures in MU that are not applicable and report zeroes in the denominator for satisfactory participation, which PQRS does not consider successful reporting.

CMS would be acting within its statutory discretion by permitting MU reporting to satisfy PQRS reporting, starting in 2015. Section 1848(k) of the Social Security Act (42 USC 1395w-4(k)) sets the general requirements for the "quality reporting system" that became PQRS. It requires the use of consensus-based quality measures, and grants the Secretary discretion to decide how quality data is submitted, including submission via Medicare claims. "Such data shall be submitted in a form and manner specified by the Secretary . . . which may include submission of such data on claims . . ." Section 1848(a)(8) of the Act governs PQRS payment adjustments starting in 2015. It states that EPs must satisfactorily submit data on "quality measures for covered professional services" to avoid such adjustments, but it does not specify or require quality measures (or quality reporting) developed specifically for PQRS. We believe these provisions allow CMS to use MU measures and reporting, to satisfy the requirements of PQRS reporting.

C. Selection of PQRS Quality Measures for Meeting the Criteria for Satisfactory Reporting for 2015 and Beyond

According to statute, the Secretary is allowed to use measures not endorsed by the National Quality Forum (NQF) in the PQRS program if the medical topic for which a feasible and practical measure has not been endorsed or adopted by a consensus organization identified by the Secretary. **The AMA continues to support the agency's ability to use non-NQF endorsed measures in the PQRS program.**

As in previous rules, CMS once again states that there should be no special restrictions on the type or make-up of organizations developing physician quality measures. However, the AMA disagrees with this statement. We support the development of quality measures through a multi-stakeholder, public and transparent process, which maintains certain processes to ensure that measures are meaningful to users, uphold national standards, and harmonize with existing measures in widespread use. A frequent criticism of the AMA-convened Physician Consortium for Performance Improvement® (PCPI®) is that its process is not sufficiently inclusive, and one reason PCPI is now undergoing an evaluation of its governance structure. The AMA views measure development in similar fashion to the development of clinical practice guidelines. The recent IOM report, *Clinical Practice Guidelines We Can Trust*, specifically states that guidelines should be developed through a multi-stakeholder process. The same perspective and standards should apply to the development of quality measures. In addition, standardized measures (using standardized specifications) can be used to compare results nationally, which is especially important as CMS proposes to expand reporting on Physician Compare and considers financial penalties.

As the field of measure developers expands, there is an increased risk of un-harmonized measures and duplicative efforts. Providing incentives to coordinate efforts and co-produce Clinical Quality Measures (CQMs) are prudent considerations as well. It is imperative that measure developers have the necessary expertise with CQM standards currently in use (e.g., Quality Data Model, HL7 (Health Level 7) HQMF eMeasure) and are involved in national efforts focused on the future direction of health care standards.

The AMA also requests, and believes it advantageous, to include a comprehensive list of the finalized measures for 2015 in the CY 2015 Physician Fee Schedule Final Rule. It is unreasonable to shift the burden on EPs to have to refer to multiple sources just to clarify current PQRS policies and measures, particularly given the inherent complexity of the program. This also raises a considerable risk of confusion and error in reporting. **The AMA also requests that a comprehensive measure list be included in every future proposed rule, to provide a complete picture of what is proposed for the following year's PQRS program.**

The AMA supports the continued development of guidance materials to further assist EPs to identify suitable PQRS measures for their specialty/care setting. We receive many questions from prospective participants asking how to determine which measures they should report on for PQRS, and believe CMS' approach to provide documents with this guidance and information will prove to be very beneficial for the EPs. It would be prudent and more beneficial for EPs if CMS published these materials prior to the start of the reporting period, so that EPs can have ample time to prepare for reporting and can select the reporting option most suitable for their practice.

1. Cross-Cutting Measures

CMS proposes criteria for the satisfactory reporting of PQRS measures for the 2017 PQRS payment adjustment, via claims and registry, which require an eligible professional or group practice to report on at least two of the 18 cross-cutting measures. CMS also seeks comment on the proposed cross-cutting measure list. **The AMA agrees with the categorization of the measures in Table 21 for which the PCPI is the steward.** These measures are applicable across various settings and specialties and provide a large percentage of eligible professionals with an opportunity to report on them. Nevertheless, we anticipate many specialties will still not find these "cross-cutting" measures applicable to the care they provide. Because of the proposed requirement of reporting two cross-cutting measures, many specialties

will still find it challenging to meet the reporting requirements for the PQRS program (e.g., radiology, and anesthesiology). **We are supportive of the concept of cross-cutting measures and CMS instituting flexibility in the ability of an EP to choose the measures it would like to report on. But we are concerned there will be some specialties that cannot find two applicable measures to report on. Therefore, we do not support the requirement.** The requirement becomes even more problematic as CMS has proposed to eliminate many measures from the program. If the measure list is finalized as proposed, some specialties (e.g., emergency medicine) will have trouble finding two germane measures.

CMS also proposes to require that a traditional registry must be capable of reporting on all 18 cross-cutting measures. This requirement is burdensome and unnecessary for most registries, particularly those that are specialty-specific. **We recommend instead that CMS require only those measures that are relevant to registry participants to be available for reporting. We defer to the specialty-specific registries to determine which cross-cutting measures are relevant for their specialty.**

We also seek clarification from CMS as to how the cross-cutting measure set will affect the measure-applicability validation (MAV) process. The MAV process remains elusive as not once has the AMA, PCPI, or specialty societies been consulted to review the MAV list or to ensure that CMS is making accurate assumptions and classifications. The MAV is determined by how an EP codes and whether their coding matches up with the measure numerator and denominators. However, it is very possible there are instances where a measure is neither relevant nor appropriate for an EP, but nevertheless is being captured in the MAV due to the EP's billing and CMS' arbitrarily created clusters. In addition, based upon our internal review of the existing MAV clusters, we believe most of the "cross-cutting" measures would inappropriately initiate the "clinical relation test" for the entire preventive care cluster. **Therefore, we request that CMS create a mechanism for specialties and measure developers to comment on the MAV algorithm to ensure that EPs are not inappropriately targeted.**

2. Measures Proposed for Removal Beginning in 2015

We recognize CMS' desire to raise the bar on quality reporting. However, we believe it is premature and short-sighted to remove a measure as "topped out" simply because it has a high performance rate, particularly when the EP reporting rates within the PQRS program are so low. We are also concerned with the significant gaps that will be created in the measure portfolio due to the number of measures CMS proposes for removal in 2015, without any advanced warning to physicians or measure owners. Based upon 2012 data:

- Only 31 percent of EPs were able to participate successfully in PQRS;
- 75 percent of measures had a successful reporting rate below 10 percent; and
- 33 percent of measures had a reporting rate below one percent.

Classifying any given measure as having a high performance rate when the overall reporting rate is less than one-third of all EPs, is not based upon an accurate picture of actual performance. This does not provide a representative sample of the nation's EPs. Since PQRS is now a program that applies penalties, we anticipate that the number of physicians who participate will increase significantly, which will likely have a great impact on the performance rates of all measures.

The AMA also does not believe that performance rates alone provide a valid reason to consider a measure "topped out." Removal from PQRS of any measure as "topped out" must be based upon consideration of several factors, including reporting rate and performance rate, at a minimum. A higher reporting rate or threshold may be indicated before decisions are made on measures based solely upon performance rates. Additionally, high performance rates (close to 100 percent) on some measures among reporting EPs may be partly attributable to intensified improvement efforts motivated by the reporting opportunities. Therefore, removal of these measures from PQRS may result in a drop in performance as well as the quality of care. CMS also states in the rule that many of the "topped out" measures are process measures, and the agency would like to move away from process measures in general. However, process measures play a very important role in improving care as well as in fostering and measuring good outcomes.

We also request that CMS provide measure owners with more detailed analysis of the use of their measures, so they can work to develop the next generation of measures and/or improve performance with its measures. Aside from what is published in the PQRS Experience Report (last released in 2012) and any information a measure owner might request from CMS on specific measures for the purposes of submissions to the NQF, measure owners are not provided any more detailed information about the use of their measures in the PQRS program. The Experience Report also does not provide measure stewards with enough level of detail that might be helpful to determine the utilization and usefulness of their measures. Therefore, it would be extremely helpful if measure owners were provided with the performance data that is required for a measure to be submitted for NQF endorsement (average performance rate, standard deviation, quintiles, etc.), at a minimum.

CMS must also consider the signal it is sending to outside organizations when classifying a measure as "topped out." This influences how other organizations, such as the NQF and the Measure Application Partnership (MAP) consider this measure, its utility for use in the future, and whether it should be classified into the NQF's new "reserve status." During recent AMA participation in NQF consensus development projects, the NQF introduced a "reserve status" for measures that seem to be "topped out," using CMS' term. However, there are currently no explicitly established criteria for deeming a measure as appropriate for reserve status. CMS has also not provided clear guidance on how it arrives at classifying a measure as "topped out," besides stating that its performance is near 100 percent.

Finally, we propose a three-year phase out period for any new measures being removed to allow for the submission of new measures within the current Call for Measures timeframe to prevent gaps in the measure portfolio. The proposed timeframe is also consistent with our call for three years of stability in CMS' quality programs to allow EPs time to adjust to changes in programs and make improvements in their practice. Under the current process for incorporating new measures into physician quality programs, CMS requires a measure developer to submit a measure two and a half years prior to the start of the program year. To consider a measure for the 2017 PQRS program, CMS had to receive the measure information by June 30, 2014—a gap of two and a half years. Prior to the requirement of MAP review, it took only six to 12 months for a measure to be included in a CMS program. With the EHR Incentive Program, the delay is even worse since CMS operates on a three-year rulemaking cycle as opposed to yearly with PQRS and the VM. We were also informed by CMS that the agency must have already received measures for the yet to be released Stage 3 EHR Incentive Program Proposed Rule. CMS needs to be realistic in setting goals for its program and consider its operating cycle, which causes a huge delay in incorporating new measures into programs.

3. Measures Groups

In the CY 2014 Physician Fee Schedule proposed rule, CMS proposed to increase the number of measures that may be included in a measures group from a minimum of four measures to a minimum of six. CMS did not finalize the proposal for CY 2014 and stated that it would work with measure developers and owners of these measures groups to appropriately add measures to measures groups containing only four measures. **However, once again, CMS is proposing to increase the number of measures that may be included in a measures group from a minimum of four measures to a minimum of six. Once again, we do not support this, as CMS has not worked with measure owners and developers over the last year to ensure the appropriate measures are part of a measures group.**

We appreciate CMS maintaining the measures group reporting option and believe it is a meaningful option for reporting since it follows a continuum of care. However, CMS has offered no evidence or rationale to support expanding measures groups by including two additional measures to groups with less than six measures. In fact, many of the measures groups which CMS is proposing to revise have been tested and endorsed by the NQF. The proposed revisions may make the group statistically invalid and/or alter the quality measurement process. For instance, a measures group that includes only one condition-specific measure does not seem to be a meaningful measures group in the context of the PQRS program. More specifically, the proposed "asthma" measures group no longer seems to be meaningful since it includes only one measure that focuses on asthma, as the other asthma specific measures have been proposed for removal beginning in 2015. If measures groups can be generic for all but one of the measures they include, this widens the possible number of measures groups that could then be created, undermining the purpose of creating a measures group reporting option.

D. PQRS Qualified Clinical Data Registries

For 2014, CMS added a new QCDR option whereby EPs may report the measures used by their QCDR, instead of those on the PQRS measure list. EPs meet the criteria for satisfactory participation by reporting on a least nine measures to the registry covering at least three of the NQS domains, and report each measure for at least 50 percent of the EP's applicable patients. At least one of the measures must be an outcomes measure. For 2015, the second year of the QCDR reporting option, CMS proposes to modify the requirements by requiring that an EP must report on three outcomes measures. If three outcomes measures are not available, the EP must report on two outcomes measures and at least one measure related to resource use, patient experience of care, or efficiency/appropriate use.

The AMA opposes CMS' proposal to modify the requirements for the QCDR option for 2015 and advocates for CMS to gradually incorporate QCDR requirements. We continue to believe the QCDR requirements are too stringent, and CMS' plan to modify the requirements in only the second year of this option is simply too aggressive. The AMA disagrees with the high bar which CMS proposes and continues to advocate for a gradual incorporation of QCDR requirements. QCDRs need a period of stability to allow those that are currently qualified to make minor adjustments. Clinical data registries that have yet to become a QCDR also need time to meet CMS' requirements. Since the QCDR is still a new PQRS participation option, the AMA recommends that CMS only make small, incremental changes in QCDR requirements while early experience is gained and evaluated. **It is premature to require the reporting on three outcomes measures and/or two resource use or patient experience of care measures before QCDRs have had the opportunity to gain experience with the program.** As QCDR

stewards and EPs become more comfortable with the requirements of the QCDR program, they will be able to focus more of their resources on innovation.

In general, medicine is currently developing tools to help physicians adopt and incorporate systems of learning into their practice, which will improve quality of care, provider workflow, patient safety, and efficiency. Capturing data through a registry allows for its collection and tracking across care settings and disease states, inpatient and/or outpatient settings, acute episodes or chronic diseases, surgical versus nonsurgical interventions, and resource-intensive versus relatively inexpensive therapies. Quality measurement must move beyond single episodes or "snapshots" of care, which focus solely on clinicians and individual patients, to a learning system with a broad focus. Utilizing third-party registries provides an opportunity to evaluate the care provided within an entire specialty, as well as at the individual physician level. However, if CMS moves forward with its QCDR proposal, this will hinder registry progression and quality improvement activities occurring outside of Medicare. CMS' overly ambitious performance program requirements hinder the ability of physicians to tailor programs to their practice. We recognize that a number of registries qualified to become a QCDR in 2014, but this should not be a signal for CMS to raise the bar after only one year of existence. Registries have devoted substantial effort and resources to become QCDRs, and incorporate enough outcomes measures so that all subspecialists within a specialty could report on at least one.

While the AMA appreciates the flexibility in a QCDR's ability to select measures to capture on behalf of its members, these multiple requirements are simply coming too quickly. If a QCDR wishes to submit quality measures data for the 2017 PQRS payment adjustment, it must provide the information to CMS by March 31, 2015. Reporting on meaningful and scientifically valid outcomes and resource use measures requires capturing data with a significant sample size. It is not something that can be turned around in six months, especially for low volume specialties.

1. Program Alignment and Electronic Interoperability Issues

We are disappointed that CMS did not address in the rule issues around QCDR reporting for satisfactorily meeting quality requirements for the MU program. This represents a missed opportunity for CMS to align reporting requirements for PQRS and EHR Incentive programs and make the programs meaningful for physicians. Alignment of quality reporting efforts is essential to reduce practical and economic burdens on individual physicians and physician groups. Physicians will still be forced to report the same quality measures that are established in the EHR Incentive Program. The measures within the EHR program are also extremely limited for specialists, so most specialists have to report separate measures to satisfy PQRS and EHR Incentive program requirements. We urge CMS to promote flexibility in its performance program requirements so that physicians participating in a QCDR can receive credit for multiple quality improvement activities.

The proposed criterion for QCDRs to report quality measures within the MU Program is simply not feasible. Essentially, QCDRs must have the ability to electronically specify their measures. As CMS has discovered, this is not a simple task and not all quality measures lend themselves to electronic specifications. In addition, QCDRs must go through the MU modular Certified Electronic Health Record Technology (CEHRT) process which assumes that an EHR is interoperable with a registry. We do not believe certification vendors are set up to certify or understand clinical data registries. Finally, requiring QCDRs to go through the CEHRT process will force registries to meet qualification requirements for both

PQRS and EHR Incentive programs. Within PQRS, QCDRs will have to meet standards for certifying both the PQRS registry and the QCDR process. The intention behind section 601(b) of the American Taxpayer Relief Act of 2012 (ATRA) was to provide physicians with greater flexibility to report on and receive credit for their quality improvement activities relevant to their practice and patients. The QCDR EHR Incentive program requirements do not allow for the true utility and purpose of registries, or the evolution of the quality measurement process.

It would be more advantageous and assist with registry evolution and participation if CMS focused its efforts by working with the Office of the National Coordinator for Health Information Technology (ONC) to develop a single standard so that EHRs are interoperable with registries. EHR code extraction is not available for the vast majority of clinical data registries and the registry objective within MU continues to miss the mark. The proposed Stage 3 objective only requires a CEHRT EHR to transmit to one registry, and does not recommend a standard. CMS needs to play a greater role in facilitating the use of clinical data registries by encouraging the development of standards for sharing/transmitting data between EHRs and registries. Presently, practices are forced to manually enter data into a registry because no streamlined process exists, and because of the proprietary nature of health information technology (HIT) products. This existing data-sharing process is particularly challenging for solo and small practices, and prevents many from participating in registries. Finally, the manual data-entry process requires a full-time or half-time employee, which is an added cost that most practices cannot easily absorb.

The current certification requirements also fail to address the need for bi-directional exchange for national clinical data registries or clinical data standardization for any other purpose. EHR vendors charge providers to map and transmit data from an EHR to a registry. The ability to transmit clinical data to national clinical registries using standardized data definitions will assist physicians and health care systems to move to a more advanced state of quality measurement. **CMS should work with ONC to require EHR vendors to provide clinical data in a standard format backed by standardized data definitions.** Providers that have purchased EHR systems should not have to incur the cost of middleware vendors mapping and transmitting the data. CMS should also engage with the physician community, including the AMA, so that the clinical content of this work is accurate and widely adopted.

2. Proposed Changes to the Requirements for the QCDR Program

As CMS works to refine the QCDR program, we seek clarification and comment on the following proposed requirements:

***a. Requiring the entity to make available to the public the quality measures data for which its EPs report and the performance results for each measure the QCDR reports*:** The AMA supports transparency, but we believe that required public reporting on first year data for new measures is problematic and in general premature. CMS has put forward a new program that will require registries to re-tool their methods to comply with CMS' requirements. A more prudently scaled approach would allow the participation of specialties in different phases of registry development. Many medical specialties are in the beginning phases of developing meaningful quality improvement programs, so we strongly believe it is premature to publicly post performance data. The necessary processes and safeguards required to make public reporting meaningful for physicians, patients, and the public take time, resources, and careful consideration. CMS should provide the necessary lead time through a scaled

or tiered approach in rulemaking that establishes criteria for moving toward accurate and meaningful public reporting of performance information.

Only the acquisition of large amounts of high quality, risk-adjusted, practice data over time will allow specialty groups to develop meaningful benchmarks for quality and also define the quality variables most likely to determine patient outcomes. First-year data will not depict an accurate view of performance or allow the setting of benchmarks. In addition, the widespread institution of quality programs will initially create disruptions to practice and increase the costs of delivering care. The practical and economic burdens on an individual physician who adopts these methods (particularly in the early stages) must be taken into account. Physicians need time to evaluate their performance and adopt improvements, prior to publicly reporting their performance data. When quality programs have matured and these efforts have become embedded within the fabric of daily practice, it may be more appropriate to recognize physicians in some comparative fashion, but we are not yet there.

In the interim, we recommend requiring QCDRs to publicly post, in layman's terms, the critical components of care that relate to the measures used within the QCDR, and explain why the measures are important. This would support clinical registries in building toward a shared responsibility for engaging the public on quality and performance, which can begin the conversation between physicians, registries, and patients on health care quality and what information is being collected and for what purposes. A recent consumer survey from the National Opinion Research Center (NORC) at the University of Chicago, funded by Robert Wood Johnson Foundation states, "Americans report that they would trust word-of-mouth and personal recommendations from doctors far more than provider quality data coming from the government or third parties." Therefore, the AMA's alternative recommendations to CMS on public reporting can assist clinical registries in facilitating consumer engagement and increasing the use of quality information among the public.

We also seek clarification from CMS on the process it will employ to determine whether a QCDR measure is deemed valid and reliable for use for public reporting and how it plans to analyze the measures. In addition, we seek clarification of the intended requirements for a QCDR to publicly report performance rates of EPs through a feedback report. Would it be sufficient for a QCDR to report the information through a feedback report and publicly post it on an internal website that only QCDR participants could view? Could the feedback report only include de-identified information on QCDR participants and/or sites?

b. Number of Non-PQRS measures: CMS still considers it necessary to limit the number of non-PQRS measures while the agency gains experience with the program. We appreciate CMS instituting flexibility in the measures that a QCDR may report, and support CMS increasing the limit of non-PQRS measures from 20 to 30 measures. This will allow QCDRs to meet the various needs of their members and take into account sub-specialties that utilize its registry.

E. EHR Reporting Option

For 2015, CMS proposes to modify the criteria for satisfactory reporting by individual EPs (to avoid the 2017 PQRS payment adjustment) to require the reporting of individual measures via a direct EHR that is CEHRT, or an EHR data submission vendor that is CEHRT. The EP would report nine measures covering at least three of the NQF domains. If the EP's CEHRT does not contain patient data for at least

nine measure covering at least three domains, then the EP would be required to report all of the measures for which there is Medicare patient data. An EP would be required to report on at least one measure for which there is Medicare patient data. **We seek clarification as to whether the MAV process would apply to EPs who chose to report through the EHR reporting option.** If so, we are concerned that an EP may believe they only have one measure for which there is Medicare patient data, but get captured in the MAV process. In addition, does this change (to requiring an EP to report on at least one measure where there is Medicare patient data) apply to EPs who only want to meet MU? Or only EPs that want to align their quality reporting with PQRS, MU and the VM? If this does apply to MU, would an EP that does not have any denominator-eligible patients still have the ability to report zeroes and satisfy their quality requirements? It is unclear whether this proposed change resolves part of the alignment problem between PQRS and MU.

F. Group Practice Reporting Option (GPRO)

For 2017, CMS proposes to modify the requirements for group practices that chose to participate in 2015 PQRS through a registry. Group practices that choose to report using a qualified registry and select to participate in the GPRO for the 2017 PQRS payment adjustment would be required to report at least nine measures, covering at least three of the NQS domains. Of these measures, if a group practice sees at least one Medicare patient in a face-to-face encounter, the group practice would report on at least two measures from the cross-cutting measure set. As indicated above, we do not support the requirement of having to report two cross-cutting measures due to CMS' proposal to eliminate such a significant number of measures from the program. We believe that group practices, especially specialty practices (e.g., ophthalmology, emergency medicine) will have difficulty finding two measures that work for the group. **CMS should scale down the number of required measures to three, consistent with our recommendation on individual reporting to allow specialty group practices the option to participate through GPRO. We also recommend that group practices who report through a registry be able to report measures groups.** Measures group reporting is a popular option for specialists.

G. Clinical and Group- Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS)

The Proposed Rule singles out the CG-CAHPS survey as the most appropriate instrument for physician groups and individual physicians to measure patient experience under the PQRS and VM programs. The AMA continues to support the use of the CG-CAHPS survey as one means of measuring the patient centricity of a medical practice. However, there are other survey instruments available, which also provide actionable feedback to physicians that can inform their actions and contribute to high quality care in everyday practice. We are also disappointed that CMS continues to fail to adopt the Surgical-Consumer Assessment of Healthcare Providers and Systems (S-CAHPS) as the appropriate means for large surgical groups to participate in the GPRO option. It is inappropriate to require a surgical practice to institute CG-CAHPS in their practice because its questions are not relevant to surgeons.

We are also disappointed to learn that CMS will no longer bear the cost for administering CG-CAHPS through a CMS certified survey vendor, especially since it is a requirement for GPRO practices of 100 or more EPs. Since CMS requires CAHPS to be administered through a CMS-Certified Survey vendor, rather than a vendor of the practice's choosing, administration of CAHPS becomes more of a burden, especially for practices that have already implemented CAHPS. We are also concerned with the cost to

implement and administer the survey given that CMS will only allow for administration through a CMS-Certified Survey vendor, which may also stifle competition.

CMS also proposes for the 2018 payment adjustment to require group practices comprised of 25 or more EPs that are participating in GPRO to report and pay for the collection of the CAHPS for PQRS survey measures. **The AMA opposes CMS' proposal to move in this direction due to the reasons mentioned above for group practices of 100 or more EPs**. Besides cost, the implementation of CAHPS is extremely burdensome on a practice, especially a small private practice with limited resources that are subject to a 12 to 13 percent payment adjustment and who may just be beginning to participate in PQRS. In addition, response rates are typically low. We have received feedback from providers that patient compliance is very difficult to obtain, and expressing concern with ample sample size for CMS to make a fair assessment of a practice. The collection of CAHPS data may also lead to survey fatigue by patients due to the requirement and inclusion in the Medicare Shared Savings Program and Inpatient Quality Reporting program. Patients do not know the difference between the CG-CAHPS, Surgical-CAHPS, and Hospital-CAHPS surveys, and this will only become more problematic if the requirement expands. A patient managed for a chronic condition by multiple group practices will be bombarded with filling out lengthy and highly subjective surveys.

If CMS moves forward, practices should not be held liable or penalized for lack of patient compliance, which is beyond their control. CMS should only require a group practice to report on three measures since implementation of CAHPS is so resource intensive and cumbersome. It also needs to be acknowledged that with all experience surveys, regardless of survey type, patients' opinions vary based on cultural and regional differences.

H. Informal Review

CMS proposes to modify the payment adjustment informal review deadline by two-thirds, from 90 to 30 days from the release of the PQRS Feedback Reports. While we support having an informal review process in place, **we do not support CMS' change in timeline for requesting an informal review to only 30 days.** The process for accessing a PQRS Feedback Report is extremely cumbersome and historically has been rife with problems. Sometimes it takes 30 days just for an EP or group practice to obtain a PQRS Feedback Report, not to mention the time needed to analyze the report and assess whether to request an informal review. We are also concerned that the Quality Net Help-Desk will be bombarded with calls and emails requesting assistance since we are now strictly in a PQRS and VM penalty phase. In addition, CMS communications channels for notifying EPs on the availability of PQRS Feedback Reports are not streamlined. For example, in 2013, the AMA was only made aware of the release of the 2012 PQRS Feedback Reports about four to six weeks after their release. CMS specifically highlights in the rule that the agency relies on specialty societies to educate physicians on the quality programs, but the AMA and specialty societies cannot provide timely updates to its members if CMS does not adequately notify its partners. Furthermore, we do not believe the proposed deadline would allow physicians to make more timely correction of reporting errors. CMS specifically states they would only allow resubmission of data that was submitted using a third-party vendor, qualified registry, EHR data submission vendor, or QCDR reporting and would not allow resubmission of data submitted via claims, direct EHR or GPRO web interface. Therefore, any identified errors resulting from the Informal Review process would be on the vendor side and not with the EPs reporting incorrectly, which does not allow an EP to internally analyze their data and potentially contest incorrect calculations by CMS.

We also urge CMS to allow EPs and groups to contest their PQRS payment adjustment if they believe there were calculation errors due to ICD-10 transition. ICD-10 begins on October 1, 2015, during the last three months of the PQRS reporting period. It is more than likely there will be calculations errors by CMS, physicians, and third-party vendors due to the transition.

I. Transition to ICD-10

The AMA welcomes the opportunity to work with CMS to address foreseeable problems with transition to ICD-10. The ICD-10 transition is scheduled to occur on October 1, 2015, and there are serious potential implementation issues for how ICD-10 will affect PQRS, VM, and MU. After that date, as stated in the 2015 Hospital Inpatient Prospective Payment System (IPPS) final rule, CMS plans to collect non-electronic health record-based quality measure data coded only in ICD-10. CMS highlights its concern that the transition to a new coding system may have unintended consequences for quality measure data denominators, statistical adjustment coefficients, and measure rates. The AMA echoes these concerns, but we are also concerned that CMS has not addressed ICD-10 with respect to Medicare Part B and CMS' plan for handling physician quality measures in programs such as PQRS, VM, and MU. The IPPS rule only provides details on non-electronic quality measures for hospitals—and does not discuss possible issues around physician eCQMs. We hope that CMS will, in the 2015 Physician Fee Schedule final rule, discuss its plans for dealing with the transition, and fully explain both the rationale for having the baseline year vary from the performance year, and the codes that will be used to perform calculations. We urge CMS to test submission of all measures with updated ICD-10 specifications prior to the deadline, and to hold physicians harmless if CMS and vendors cannot accurately accept and calculate the measures. The difficulties around the ICD-10 transition present another reason why penalties need to be modest. CMS should exempt physicians from all penalties if CMS cannot accurately calculate measures due to the transition.

We are most concerned about the effects of ICD-10 on VM measures, as measure calculations and associated costs will vary depending upon the utilization of ICD-9 or ICD-10. There are several ways that CMS could handle the transition, outside of exemptions. CMS could consider an alternative reporting period of 90 days for the 2015 PQRS and VM programs. Or create a reporting period that only uses ICD-9 (Jan. 1-Sept. 30) or ICD-10 (Oct. 1-Dec. 31) or maintain the current structure, but the AMA perceives problems with calculations when the baseline is coded differently from the performance year. CMS cannot assume that evaluations and comparisons under ICD-10 will be the same as those under ICD-9. We foresee unintended consequences for measure denominators and measure rates. Transitioning the VM program to the ICD-10 system could significantly alter how measures are scored between the baseline and performance periods. We, therefore, urge CMS to run both the baseline data and the performance data using ICD-9-CM and ICD-10-CM (using crosswalk software) and make the results of the testing public. This would also assist with determining whether the crosswalks are valid since we have no knowledge of the potential repercussions.

However, instituting a shortened reporting period in 2015 would prevent foreseeable problems with capturing measures correctly due to the ICD-9/ICD-10 transition, since physicians would only be reporting on measures that include ICD-10. This would also allow physicians an additional opportunity to avoid 2017 payment adjustments and appropriately plan for ICD-10 transition, as well as be in line with 90-day reporting for first year MU participants. A 90-day period also provides EPs the opportunity to obtain and review their 2014 PQRS Feedback Report to determine whether they made mistakes with

their reporting and correct the errors for 2015. CY 2014 was the first year of payment adjustments so it is even more critical for CMS to allow physicians to have an opportunity to evaluate their mistakes and make corrections. CMS only has to look back to the 2013 PQRS program where it provided multiple PQRS reporting periods for avoiding the 2015 PQRS penalty.

We also suggest that CMS consider how it plans to account for claims that must be resubmitted with a service date prior to October 1, 2015, and how the agency plans to handle appeals. We understand that CMS will need to be able to continue to accept ICD-9 codes in order to accommodate these situations. Services that fall into these categories should be included for quality reporting purposes.

Congress left it up to HHS to define the "quality reporting period" for PQRS penalties in 2015 and beyond. Section 1848(a)(8) of the Social Security Act requires a PQRS adjustment "if an eligible professional does not satisfactorily submit data on quality measures for covered professional services for the **quality reporting period** for the year (as determined under subsection (m)(3)(A) . . ." Section 1848(a)(8) also states that "The term 'quality reporting period' means, with respect to a year, a period specified by the Secretary." There is no explicit requirement that the "period specified by the Secretary" has to be an entire year. Moreover, the phrase "with respect to a year" logically refers to the year in which penalties would apply; otherwise, Congress could have said that the "quality reporting period" means a "prior year" specified by the Secretary, instead of a "period specified by the Secretary." The referenced subsection (m)(3)(A) (of section 1848) says "an eligible professional shall be treated as satisfactorily submitting data on quality measures for covered professional services for a reporting period (or, for purposes of subsection (a)(8), for the quality reporting period for the year) if quality measures have been reported" in the number specified, for "services of such professional furnished during the period . . ." Again, the term "for the year" refers to the year that penalties will apply, as differentiated from the quality reporting <u>period</u>.

XVIII. Electronic Health Record (EHR) Incentive Program

CMS is proposing that beginning in CY 2015, EPs would not be required to ensure that their certified electronic health record technology (CEHRT) products are recertified to the most recent version of the electronic specifications for clinical quality measures (CQMs). While the AMA appreciates CMS instituting flexibility with respect to CEHRT, we are concerned that this proposal will not resolve the EHR certification problem as EPs are required to use CEHRT for all the other MU objectives.

CMS also proposes that if errors are discovered in the July 2014 release of the eCQMs, the PQRS program would revert back to the version of each measure that immediately precedes that release. **However, the AMA strongly discourages using specifications when a more current version exists**. Each year during the annual update process for eCQMs, measure developers review each measure to ensure that it aligns with industry standards for electronic measurement, and captures acceptable clinical practices based on clinical guidelines. Especially in the context of the release of the updated version of the Quality Data Model (QDM) version 4.1, as well as HQMF (Health Quality Measures Format) eMeasure Release 2 (HQMF R2), which is used to create logic for a measure, we believe the approach to adopt an old version of measure specifications to report could be detrimental. There are many changes to these data standards that impact future versions of the eCQM specifications. Once the measures incorporate QDM 4.1, which is scheduled for release in July 2015, measures will have a very different structure. If in future PQRS program years, specifically with the EHR reporting modality, an error is

found, CMS is essentially suggesting that a version of the measure that is no longer supported should be implemented which is inconsistent with program goals. **Reverting back to an older version of a measure will requires users of the measures, including EPs and EHR vendors, to support two versions of a single standard (e.g., HQMF, QDM), thus increasing the burden on these stakeholders and creating the possibility for substantial confusion and errors.**

XIX. Medicare Shared Savings Program

A. Proposed Changes to the Quality Measures

1. Controlling the Burden of Quality Measurement

We support efforts by CMS to retire measures that are duplicative or no longer useful, to replace measures that are outdated, and to change to measures that are more likely to address important quality goals. However, this should occur without a net increase in quality measures over time.

It is important to ensure that Accountable Care Organizations (ACOs) are not achieving savings by inappropriately withholding or limiting care that Medicare beneficiaries need. However, adding more quality measures does not necessarily mean better protection for beneficiaries, and indeed, the more quality measures there are, the less impact any individual measure will have. Moreover, too many quality measures can make the program too burdensome for physicians, deter physician participation in ACOs, and thereby deny patients the benefits of better care coordination.

The proposed regulations retire or replace eight measures but add 12 new ones, resulting in a 12 percent increase in the number of measures. CMS asserts that this will not increase the burden on ACOs because the new measures would be calculated by CMS using administrative claims data or patient survey data. However, in order for an ACO to improve performance on any measure, it will need to collect its own data relevant to that measure, and if the measure is being computed by CMS from claims data, the ACO will also need to analyze the calculations done by CMS to verify their accuracy, reconcile them with the ACO's own data, and determine appropriate actions. Consequently, adding any new measure, even if computed from claims data, will increase the burden on ACOs with no compensation for that additional time.

However, focusing only on changes in the total number of measures underestimates the burden that is created by changes in the underlying measures. Changes in measures require ACOs to shift focus to different aspects of clinical care, change data collection and analysis systems, etc. Under the Proposed Rule, more than one-third of the new set of measures would be different from the current measures, which would create a significant burden for ACOs. Frequent changes in quality measures are a recipe for failure of this vital Medicare program. Instead of continuously moving the goal posts, CMS should be working to provide more stability for Medicare ACOs by setting quality standards for the entire three-year agreement period and only changing them during that time if both CMS and the **majority of ACOs** agree the change is needed.

2. Measuring Care Coordination

Nearly half of the completely new measures are inconsistent with CMS' own criterion not to include "measures addressing high cost services or utilization" or its statement that "the potential to earn shared savings offers an important and direct incentive for ACOs to address utilization issues in a way that is most appropriate for their organization, patient population, and local healthcare environment." While the term "utilization" in the policy may have been conceived narrowly as meaning services directly ordered by a physician or other provider, the policy statement is equally relevant to complications, ambulatory care sensitive hospitalizations, readmissions, etc. that are potentially preventable through better patient care.

- **We recommend that measure ACO-35 not be adopted.** The proposed ACO-35 measure (Skilled Nursing Facility 30-Day All Cause Readmission Measure) measures hospitalizations that would be included in the overall spending assigned to the ACO. An ACO will be penalized through a reduction in shared savings if it has a high rate of readmissions, so it is duplicative and unnecessary to include this as a quality measure. Moreover, ACOs that focus the use of skilled nursing facilities (SNFs) more on higher-acuity patients could see an *increase* in SNF readmission *rates,* even though the total *number* of readmissions from SNFs actually *decreased.* This would inappropriately penalize the ACO for doing something CMS is encouraging.

- **We recommend that measures ACO-36, ACO-37, and ACO-38 not be adopted, or they should at least be delayed until the specifications and results of measure testing are available.** The proposed ACO-36, ACO-37, and ACO-38 measures (All-Cause Unplanned Admissions for Patients with Diabetes Mellitus, Heart Failure, and Multiple Chronic Conditions) are all based on hospitalizations that would be included in the overall spending assigned to the ACO. An ACO will be penalized through a reduction in shared savings if it has a high rate of any of these admissions, so it is unnecessary to include these as quality measures. These measures might be appropriate if there were reason to believe that ACOs would avoid addressing these areas. But these all represent large patient populations for ACOs, and there are known ways to reduce high rates of admissions and readmissions for these patient populations. Thus, ACOs are unlikely to ignore these areas if there are opportunities to reduce them. Including them as quality measures could also force the ACO to focus on areas that do not represent the best opportunity to improve patient care and reduce spending. There is already a measure of admissions for heart failure in the ACO quality measures (ACO-10), which should be deleted if a new measure of heart failure admissions is added.

- Since the Proposed Rule indicates that the three unplanned admission measures are "under development," it is difficult to evaluate them in any detail. If they are to be used, it is important that they be risk adjusted appropriately.

- **We also recommend that CMS drop measures ACO-9 and ACO-10 because of the inadequate risk adjustment in the measures.** The current Ambulatory Sensitive Condition Admissions measures for COPD (chronic obstructive pulmonary disease)/asthma and heart failure (ACO-9 and ACO-10) were designed as population level measures for a community, not as performance measures for a provider organization. The risk adjustment for these measures is very limited and neither adjusts for the severity of the primary condition (COPD/asthma or heart failure) nor for other comorbidities; as a result, the measures can penalize ACOs whose patients are sicker, and they can be particularly

problematic for small ACOs because of the greater likelihood of variation in the mix of health problems for their patients. Any new measures need to avoid creating a similar problem.

- **We would also recommend that CMS drop measure ACO-11 ("Percent of PCPs [primary care providers] Who Successfully Qualify for an EHR Incentive Program Payment") rather than modify it.** This measure has no direct relationship to the quality of patient care. To the extent that EHRs will improve patient care, then ACOs already have an incentive to use them in order to improve their performance on the quality measures as well as on spending, so there is no need to measure this separately. Moreover, since CMS has stated that its goal is to move to outcome-based measures, it is inappropriate to use a process measure like this.

3. Measuring Clinical Care for At-Risk Populations

We strongly support updating measures to match the latest clinical evidence and to ensure that they do not encourage care that is inappropriate for the elderly, particularly frail elderly and patients with multiple health problems. Consequently, **we support revising the measures used for diabetes and cardiovascular care to conform to the most current evidence.**

However, **we are concerned by the proposal to create wholly new composites of measures for diabetes and coronary artery disease.** The current ACO quality measures use a composite diabetes measure that was developed by Minnesota Community Measurement and endorsed by the National Quality Forum. In the Proposed Rule, CMS is creating an entirely new composite using a combination of measures from Minnesota Community Measurement and NCQA. Similarly, a wholly new composite is being created for coronary artery disease. The rule does not define the methodology that will be used for the new composites, but if it is based on all-or-nothing scoring, there will be no ability to benchmark providers' performance because no similar composite measure is being used in the Medicare program or elsewhere in the country. **If CMS is going to create wholly new composites, then it should extend the phase-in period to allow at least two years for reporting before performance is used to modify shared savings payments.**

The Proposed Rule adds a new measure for depression remission because it "is a serious health condition for the Medicare population," it "can decrease patient adherence to treatment for chronic conditions," and it "is appropriate to be addressed by ACOs." However, these same statements could be made about many other health problems as well as about non-health factors such as income, functional limitations, etc. Since it has been shown that better care for patients with depression results in fewer hospitalizations and lower spending on other types of care, and since evidence has shown that low cost interventions can result in significant improvements in depression outcomes, ACOs already have a natural incentive to do what they can to improve care of patients with depression, so **there is no need to add a separate measure for depression remission.** No information is given to suggest that ACOs are in any fashion delivering lower-quality care to patients with depression than are any other providers, nor is there any information given to support adding a measure for this condition rather than measures for other conditions.

Medicare beneficiaries experience many different important health problems, and it would be impossible to include measures for all of them in the ACO program, so clear guiding principles are needed to decide which measures to include and why. **We would suggest that the focus of quality measures for the ACO program be on preventive health measures.** Since delivering preventive services increases

spending in the short run but in many cases, most of the associated savings will occur several years in the future, a three-year ACO shared savings contract does not provide the same incentive to invest in preventive care as it does to invest in care coordination or more effective management of current health problems. Consequently, quality measures around prevention help to offset the financial incentive to underinvest in preventive care.

4. Measuring Patient/Caregiver Experience

Patient experience measures can be a helpful way of ensuring that patient care does not suffer when providers are under pressure to reduce spending. However, it seems unlikely that most patients would view a discussion about the cost of their medicines—the issue addressed by the proposed ACO-34 measure ("Stewardship of Patient Resources")—as equivalent in importance to their ability to get timely care, communicate with their physician, or improve their health status. Yet the proposal would give this new measure equal weight with the other CG-CAHPS measures. The measure itself is also ambiguous, failing to specify whether the discussion with the patient should emphasize the cost of the medicines to Medicare, or to the patient. In addition, the wide variation in Part D plan formularies and cost-sharing among the patients attributed to the ACO will make it difficult to approach this issue in any standardized way. A drug that is very expensive for one patient may be very affordable for another. Encouraging adherence to medications is a key strategy for reducing avoidable costs, and inability to afford medications is a key barrier to adherence, so ACOs already have an incentive to discuss the cost of medications with their patients. Consequently, **there is no need to add the proposed ACO-34 measure.**

5. Truly Rewarding Higher Quality

If CMS wishes to expand the number of quality measures or to make quality improvement into a primary goal for the ACO program, then it should provide a higher share of savings to ACOs than under the current MSSP rules. Today, the *maximum* share of savings that ACOs can receive is 50 percent in Track 1 and 60 percent in Track 2. That share is reduced if *any* of the quality measures fall below the highest performance level. The more quality measures that are added, the less likely it is that the ACO will receive the maximum share of savings. Yet the more quality measures an ACO needs to pursue, the more it will need to spend in order to improve quality and the greater the financial losses it will likely incur, particularly in areas where the fee-for-service system either fails to pay for high-value services (e.g., chronic disease management) or reduces providers' revenue when quality improves (e.g., fewer readmissions), or both. So the ACO is in a Catch-22; the more quality measures it pursues, the higher its costs and lower its revenues will be, but it will be less likely to receive shared savings to offset those costs and losses. Moreover, increasing the share of savings given to ACOs will not necessarily reduce the amount of savings to the Medicare program. It is quite possible that CMS would obtain more savings for the Medicare program *in total* if increasing the proportion of savings given to ACOs creates a greater incentive for providers to participate in the shared savings program and for ACOs to find ways to generate savings.

Nothing in the Affordable Care Act requires that ACOs receive such a small share of the savings they generate for Medicare. Once sufficient savings have been achieved to assure CMS that the savings were not due to random variation, an ACO could be paid 70 percent, 80 percent, or 90 percent of the savings, and they would still reduce net spending for the Medicare program. If CMS wants to encourage improvements in quality, particularly in areas of patient care where such improvements are difficult to

achieve, then it should *increase* the share of savings above 50 percent or 60 percent for those ACOs that achieve higher quality.

B. Future Quality Measures

We believe that quality measures should be primarily designed to *protect* beneficiaries from inappropriate reductions in services by ACOs. Quality measures should focus on the kinds of services where a lack of care today would not result in more expensive care within the timeframe of an ACO contract, such as preventive care services. If CMS wants quality measures to *improve* care for beneficiaries, then the measures should focus on areas where: (a) CMS believes that Medicare beneficiaries are receiving poor care today; and (b) it is feasible for an ACO to make changes in care that would improve care in those areas using the limited resources available in the shared savings program. As noted earlier, if the goal is quality improvement—rather than preservation of current quality—then the shared savings formula needs to be restructured to ensure that adequate resources are directed to providers to achieve this. With respect to the specific areas identified in the Proposed Rule as candidates for new measures:

- *Gaps in measures and additional specific measures.* ACOs are accountable for total spending, and so they have a natural incentive to improve care coordination. **There is no need to add more care coordination measures. Adding measures specific to particular settings can be very problematic if ACOs change the mix of patients in different settings.** For example, if an ACO arranges for more patients to receive home health care rather than care in a skilled nursing facility (SNF) after discharge, the acuity level of patients in both home health and SNF in that community will be higher than in other communities, which could make the ACO appear worse on quality measures in those settings. As noted earlier, if the number of patients using SNFs decrease, then the smaller, higher acuity group of SNF patients might have a higher readmission *rate*, even though there would be fewer readmissions in total than before.

- *Caregiver experience of care.* Caregivers can make a major difference in patients' adherence to treatment plans, early access to care, etc. **ACOs already have a strong incentive to effectively engage caregivers in improving care for patients, so there is no need to add measures specifically in this area.** Moreover, the patients in different ACOs may have very different access to different kinds of caregivers, and so measuring caregiver experience may lead to non-comparable results across ACOs.

- *Alignment with the Value-Based Payment Modifier*. **We do not believe the current Ambulatory Sensitive Condition Admissions measures for COPD/asthma and heart failure (ACO-9 and ACO-10) are appropriate for ACOs**, since they were designed as population level measures for a community, not as performance measures for a provider organization. The risk adjustment for these measures is very limited and neither adjusts for the severity of the primary condition (COPD/asthma or heart failure) nor for other comorbidities; as a result, they can penalize ACOs whose patients are sicker, and they can be particularly problematic for small ACOs because of the greater likelihood of variation in the mix of health problems for their patients. We believe that the measures CMS is using for the Value-Based Payment Modifier (VM) are similarly flawed; indeed, they are even more inappropriate for use with solo physicians and small practices than with ACOs. Problems with the individual measures cannot be solved by combining them into a composite. We recommend aligning the ACO and VM programs by removing these measures from both programs.

- *Assessing Care for Frail Elderly*. Rather than adding additional measures focused on the frail elderly, **we recommend that CMS provide additional flexibility to physicians to exclude patients from the quality measures if their frailty or multiple health problems require a different approach in care.** A physician or ACO should not have to wait for a change in regulations, such as what CMS is proposing with the deletion of ACO-22, in order to avoid a financial penalty for providing the most appropriate care to their patients.

- *Utilization.* We recommend that CMS continue to provide information on utilization to ACOs but not add measures of utilization to the quality measurement formula. ACOs should have the flexibility to use different combinations of services to achieve the best outcomes for their patients at the lowest cost. Higher-than-average utilization of a particular service may help reduce utilization of other services or improve quality for patients. This should not be precluded by creating separate measures of specific types of utilization. In addition, if ACOs are successful in keeping their patients healthier, the proportion of patients who are no longer attributed to the ACO may decrease, making utilization rates for the remaining, attributed patients appear artificially high.

- *Health Outcomes*. We believe it is important to move away from process-based measures toward outcome-based measures. However, the outcomes that are measured must be within the control of the ACO, and there must be effective risk adjustment to avoid penalizing ACOs that manage the care of beneficiaries with more needs and to avoid causing access problems for such beneficiaries.

- *Measures for Retirement.* We believe that measures should be retired when they are no longer supported by clinical evidence or when use of them could lead to undesirable consequences. However, we do not believe that measures should be retired simply because they are "topped-out," as we discuss further below.

- *Additional Public Health Measures.* As noted above, we support the use of preventive health measures in the quality performance formula for ACOs in cases when the majority of savings from improved preventive care will likely occur several years in the future. Screening and brief counseling for alcohol use is a highly desirable component of care, but it will likely have significant short-term benefits as well as long-term benefits. So ACOs will have a natural incentive to pursue this without adding a separate quality measure for it.

Rather than adding more quality measures, the priority should be improving the attribution methodologies and the spending measures for ACOs. **ACOs should be held accountable only for services they have the ability to control, and they should receive "credit" for patients who are healthy and don't need frequent office visits.**

C. Electronic Health Record Reporting

If the use of EHRs and HIE (health information exchange) will improve quality of care, improve care coordination, reduce duplicative services, etc., then the Shared Savings Program gives ACOs a natural incentive to use them, and there is no need for the program to separately require or incentivize the use of the technology. If ACOs find that EHRs and HIEs are the most effective way to improve quality, then reporting quality measures through EHRs will also become the simplest approach to reporting. Rather

than requiring EHR-based reporting, CMS should give providers the option to report through EHRs. If they do not report through EHRs, rather than assuming that this is due to resistance that has to be overcome through mandates, CMS should seek input from providers to determine whether there are barriers to reporting through EHRs or whether the EHRs are not providing adequate value for quality improvement efforts.

D. Revisions to "Topped Out" Measures

The AMA opposes removing measures simply because they are "topped out." If a measure was appropriate to include as a quality measure for ACOs when it was *not* "topped out," then the mere fact that it is now "topped out" does not justify removing it. Quality measures are intended to protect Medicare beneficiaries from receiving inappropriate care. Even if "all but a very few" organizations achieve "near perfect" performance, it is important to retain that measure to encourage better performance from the low performing organizations, and to prevent backsliding by the high performers.

We strongly disagree with the assertion on page 40488 that "smaller practices may be able to achieve these higher levels of performance more easily than larger practices or organizations with larger patient populations." Many aspects of the ACO program implicitly or explicitly favor larger organizations, such as the lower thresholds for achieving shared savings and the greater economies of scale in complying with EHR requirements. If small practices do better, it is because they work harder at delivering high quality care and they remain more closely connected to their patients' needs than large healthcare systems.

Removing a measure that providers perform well on, in order to add a measure they do not perform well on, penalizes ACOs for making the investments of time and money needed to achieve high performance. The fact that a measure is currently "topped out" does not mean that it was easy to achieve that level of high performance or to maintain it consistently over time. In addition, the current standards for determining that measures are "topped out" are based on the quality measure experience of early adopters, generally larger health systems. As smaller ACOs and smaller practices enter the programs, these measures may not remain "topped out." If the measures truly are more achievable than some other measures, they should not be retained.

E. Standards in Subsequent Performance Periods

A performance standard for a quality measure should not be continued into a second or a subsequent participation agreement, if there have been any significant changes in the specifications used to calculate the measures. An ACO's performance level on quality measures will vary depending on how the measures are calculated. Moreover, there are serious problems with the attribution methods currently used in the Shared Savings Program that we hope will be addressed in future regulations. Improvements in attribution could result in significant changes in ACO's performance on some or all of the measures, making it inappropriate to continue using benchmarks based on previous, flawed attribution methodologies.

F. Timing for Updating Benchmarks

We agree that ACOs need to have stable benchmarks in order to plan quality improvement interventions and predict the impact on their shared savings payments. However, if the specifications for a quality

measure change, then the benchmark for that quality measure should be updated immediately so that the ACO's performance on the measure and the benchmark are comparable.

G. Rewards for Quality Improvement

We support modifying the quality performance formula to explicitly recognize and reward improvement on quality measures as well as the attainment of high performance. However, if CMS wishes to create greater incentives for quality improvement, then ACOs need to receive a higher share of savings than under the current MSSP rules, rather than simply receiving bonus points for improvement under the current formula. Even if CMS retains a lower share of savings, it would still be spending less than it would have otherwise. Moreover, CMS may well be able to save more in total than it would by retaining a higher share of savings, and it would likely see more significant quality improvements on a broader range of measures.

XX. Value-Based Payment Modifier and Physician Feedback Program

In this Proposed Rule, CMS accelerates a rapid and risky expansion of the ACA-mandated VM with proposals to double both the number of physicians affected and the size of the penalties they could incur. The AMA acknowledges that the extension of this untested concept to an additional 331,141 physicians in small or solo practices was required by law. However, we have repeatedly urged CMS to seek a modification in that directive. **The AMA is very troubled by the agency's continued failure to conduct a rigorous impact analysis of its VM framework before proceeding recklessly with plans to increase the VM penalty from two percent to four percent, leaving some practices vulnerable to total Medicare payment cuts of 11 percent in 2017.**

What little analysis has been conducted is based on a period when the PQRS program that underpins the VM was far less rigorous than it is today, potentially underestimating the number of physicians who will face penalties under the current program. What data we do have suggests that the modifier discriminates against Medicare's frailest patients and their physicians. Studies to date have not attempted to gauge the combined impact of PQRS, VM and other penalties on vulnerable practices. Numbers cited in the NPRM to justify the rapid adoption and escalation of VM penalties focus on "average" impacts. They fail to provide reasonable assurances that the VM will not routinely penalize certain categories of patients and physicians.

There are also serious questions about the efficacy of the VM, which shares the flaws of many of the current approaches to measuring and assigning accountability for health care spending, as outlined in a recent paper by Center for Healthcare Quality and Payment Reform President Harold Miller.[12] These include the assignment of accountability based on aggregate costs rather than those services that a particular physician or group actually had control of, failure to incorporate prescription drug costs, the inability to distinguish between appropriate and inappropriate spending, and inadequate adjustment for patient risk and structural differences in costs. Moreover, as CMS' own studies have shown, even medical groups of 25 or more often have inadequate data from which to draw conclusions about costs

[12] Miller, H.D. "Measuring and Assigning Accountability for Healthcare Spending." Center for Healthcare Quality and Payment Reform, August 2014. http://www.chqpr.org/downloads/AccountabilityforHealthcareSpending.pdf

and/or quality. How then can the VM be applied with any confidence to even smaller groups and solo practitioners?

Coupling the seriously flawed VM concept with a shortage of time and resources for CMS outreach to the more than 1.1 million practitioners (to whom CMS wants to apply the VM), and the aggressive VM expansion envisioned in this rule, is inappropriate to say the least. Some of Medicare's sickest patients could lose access to their doctors, some physicians could be driven out of business, and the government will have diverted scarce resources from other payment and delivery reforms that have a far better chance of achieving a more value-based health care system.

As noted in our comments on the 2014 Physician Fee Schedule proposed rule, the Administration wisely chose to delay the ACA's employer mandate rather than proceed without adequate structure and outreach. We strongly urge that CMS adopt a more cautionary and realistic approach to the VM as well. Ideally, this would include a request to Congress for authority to adopt a more targeted approach. At the very least, the agency should slow the VM's expansion and provide a more stable environment as the VM is implemented. It is disconcerting and confusing for practices to be subject to rules which were in place in a performance year that occurred two years earlier, but were replaced in the following year. **The AMA specifically opposes: increasing the VM penalty from two percent to four percent; mandating participation in the tiering competition; and continuing the use of cost and outcome measures that have never been tested for use in physician offices. We also believe that it is not necessary to compound the complexity of the VM by extending it to ACOs and other alternative payment and delivery models.**

A. Trouble Signs

As noted above, what little data we do have raises serious concerns. At several points in the rule, CMS offers reassurance that based on their 2012 cost and quality data, only 11 percent of physicians would have incurred a VM penalty. This means that a minimum of 90,000 physicians and 35,000 other practitioners would face penalties of up to four percent. This does not even include those physicians who incur a penalty because neither they nor their group successfully participated in PQRS. Without more information on the expected PQRS failure rates, it is impossible to estimate the total number of physicians who will face the four percent VM penalty and what proportion of those will also face a PQRS penalty. **However, the number of penalized practitioners is potentially considerably larger than 125,000, and with a four percent penalty, a significant number of these practitioners may choose to reduce the number of Medicare patients in their practice, particularly if they are facing other penalties as well.**

An evaluation of the 2012 QRURs that contain the data used to compute payment adjustments under the VM is cause for further concern. In the report, Mathematica Policy Research found that among medical groups with 25 or more practitioners, **the groups most likely to incur penalties are comprised mostly of primary care physicians, who have the sickest patients.** Specifically, among groups with patient risk scores in the highest quartile or at least 80 percent of their physicians providing primary care, one in four—or roughly three times more than the average for all groups—were scored as having low quality. With respect to cost, about one in three of the groups with high risk patients and a primary care focus fell into the high cost category—compared to only eight percent of all groups of 25 or more. In a similar vein, data published in the 2014 proposed rule found that **physician specialties, such as oncologists and**

geriatricians, who typically treat patients with multiple and/or very serious conditions were more likely to be seen as having high aggregate costs per patient than other physicians.

As noted above and in past AMA comments on this issue, most private payers have limited the use of pay-for-performance programs to certain specialties and certain conditions. We do not believe it is feasible or cost-effective to expand the concept to small practices. The 2012 QRUR Experience Report reinforces that view with its finding that **among groups of 25 or more, one-third had no Medicare patients attributed to them, and another nine percent did not have enough Medicare patients attributed to them to compile a report.** These were primarily groups in which at least 50 percent of the physicians were in the same specialty. After modification of the attribution methodology proved unsatisfactory, the agency resorted to simply calling all of these practices "average." It seems likely that the failure to meet minimum patient attribution numbers will be even more pronounced as the VM is expanded to smaller practices, which raises important questions. **What is the point in wasting CMS and physician resources on an empty report? Would it not be more productive to target these resources on improving both the content and timeliness of reports for a smaller number of conditions and practices?**

In response to specific issues and questions raised in the Proposed Rule, we offer the following views:

B. Structure of the VM/Two Category Approach

CMS is proposing to retain a two-step structure that divides physicians into two groups: those who did comply with PQRS reporting requirements, and those who did not. Non-compliant practices would automatically receive the maximum four-percent penalty. Those who did comply would be placed in a mandatory competition or "tiering" process where their cost and quality is compared to that of other successful PQRS participants—which could result in a four-percent penalty, a two-percent penalty, no adjustment, or an as yet undetermined bonus.

While the AMA has never supported the VM, we agree that if there is to be a VM, basing its quality component on PQRS is a reasonable approach. We do not object to a second step where groups can compete for bonus money at the risk of finding themselves facing a penalty instead. However, we believe it is counterproductive to mandate participation in a tiering competition where physicians who fulfilled the PQRS reporting requirements are at risk for the same penalties as practices that did not. It is also irresponsible to apply penalties to practices that have done their best to comply with PQRS requirements, but were scored as having high costs and/or low quality because the risk and specialty adjustments and overlapping cost measures employed in the VM disadvantage practices that treat Medicare's frailest patients. The proposed exemption from negative adjustments in the first year a practice is subject to the VM is better than nothing, but ultimately insufficient to compensate for all the methodological problems that plague the VM.

We are also concerned that some physicians will incur penalties in the tiering process, simply because CMS had insufficient data to judge them on. The agency's solution for these groups is to default them into the "average" tier but groups could still incur a two-percent penalty if they had enough data to be scored for one category but not the other. Other groups with sufficient data for both cost and quality could potentially offset a bad score on one component with a good score on the other. But groups defaulted into the "average" tier for one component or the other would not have that opportunity. In our

view, it is unfair to disadvantage these groups simply because the VM methodology does not work for them. To resolve the issue, **CMS should go back to making tiering voluntary for all practices**.

C. Maximum VM-Related Penalty

We understand that CMS officials may feel the need to respond to critics who argue that physicians will never participate in Medicare's value-based purchasing programs unless they face substantial penalties for not doing so. **However, as previously stated, CMS' proposal could lead to an 11 percent payment cut for many practices—and is just as likely to drive physicians out of Medicare as into the various value-based incentive programs.** A far better motivation would be to put more effort into improving the PQRS program, dealing with the array of methodological issues that plague the VM, and creating feedback reports that provide data that is timely, reliable, and relevant to daily practice. It is also worth noting that many of the practices that will be subject to 2016 VM adjustments, based upon their performance in 2014, have still never received a QRUR and have no idea what is coming. We sincerely hope that additional resources and outreach will be made available when the program doubles in size.

D. Application of the VM to ACOs

CMS' decision to reverse its own policy of exempting ACOs and other alternative payment and delivery models approved by the CMMI, is both disappointing and unnecessary. The NPRM suggests that the policy reversal stems from a rigid interpretation of the legislative language stipulating that the VM should apply to ALL physicians in 2017. **We do not believe that Congress intended such a broad interpretation. These practices are already subject to quality improvement requirements and cost-saving incentives set by CMMI. Bringing them under the VM umbrella is duplicative, unnecessary, and counterproductive.** If CMS officials believe the agency needs additional authority to continue the current VM exemption for new models of care, the Administration should seek that authority from Congress. We note that based on a comprehensive SGR replacement bill they approved earlier this year, the three Congressional committees with jurisdiction over Medicare are likely to view such a request favorably.

E. Treatment of Non-Assigned Claims for Non-Participating Physicians

We support the decision to exempt non-assigned claims from payment cuts triggered by the VM and request that this policy also be applied to penalties tied to PQRS and MU of health information technology.

F. Quality Measures in the VM

As noted in our comments on the 2014 proposed rule, the AMA generally supports the alignment of VM and PQRS quality measures. But we are concerned that the simultaneous expansion of PQRS requirements and VM penalties will increase the risk of physicians incurring penalties for both programs due to misunderstandings or unresolved problems surrounding the expanded PQRS requirements. Moreover, we continue to believe that due to the ever-changing nature of both the PQRS program and the VM, as well as potential problems related to the upcoming transition from ICD-9 to ICD-10 diagnosis codes, physicians should continue to have the option of avoiding penalties under both programs by asking CMS to calculate quality and cost data from administrative claims measures.

We also continue to believe, as stated in prior comments, that the three claims-based outcome measures which CMS has adopted are not appropriate for use at the level of physician practices. The "Hospital All-Cause Readmission" measure provides an instructive example of why the agency should resist the temptation to incorporate any available measure without sufficiently considering its reliability and validity for physician practices. If 2012 data indicated the measure could not meet even a very marginal reliability test (0.4 percent) at a 20-case threshold, why was it included in the VM in the first place? Will practices be judged on this measure with a 20-case threshold for the performance year of 2014, and a 200-case threshold in 2015? What is the justification for retaining this measure when it will still have only 0.4 percent reliability—well below the 0.7 percent reliability threshold that other researchers believe is needed for performance-based payment? What is the point of applying a measure that will only be applicable to 30 percent of groups with 10 or more practitioners, and three percent of smaller groups, and that as highlighted in the Proposed Rule is largely duplicative of VM's various cost measures?

G. Process for Correcting the VM

The AMA appreciates CMS' decision to develop a process that would permit physicians to contest various aspects of the calculations used to compute their particular VM adjustment. We agree it is desirable to align the PQRS and VM correction process, although we hope the final rule will further clarify how and when this process is to occur. Our general view is that dates for correcting this and other data being collected on physicians should occur at a set time each year. Physicians should not be expected to continue checking various web sites at various times of the year simply to determine whether they need to take action. Given the complexity of the VM and the length of time it takes CMS to compile the data, it seems highly unrealistic to expect physicians to review and contest the data within a 30-day period. For 2015, we would prefer the proposal to extend the process through the end of February rather than ending it on January 31. Other elements that should be considered in the correction process include the accuracy of patient attribution and risk adjustment. Based upon experience to date, we are concerned as to whether questions related to this process can be adequately handled through a help desk.

H. Modifications in the Total Per Capita Cost Measures

As currently constructed, the overlapping cost measures used in the VM will punish physicians repeatedly for the treatment of a subset of patients with multiple chronic diseases and acute conditions who require more frequent hospitalizations and post-acute care stays than the average patient. It is little wonder that practices treating high risk patients fared poorly in the 2012 QRUR evaluation. Rather than focusing on minor issues, CMS needs to reconsider the use of multiple measures which are all heavily influenced by the same patient population.

That said, the AMA would also like to register some concern regarding the proposals to modify the calculation of the five per capita cost measures and the three claims-based outcome measures. As noted earlier, we are troubled by CMS' failure to make adequate adjustments for differences in patients' socioeconomic status. On the other hand, we see the adoption of two other modifications in the cost and outcome measures as premature.

The first of these would modify the process of attributing patients to a practice by including care provided by nurse practitioners (NPs), physician assistants (PAs), and clinical nurse specialists (CNSs) in the initial determination of which group provided the plurality of primary care to a given patient. This approach

ignores the fact that a large percentage of NPs, PAs, and CNSs are not actually providing primary care, but instead work in various specialty practices and areas. This assumption has ramifications well beyond the calculation of Medicare cost measures, including the adjustments that are made for a group's specialty composition. Under this proposal, specialty practices that include non-physician practitioners would be expected to show lower costs than those that did not include the non-physicians, potentially discouraging team-based practices that include both specialists and non-physician practitioners. The AMA therefore recommends that CMS withdraw this proposal until the agency has studied its impact on group benchmarks and other unintended consequences.

A second proposal would include patients who died during the performance year that is being assessed. Data presented to NQF indicates that the average mean per capita cost of these patients was 11 percent higher than the average for full-year patients. In view of the evidence that suggests that groups treating high risk patients are already at the greatest risk of incurring VM penalties, we do not support a policy that has the potential to exacerbate that problem.

I. Hospital-Based Physicians

The AMA continues to support proposals that would enable hospital-based specialties to tie their VM adjustments to the performance of the hospital or hospitals where they work. We appreciate CMS' efforts to work through the technicalities of such an approach and to consult with physicians. The process is obviously complicated and could potentially benefit from a work group consisting of representatives of relevant physician organizations, CMS staff in charge of the VM, and the contractors that are assisting in its development. In general, we favor an approach that is voluntary and flexible enough to accommodate the wide array of practice arrangements that exist between hospitals and the hospital-based specialties. It is preferable to have an approach that would accommodate the many physicians and physician groups which have arrangements with multiple hospitals. It would not be appropriate to force them to choose a single facility. Requiring that the majority of its services must be hospital-based in order for a group to be eligible for this option seems reasonable. But the 90-percent threshold mentioned in the Proposed Rule is far too high.

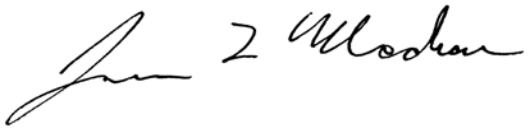
J. Physician Feedback Reports/Quality and Resource Use Reports

The AMA appreciates CMS' efforts to make the QRURs more informative and actionable. However, we are worried that the agency may be relying too heavily on these reports to warn physicians that they face substantial payment cuts if they do not participate in PQRS and do well in the VM tiering process. Experience with earlier QRURs suggests that very few physicians are actually reviewing them, but it is hard to fault them for that when more than 40 percent of groups of 25 or more practitioners would have received only a single page report saying that there was not enough data to calculate their cost and quality score. To have gotten to this point in the process, they will have had go through a tedious process of creating an account that allows them to gain access to the portal where CMS will post the QRURs. Understandably many physicians, especially those in small practices with limited administrative staff, will give up before they get this far. We understand that CMS also intends to send emails or letters informing physicians about the VM. We would like to see a fuller discussion of the agency's outreach plans in the final rule.

XXI. Conclusion

We greatly appreciate this opportunity to share the views of the AMA regarding the proposals, issues, and questions that CMS has raised in the Proposed Rule entitled *Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models & Other Revisions to Part B for CY 2015* [CMS-1612-P]. If you should have any questions regarding this letter, please feel free to contact Margaret Garikes, Vice President for Federal Affairs, at margaret.garikes@ama-assn.org or 202-789-7409.

Sincerely,



James L. Madara, MD

Attachments

APPENDIX A: AMA Comments on CMS Table 21 / Proposed "Cross-Cutting" Measures Beginning 2015

NQF/ PQRS	CMS E-Measure ID	NQS Domain	Measure Title and Description	Measure Steward	AMA Comments
0097/ 46	N/A	Communication and Care Coordination	Medication Reconciliation: Percentage of patients aged 65 years and older discharged from any inpatient facility (e.g. hospital, skilled nursing facility, or rehabilitation facility) and seen within 30 days following discharge in the office by the physician, prescribing practitioner, registered nurse, or clinical pharmacist providing on-going care who had a reconciliation of the discharge medications with the current medication list in the outpatient medical record documented.	AMA-PCPI / NCQA	The AMA agrees that this measure has been appropriately designated as cross-cutting. There is a high interest from various specialties for use in different care settings.
0326/ 47	N/A	Person and Caregiver-Centered Experience and Outcomes	Care Plan: Percentage of patients aged 65 years and older who have an care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an care plan.	AMA-PCPI / NCQA	The AMA agrees that this measure has been appropriately designated as cross-cutting.
0041/ 110	147 v2	Community /Population Health	Preventive Care and Screening: Influenza Immunization: Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization	AMA-PCPI	The AMA agrees that this measure has been appropriately designated as cross-cutting.
0028/ 226	138 v2	Community /Population Health	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention: Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user	AMA-PCPI	The AMA agrees that this measure has been appropriately designated as cross-cutting.
0101/ 318	139 v2	Patient Safety	Falls: Screening for Fall Risk: Percentage of patients 65 years of age and older who were screened for future fall risk at least once during the measurement period.	AMA-PCPI/ NCQA	The AMA agrees that this measure has been appropriately designated as cross-cutting.
N/A/ N/A	N/A	Community /Population Health	Hepatitis C: One-Time Screening for Hepatitis C Virus (HCV) for Patients at Risk: Percentage of patients aged 18 years and older with one or more of the following: a history of injection drug use, receipt of a blood transfusion prior to 1992, receiving maintenance hemodialysis OR birthdate in the years 1945-1965 who received a one-time screening for HCV infection	AGA/AASLD/ AMA/PCPI	The AMA agrees that this measure has been appropriately designated as cross-cutting. The measure title and description have been updated. The "Measure Steward" should be listed as the following: AMA-PCPI.

APPENDIX B: AMA Comments on CMS Table 22 / Proposed New Measures Beginning 2015

NQF/ PQRS	NQS Domain	Measure Title and Description	Measure Steward	AMA Comments
N/A / N/A	Effective Clinical Care	Annual Hepatitis C Virus (HCV) Screening for Patients who are Active Injection Drug Users: Percentage of patients regardless of age who are active injection drug users who received screening for HCV infection within the 12 month reporting period	AGA / AASLD / PCPI	The AMA supports the inclusion of this measure in PQRS 2015. However, we recommend changing the NQS domain of this measure to "Community/Population Health" to be consistent and align with our other screening measure proposed for inclusion in PQRS 2015. The measure title and description have been updated.
N/A / N/A	Effective Clinical Care	Post-procedural Optimal medical therapy Composite (percutaneous coronary intervention): Percentage of patients aged 18 years and older for whom PCI is performed who are prescribed optimal medical therapy at discharge	ACC-AHA	The AMA supports the inclusion of this measure in PQRS.
N/A / N/A	Community/ Population Health	Hepatitis C: One-Time Screening for Hepatitis C Virus (HCV) for Patients at Risk: Percentage of patients aged 18 years and older with one or more of the following: a history of injection drug use, receipt of a blood transfusion prior to 1992, receiving maintenance hemodialysis OR birthdate in the years 1945-1965 who received a one-time screening for HCV infection	AGA / AMA-PCPI	The AMA supports the inclusion of this measure in PQRS 2015. This HCV screening measure is assigned NQS domain "Community/Population Health" while the other HCV screening measure is assigned "Effective Clinical Care"—we believe this measure has been appropriately classified in the NQS domain and recommend changing the NQS domain of other measure to be consistent with this one. The "Measure Steward" should be listed as the following: AMA-PCPI. The measure title and description have been updated.
N/A / N/A	Efficiency and Cost Reduction	Avoidance of inappropriate use of imaging for adult ED patients with traumatic low back pain: Avoidance of inappropriate use of imaging for adult ED patients with atraumatic low back pain	ACEP	Neither the American College of Emergency Physicians nor the AMA supports inclusion of this measure in PQRS.
N/A / N/A	Patient Safety	Discontinuation of Antiviral Therapy for Inadequate Viral Response: Percentage of patients aged 18 years and older with a diagnosis of hepatitis C genotype 1 who have an inadequate response to antiviral treatment for whom antiviral treatment was discontinued	AGA / AMA-PCPI	The AMA supports the inclusion of this measure in PQRS.
N/A / N/A	Person and Caregiver-Centered Experience and Outcomes	Discussion and Shared Decision Making Surrounding Treatment Options: Percentage of patients aged 18 years and older with a diagnosis of hepatitis C with whom a physician or other clinician reviewed the range of treatment options appropriate to their genotype and demonstrated a shared decision making approach with the patient.	AGA / AMA-PCPI	The AMA supports the inclusion of this measure in PQRS.
N/A / N/A	Effective Clinical Care	Screening for Hepatocellular Carcinoma (HCC) in patients with Hepatitis C Cirrhosis: Percentage of patients aged 18 years and older with a diagnosis of chronic hepatitis C cirrhosis who were screened with either ultrasound, triple-contrast CT or triple-contrast MRI for hepatocellular carcinoma (HCC) at least once within the 12 month reporting period	AGA / AMA-PCPI	The AMA supports the inclusion of this measure in PQRS.

APPENDIX C: AMA Comments on CMS Table 23 / Proposed Measure NQS Domain Changes Beginning 2015

NQF/ PQRS	NQS Domain 2014	Proposed NQS Domain 2015	Measure Title and Description	AMA Comments
0097/ 46	Patient Safety	Communication and Care Coordination	Medication Reconciliation: Percentage of patients aged 65 years and older discharged from any inpatient facility (e.g. hospital, skilled nursing facility, or rehabilitation facility) and seen within 30 days following discharge in the office by the physician, prescribing practitioner, registered nurse, or clinical pharmacist providing on-going care who had a reconciliation of the discharge medications with the current medication list in the outpatient medical record documented	Based on the Clinical Recommendation statements, the AMA believes the re-categorization of this measure to "Communication and Care Coordination" seems appropriate.
0321/ 82	Communication and Care Coordination	Effective Clinical Care	Adult Kidney Disease: Peritoneal Dialysis Adequacy: Solute: Percentage of patients aged 18 years and older with a diagnosis of End Stage Renal Disease (ESRD) receiving peritoneal dialysis who have a total Kt/V $\geq$ 1.7 per week measured once every 4 months	The AMA agrees with the re-categorization of this measure included under the NQS Domain: "Effective Clinical Care." The Renal Physicians Association will steward this measure for PQRS 2015, so we ultimately defer to that organization.
0654/ 93	Communication and Care Coordination	Effective Clinical Care	Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy – Avoidance of Inappropriate Use: Percentage of patients aged 2 years and older with a diagnosis of AOE who were not prescribed systemic antimicrobial therapy	The AMA believes that this measure would be more appropriately categorized under the NQS Domain "Efficiency and Cost-Reduction," similar to other antibiotic choice measures. The American Academy of Otolaryngology-Head and Neck Surgery will steward this measure for PQRS 2015, so we ultimately defer to that organization.
0650/ 137	Effective Clinical Care	Communication and Care Coordination	Melanoma: Continuity of Care – Recall System: Percentage of patients, regardless of age, with a current diagnosis of melanoma or a history of melanoma whose information was entered, at least once within a 12 month period, into a recall system that includes: • A target date for the next complete physical skin exam, AND • A process to follow up with patients who either did not make an appointment within the specified timeframe or who missed a scheduled appointment	The AMA agrees with the re-categorization of this measure included under the NQS Domain: "Communication and Care Coordination." The American Academy of Dermatology will steward this measure for PQRS 2015, so we ultimately defer to that organization.
N/A/ 180	Communication and Care Coordination	Effective Clinical Care	Rheumatoid Arthritis (RA): Glucocorticoid Management: Percentage of patients aged 18 years and older with a diagnosis of rheumatoid arthritis (RA) who have been assessed for glucocorticoid use and, for those on prolonged doses of prednisone $\geq$ 10 mg daily (or equivalent) with improvement or no change in disease activity, documentation of glucocorticoid management plan within 12 months	The AMA agrees with the re-categorization of this measure to be included under the NQS Domain: "Effective Clinical Care." However, the American College of Rheumatology will steward this measure for PQRS 2015, so we ultimately defer to that organization.

NQF/ PQRS	NQS Domain 2014	Proposed NQS Domain 2015	Measure Title and Description	AMA Comments
N/A/ 280	Communication and Care Coordination	Effective Clinical Care	Dementia: Staging of Dementia: Percentage of patients, regardless of age, with a diagnosis of dementia whose severity of dementia was classified as mild, moderate or severe at least once within a 12 month period	The AMA agrees with the re-categorization of this measure included under the NQS Domain: "Effective Clinical Care." The American Academy of Neurology Institute and American Psychiatric Association will steward this measure for PQRS 2015, so we ultimately defer to those organizations.
N/A/ 288	Effective Clinical Care	Communication and Care Coordination	Dementia: Caregiver Education and Support: Percentage of patients, regardless of age, with a diagnosis of dementia whose caregiver(s) were provided with education on dementia disease management and health behavior changes AND referred to additional sources for support within a 12 month period	The AMA agrees with re-categorizing this measure, but believes the measure seems more applicable to the "Person and Caregiver-centered Experience and Outcomes" NQS Domain based on CMS' description (79 Fed. Reg. 40,401). The American Academy of Neurology Institute and American Psychiatric Association will steward this measure for PQRS 2015, so we ultimately defer to those organizations.
N/A/ 325	Effective Clinical Care	Communication and Care Coordination	Adult Major Depressive Disorder (MDD): Coordination of Care of Patients with Specific Comorbid Conditions: Percentage of medical records of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) and a specific diagnosed comorbid condition (diabetes, coronary artery disease, ischemic stroke, intracranial hemorrhage, chronic kidney disease [stages 4 or 5], End Stage Renal Disease [ESRD] or congestive heart failure) being treated by another clinician with communication to the clinician treating the comorbid condition	The AMA agrees with the re-categorization of this measure included under the NQS Domain: "Communication and Care Coordination." The American Psychiatric Association will steward this measure for PQRS 2015, so we ultimately defer to that organization.
1525/ 326	Patient Safety	Effective Clinical Care	Atrial Fibrillation and Atrial Flutter: Chronic Anticoagulation Therapy: Percentage of patients aged 18 years and older with a diagnosis of nonvalvular atrial fibrillation (AF) or atrial flutter whose assessment of the specified thromboembolic risk factors indicate one or more high-risk factors or more than one moderate risk factor, as determined by CHADS2 risk stratification, who are prescribed warfarin OR another oral anticoagulant drug that is FDA approved for the prevention of thromboembolism	The AMA agrees with the re-categorization of this measure included under the NQS Domain: "Effective Clinical Care."
N/A/ 331	Effective Clinical Care	Efficiency and Cost Reduction	Adult Sinusitis: Antibiotic Prescribed for Acute Sinusitis (Appropriate Use): Percentage of patients, aged 18 years and older, with a diagnosis of acute sinusitis who were prescribed an antibiotic within 7 days of diagnosis or within 10 days after onset of symptoms	The AMA agrees with the re-categorization of this measure included under the NQS Domain: "Efficiency and Cost Reduction" similar to other antibiotic related measures" categorization. The American Academy of Otolaryngology-Head and Neck Surgery will steward this measure for PQRS 2015, so we ultimately defer to that organization.

NQF/ PQRS	NQS Domain 2014	Proposed NQS Domain 2015	Measure Title and Description	AMA Comments
N/A/ 332	Effective Clinical Care	Efficiency and Cost Reduction	Adult Sinusitis: Appropriate Choice of Antibiotic: Amoxicillin Prescribed for Patients with Acute Bacterial Sinusitis (Appropriate Use): Percentage of patients aged 18 years and older with a diagnosis of acute bacterial sinusitis that were prescribed amoxicillin, with or without clavulanate, as a first line antibiotic at the time of diagnosis	The AMA agrees with the re-categorization of this measure included under the NQS Domain: "Efficiency and Cost Reduction" similar to other antibiotic related measures' categorization. The measure title was updated. The American Academy of Otolaryngology-Head and Neck Surgery will steward this measure for PQRS 2015, so we ultimately defer to that organization.
N/A/ 356	Effective Clinical Care	Communication and Care Coordination	Unplanned Hospital Readmission within 30 Days of Principal Procedure: Percentage of patients aged 18 years and older who had an unplanned hospital readmission within 30 days of principal procedure	The AMA has concerns about attributing this measure to an individual clinician. We also disagree with the change to the NQS domain, as we feel unplanned readmissions can be the result of many factors which extend well beyond communication and care coordination.

APPENDIX D: AMA Comments on CMS Table 24 / Measures Proposed for Removal Beginning 2015

The AMA believes it is premature to remove a measure based upon a high-performance rate when the eligible professional (EP) reporting rate within the PQRS program is low. Based upon 2012 data, only 31 percent of EPs were able to participate successfully in PQRS. Additionally, the 2012 data indicate that 75 percent of measures had a successful reporting rate below ten percent and 33 percent of measures had a reporting rate below one percent. Classifying a measure as having a high performance rate, when the total EP reporting rate is less than one-third of those eligible, may not provide an accurate picture of performance on any given measure. A higher reporting rate or threshold may be indicated before decisions are made regarding measure performance rates. Additionally, if the rates among reporting EPs are close to 100 percent, it may be due to the very existence of the measure. Removal of these measures from PQRS may result in a drop in performance and quality of care. Finally, we propose a three-year phase out period for any measures being removed so as to allow the submission of new measures within the current measure submission timeframe to prevent gaps in reporting.

NQF/ PQRS	NQS Domain	Measure Title and Description	Measure Steward	AMA Comments
0087/ 14	Effective Clinical Care	Age-Related Macular Degeneration (AMD): Dilated Macular Examination: Percentage of patients aged 50 years and older with a diagnosis of age-related macular degeneration (AMD) who had a dilated macular examination performed which included documentation of the presence or absence of macular thickening or hemorrhage AND the level of macular degeneration severity during one or more office visits within 12 months	AMA-PCPI NCQA	The AMA does not support removal of this measure. We believe it is premature to remove a measure based on a high-performance rate when the EP reporting rate within the PQRS program is low. Classifying a measure as having a high performance rate, when the total EP reporting rate is less than one-third of all those eligible, may not provide an accurate picture of performance on any given measure. Additionally, if the rates among reporting EPs are close to 100 percent, it may be due to the very existence of the measure and removal of these measures from PQRS may result in a drop in performance and therefore quality of care. The "Measure Steward" should be listed as the following: AAO/AMA-PCPI. The American Academy of Ophthalmology (AAO) will steward this measure for PQRS 2015.
0270/ 20	Patient Safety	Perioperative Care: Timing of Prophylactic Parenteral Antibiotic – Ordering Physician: Percentage of surgical patients aged 18 years and older undergoing procedures with the indications for prophylactic parenteral antibiotics, who have an order for prophylactic parenteral antibiotic to be given within one hour (if fluoroquinolone or vancomycin, 2 hours), prior to the surgical incision (or start of procedure when no incision is required)	AMA-PCPI/ NCQA	The AMA agrees with the removal of this measure from the PQRS program beginning in 2015. During our internal measure maintenance process conducted in consultation with the expert work group, we decided to retire measure 0270: "Perioperative Care: Timing of Prophylactic Parenteral Antibiotics—Ordering Physician" in order to better emphasize another related measure in the set: measure 0269: "Perioperative Care: Timing of Prophylactic Antibiotics—Administering Physician." We felt it was necessary to highlight the importance of timely administration of prophylactic antibiotics rather than the more upstream process of placing the order for antibiotics, which in some cases can be an automated process. Given this emphasis on administration rather than ordering of antibiotics, we felt that measure 0269 better addressed this particular topic and we decided to retire measure 0270.
0268/ 21	Patient Safety	Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second Generation Cephalosporin: Percentage of surgical patients aged 18 years and older undergoing procedures with the indications for a first OR second generation	AMA-PCPI/ NCQA	The AMA does not support removal of this measure. We believe that it is premature to remove a measure based on a high-performance rate when the EP reporting rate within the PQRS program is low. Classifying a measure as having a high performance rate, when the total EP reporting rate is less than one-third of all those eligible, may not provide an accurate picture of performance on any given measure. Additionally, if the rates among reporting EPs are close to 100 percent, it may be due

NQF/ PQRS	NQS Domain	Measure Title and Description	Measure Steward	AMA Comments
		cephalosporin prophylactic antibiotic, who had an order for a first OR second generation cephalosporin for antimicrobial prophylaxis		to the very existence of the measure and removal of these measures from PQRS may result in a drop in performance and therefore quality of care. The "Measure Steward" should be listed as the following: AMA-PCPI.
0271/ 22	Patient Safety	Perioperative Care: Discontinuation of Prophylactic Parenteral Antibiotics (Non-Cardiac Procedures): Percentage of non-cardiac surgical patients aged 18 years and older undergoing procedures with the indications for prophylactic parenteral antibiotics AND who received a prophylactic parenteral antibiotic, who have an order for discontinuation of prophylactic parenteral antibiotics within 24 hours of surgical end time	AMA-PCPI/ NCQA	The AMA does not support removal of this measure. We believe it is premature to remove a measure based on a high-performance rate when the EP reporting rate within the PQRS program is low. Classifying a measure as having a high performance rate, when the total EP reporting rate is less than one-third of all those eligible, may not provide an accurate picture of performance on any given measure. Additionally, if the rates among reporting EPs are close to 100 percent, it may be due to the very existence of the measure and removal of these measures from PQRS may result in a drop in performance and therefore quality of care. The "Measure Steward" should be listed as the following: AMA-PCPI.
0239/ 23	Patient Safety	Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients): Percentage of surgical patients aged 18 years and older undergoing procedures for which VTE prophylaxis is indicated in all patients, who had an order for Low Molecular Weight Heparin (LMWH), Low-Dose Unfractionated Heparin (LDUH), adjusted-dose warfarin, fondaparinux or mechanical prophylaxis to be given within 24 hours prior to incision time or within 24 hours after surgery end time	AMA-PCPI/ NCQA	The AMA does not support removal of this measure. We believe it is premature to remove a measure based on a high-performance rate when the EP reporting rate within the PQRS program is low. Classifying a measure as having a high performance rate, when the total EP reporting rate is less than one-third of all those eligible, may not provide an accurate picture of performance on any given measure. Additionally, if the rates among reporting EPs are close to 100 percent, it may be due to the very existence of the measure and removal of these measures from PQRS may result in a drop in performance and therefore quality of care. The "Measure Steward" should be listed as the following: AMA-PCPI.
0092/ 28	Effective Clinical Care	Aspirin at Arrival for Acute Myocardial Infarction (AMI): Percentage of patients, regardless of age, with an emergency department discharge diagnosis of acute myocardial infarction (AMI)who had documentation of receiving aspirin within 24 hours before emergency department arrival or during emergency department stay	AMA-PCPI NCQA	The AMA does not support removal of this measure. This presents a reporting opportunity for emergency physicians. The removal of this measure could potentially create a reporting gap. "Substantial adoption" may signify room for additional adoption and therefore improvement. We propose a three-year phase out period for any measures being removed so as to allow the submission of new measures within the current measure submission timeframe to prevent gaps in reporting. The "Measure Steward" should be listed as the following: AMA-PCPI.
0269/ 30	Patient Safety	Perioperative Care: Timing of Prophylactic Antibiotic—Administering Physician: Percentage of surgical patients aged 18	AMA-PCPI NCQA	The AMA does not support removal of this measure. We believe it is premature to remove a measure based on a high-performance rate when the EP reporting rate within the PQRS program is low. Classifying a measure as having a high

NQF/ PQRS	NQS Domain	Measure Title and Description	Measure Steward	AMA Comments
		years and older who receive an anesthetic when undergoing procedures with the indications for prophylactic parenteral antibiotics for whom administration of a prophylactic parenteral antibiotic ordered has been initiated within 1 hour (if fluoroquinolone or vancomycin, 2 hours) prior to the surgical incision (or start of procedure when no incision is required)		performance rate, when the total EP reporting rate is less than one-third of all those eligible, may not provide an accurate picture of performance on any given measure. Additionally, if the rates among reporting EPs are close to 100 percent, it may be due to the very existence of the measure and removal of these measures from PQRS may result in a drop in performance and therefore quality of care. The "Measure Steward" should be listed as the following: ASA/AMA-PCPI. The American Society of Anesthesiologists (ASA) will steward this measure for PQRS 2015.
0240/ 31	Effective Clinical Care	Stroke and Stroke Rehabilitation: Venous Thromboembolism (VTE) Prophylaxis for Ischemic Stroke or Intracranial Hemorrhage: Percentage of patients aged 18 years and older with a diagnosis of ischemic stroke or intracranial hemorrhage who were administered venous thromboembolism (VTE) prophylaxis the day of or the day after hospital admission	AMA-PCPI/ NCQA	The AMA does not support removal of this measure. This measure was designed with knowledge that facility level measures existed related to this topic. Even with the current inpatient standards, we believe this clinical concept is appropriate for measurement at the individual physician level in addition to the facility level to help ensure the continuous care of stroke patients. The "Measure Steward" should be listed as the following: AANI/AMA-PCPI. The American Academy of Neurology Institute (AANI) will steward this measure for PQRS 2015.
0325/ 32	Effective Clinical Care	Stroke and Stroke Rehabilitation: Discharged on Antithrombotic Therapy: Percentage of patients aged 18 years and older with a diagnosis of ischemic stroke or transient ischemic attack (TIA) who were prescribed antithrombotic therapy at discharge	AMA-PCPI/ NCQA	The AMA does not support removal of this measure. This measure was designed with knowledge that facility level measures existed related to this topic. Even with the current inpatient standards, we believe this clinical concept is appropriate for measurement at the individual physician level in addition to the facility level to help ensure the continuous care of stroke patients. The "Measure Steward" should be listed as the following: AANI/AMA-PCPI. The AANI will steward this measure for PQRS 2015.
0241/ 33	Effective Clinical Care	Stroke and Stroke Rehabilitation: Anticoagulant Therapy Prescribed for Atrial Fibrillation (AF) at Discharge: Percentage of patients aged 18 years and older with a diagnosis of ischemic stroke or transient ischemic attack (TIA) with documented permanent, persistent, or paroxysmal atrial fibrillation who were prescribed an anticoagulant at discharge	AMA-PCPI/ NCQA	The AMA does not support removal of this measure. This measure was designed with knowledge that facility level measures existed related to this topic. Even with the current inpatient standards, we believe this clinical concept is appropriate for measurement at the individual physician level in addition to the facility level to help ensure the continuous care of stroke patients. The "Measure Steward" should be listed as the following: AANI/AMA-PCPI. The AANI will steward this measure for PQRS 2015.
0243/ 35	Effective Clinical Care	Stroke and Stroke Rehabilitation: Screening for Dysphagia: Percentage of patients aged 18 years and older with a diagnosis of ischemic stroke or intracranial hemorrhage who receive any food, fluids or medication by mouth (PO) for whom a	AMA-PCPI/ NCQA	The AMA does not support removal of this measure. This measure was designed with knowledge that facility level measures existed related to this topic. Even with the current inpatient standards, we believe this clinical concept is appropriate for measurement at the individual physician level in addition to the facility level to help ensure the continuous care of stroke patients.

NQF/ PQRS	NQS Domain	Measure Title and Description	Measure Steward	AMA Comments
		dysphagia screening was performed prior to PO intake in accordance with a dysphagia screening tool approved by the institution in which the patient is receiving care		The "Measure Steward" should be listed as the following: AANI/AMA-PCPI. The AANI will steward this measure for PQRS 2015.
0244/ 36	Effective Clinical Care	Stroke and Stroke Rehabilitation: Rehabilitation Services Ordered: Percentage of patients aged 18 years and older with a diagnosis of ischemic stroke or intracranial hemorrhage for whom occupational, physical, or speech rehabilitation services were ordered at or prior to inpatient discharge OR documentation that no rehabilitation services are indicated at or prior to inpatient discharge	AMA-PCPI/ NCQA	The AMA-PCPI does not support removal of this measure. This measure was designed with knowledge that facility level measures existed related to this topic. Even with the current inpatient standards, we feel this clinical concept is appropriate for measurement at the individual physician level in addition to the facility level to help ensure the continuous care of stroke patients. The "Measure Steward" should be listed as the following: AANI/AMA-PCPI. The AANI will steward this measure for PQRS 2015.
0637/ 45	Patient Safety	Perioperative Care: Discontinuation of Prophylactic Parenteral Antibiotics (Cardiac Procedures): Percentage of cardiac surgical patients aged 18 years and older undergoing procedures with the indications for prophylactic parenteral antibiotics AND who received a prophylactic parenteral antibiotic, who have an order for discontinuation of prophylactic parenteral antibiotics within 48 hours of surgical end time	AMA-PCPI/ NCQA	The AMA-PCPI will no longer be the steward for this measure as of 2015. No steward for this measure has been identified for the 2015 program year.
0099/ 49	Effective Clinical Care	Urinary Incontinence: Characterization of Urinary Incontinence in Women Aged 65 Years and Older: Percentage of female patients aged 65 years and older with a diagnosis of urinary incontinence whose urinary incontinence was characterized at least once within 12 months	AMA-PCPI NCQA	The AMA does not support removal of this measure. We believe it is premature to remove a measure based on a high-performance rate when the EP reporting rate within the PQRS program is low. Classifying a measure as having a high performance rate, when the total EP reporting rate is less than one-third of those eligible, may not provide an accurate picture of performance on any given measure. Additionally, if the rates among reporting EPs are close to 100 percent, it may be due to the very existence of the measure and removal of these measures from PQRS may result in a drop in performance and therefore quality of care.
0091/ 51	Effective Clinical Care	Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation: Percentage of patients aged 18 years and older with a diagnosis of COPD who had spirometry results documented	AMA-PCPI	The AMA does not support removal of this measure. The "Measure Steward" should be listed as the following: AMA-PCPI. The measure description has been updated.

NQF/ PQRS	NQS Domain	Measure Title and Description	Measure Steward	AMA Comments
0102/ 52	Effective Clinical Care	Chronic Obstructive Pulmonary Disease (COPD): Inhaled Bronchodilator Therapy: Percentage of patients aged 18 years and older with a diagnosis of COPD and who have an FEV1/FVC less than 60% and have symptoms who were prescribed an inhaled bronchodilator	AMA-PCPI	The AMA does not support removal of this measure. The "Measure Steward" should be listed as the following: AMA-PCPI.
0093/ 55	Effective Clinical Care	Emergency Medicine: 12-Lead Electrocardiogram (ECG) Performed for Syncope: Percentage of patients aged 60 years and older with an emergency department discharge diagnosis of syncope who had a 12-lead electrocardiogram (ECG) performed	AMA-PCPI/ NCQA	The AMA does not support removal of this measure. We believe it is premature to remove a measure based on a high-performance rate when the EP reporting rate within the PQRS program is low. Classifying a measure as having a high performance rate when the total EP reporting rate is less than one-third of those eligible, may not provide an accurate picture of performance on any given measure. Additionally, if the rates among reporting EPs are close to 100 percent, it may be due to the very existence of the measure and removal of these measures from PQRS may result in a drop in performance and therefore quality of care. The "Measure Steward" should be listed as the following: AMA-PCPI.
0232/ 56	Effective Clinical Care	Community-Acquired Bacterial Pneumonia (CAP): Vital Signs: Percentage of patients aged 18 years and older with a diagnosis of community-acquired bacterial pneumonia (CAP) with vital signs documented and reviewed	AMA-PCPI/ NCQA	The AMA does not support removal of this measure. We believe it is premature to remove a measure based on a high-performance rate when the EP reporting rate within the PQRS program is low. Classifying a measure as having a high performance rate, when the total EP reporting rate is less than one-third of those eligible, may not provide an accurate picture of performance on any given measure. Additionally, if the rates among reporting EPs are close to 100 percent, it may be due to the very existence of the measure and removal of these measures from PQRS may result in a drop in performance and therefore quality of care. The "Measure Steward" should be listed as the following: AMA-PCPI. The measure title has been updated for this measure.
0096/ 59	Effective Clinical Care	Community-Acquired Bacterial Pneumonia (CAP): Empiric Antibiotic: Percentage of patients aged 18 years and older with a diagnosis of community-acquired bacterial pneumonia (CAP) with an appropriate empiric antibiotic prescribed	AMA-PCPI/ NCQA	The AMA does not support removal of this measure. We believe that it is premature to remove a measure based on a high-performance rate when the EP reporting rate within the PQRS program is low. Classifying a measure as having a high performance rate, when the total EP reporting rate is less than one-third of those eligible, may not provide an accurate picture of performance on any given measure. Additionally, if the rates among reporting EPs are close to 100 percent, it may be due to the very existence of the measure and removal of these measures from PQRS may result in a drop in performance and therefore quality of care. The "Measure Steward" should be listed as the following: AMA-PCPI. The measure title has been updated for this measure.

NQF/ PQRS	NQS Domain	Measure Title and Description	Measure Steward	AMA Comments
0001/ 64	Effective Clinical Care	Asthma: Assessment of Asthma Control – Ambulatory Care Setting: Percentage of patients aged 5 years and older with a diagnosis of asthma who were evaluated at least once during the measurement period for asthma control (comprising asthma impairment and asthma risk)	AMA-PCPI NCQA	The AMA does not support removal of this measure. The goal of asthma therapy is to achieve asthma control. Once asthma is diagnosed and therapy is initiated, clinical management shifts to the periodic assessment of asthma control, as the level of asthma control will guide decisions either to maintain or adjust therapy. We opted to develop this measure to ensure that asthma control is assessed as this is essential in order to ensure appropriate treatment for asthma which currently is less than optimal. We updated this measure to include patients aged 5 years and older, removing the upper age limit. The "Measure Steward" should be listed as the following: AMA-PCPI. The measure description has been updated.
0393/ 83	Effective Clinical Care	Hepatitis C: Confirmation of Hepatitis C Viremia: Percentage of patients aged 18 years and older who are hepatitis C antibody positive seen for an initial evaluation for whom hepatitis C virus (HCV) RNA testing was ordered or previously performed	AMA-PCPI	The AMA does not support removal of this measure. We believe that it is premature to remove a measure based on a high-performance rate when the EP reporting rate within the PQRS program is low. Classifying a measure as having a high performance rate when the total EP reporting rate is less than one-third of those eligible, may not provide an accurate picture of performance on any given measure. Additionally, if the rates among reporting EPs are close to 100 percent, it may be due to the very existence of the measure and removal of these measures from PQRS may result in a drop in performance and therefore quality of care. The "Measure Steward" should be listed as the following: AGA/AMA-PCPI. The American Gastroenterological Association (AGA) will steward this measure for PQRS 2015.
0103/ 106	Effective Clinical Care	Adult Major Depressive Disorder (MDD): Comprehensive Depression Evaluation: Diagnosis and Severity: Percentage of patients aged 18 years and older with a new diagnosis or recurrent episode of major depressive disorder (MDD) with evidence that they met the Diagnostic and Statistical Manual of Mental Disorders (DSM)-5 criteria for MDD AND for whom there is an assessment of depression severity during the visit in which a new diagnosis or recurrent episode was identified	AMA-PCPI	The AMA does not support the removal of this measure. This measure was designed because appropriate diagnosis and classification of severity are essential in order to ensure appropriate treatment for major depressive disorder. The use of the diagnostic tools included in the measure is currently less than optimal. The "Measure Steward" should be listed as the following: APA/AMA-PCPI. The American Psychiatric Association (APA) will steward this measure for PQRS 2015.
0050/ 109	Person and Caregiver-Centered Experience and Outcomes	Osteoarthritis (OA): Function and Pain Assessment: Percentage of patient visits for patients aged 21 years and older with a diagnosis of osteoarthritis (OA) with assessment for function and pain	AMA-PCPI	The "Measure Steward" should be listed as the following: AAOS/AMA-PCPI. The American Academy of Orthopaedic Surgeons (AAOS) will steward this measure for PQRS 2015.

NQF/ PQRS	NQS Domain	Measure Title and Description	Measure Steward	AMA Comments
1666/ 123	Effective Clinical Care	Adult Kidney Disease: Patients On Erythropoiesis-Stimulating Agent (ESA) - Hemoglobin Level > 12.0 g/dL: Percentage of calendar months within a 12-month period during which a hemoglobin level is measured for patients aged 18 years and older with a diagnosis of advanced chronic kidney disease (CKD) (stage 4 or 5, not receiving Renal Replacement Therapy ([RRT]) or End Stage Renal Disease (ESRD) (who are on hemodialysis or peritoneal dialysis) who are also receiving erythropoiesis-stimulating agent (ESA) therapy AND have a hemoglobin level > 12.0 g/dL	AMA-PCPI	The AMA does not support the removal of this measure. This measure represents the assessment of a diagnostic level that is required for making treatment decisions regarding the provision of erythropoiesis-stimulating agent. To ensure proper treatment, a diagnostic level is needed though it may not always be assessed. Therefore, we believe this measure provides clinical value to ensure informed clinical decisions regarding treatment for kidney disease patients. The "Measure Steward" should be listed as the following: RPA/AMA-PCPI. The Renal Physicians Association (RPA) will steward this measure for PQRS 2015.
0566/ 140	Effective Clinical Care	Age-Related Macular Degeneration (AMD): Counseling on Antioxidant Supplement: Percentage of patients aged 50 years and older with a diagnosis of age-related macular degeneration (AMD) or their caregiver(s) who were counseled within 12 months on the benefits and/or risks of the Age-Related Eye Disease Study (AREDS) formulation for preventing progression of AMD	AMA-PCPI NCQA	The AMA does not support removal of this measure. We believe that it is premature to remove a measure based on a high-performance rate when the EP reporting rate within the PQRS program is low. Classifying a measure as having a high performance rate, when the total EP reporting rate is less than one-third of those eligible, may not provide an accurate picture of performance on any given measure. Additionally, if the rates among reporting EPs are close to 100 percent, it may be due to the very existence of the measure and removal of these measures from PQRS may result in a drop in performance and therefore quality of care. The "Measure Steward" should be listed as the following: AAO/AMA-PCPI. The AAO will steward this measure for PQRS 2015.
0051/ 142	Effective Clinical Care	Osteoarthritis (OA): Assessment for Use of Anti-Inflammatory or Analgesic Over-the-Counter (OTC) Medications: Percentage of patient visits for patients aged 21 years and older with a diagnosis of osteoarthritis (OA) with an assessment for use of anti-inflammatory or analgesic over-the-counter (OTC)medications	AMA-PCPI	The AMA-PCPI will no longer be the steward for this measure as of 2015. No steward for this measure has been identified for the 2015 program year.
0508/ 146	Efficiency and Cost Reduction	Radiology: Inappropriate Use of "Probably Benign" Assessment Category in Screening Mammograms: Percentage of final reports for screening mammograms that are classified as "probably benign"	AMA-PCPI/ NCQA	The AMA does not support removal of this measure. We believe it is premature to remove a measure based on a high-performance rate when the EP reporting rate within the PQRS program is low. Classifying a measure as having a high performance rate, when the total EP reporting rate is less than one-third of those eligible, may not provide an accurate picture of performance on any given measure. Additionally, if the rates among reporting EPs are close to 100 percent, it may be due to the very existence of the measure and removal of these measures from PQRS may result in a drop in performance and therefore quality of care.

NQF/ PQRS	NQS Domain	Measure Title and Description	Measure Steward	AMA Comments
				The "Measure Steward" should be listed as the following: ACR/AMA-PCPI. The ACR will steward this measure for PQRS 2015. The measure title was updated for this measure.
N/A/ 147	Communication and Care Coordination	Nuclear Medicine: Correlation with Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy: Percentage of final reports for all patients, regardless of age, undergoing bone scintigraphy that include physician documentation of correlation with existing relevant imaging studies (e.g., x-ray, MRI, CT, etc.) that were performed.	AMA-PCPI	The "Measure Steward" should be listed as the following: SNMMI/AMA-PCPI. The Society of Nuclear Medicine and Molecular Imaging will steward this measure for PCPI 2015.
0404/ 159	Effective Clinical Care	HIV/AIDS: CD4+ Cell Count or CD4+ Percentage Performed: Percentage of patients aged 6 months and older with a diagnosis of HIV/AIDS for whom a CD4+ cell count or CD4+ cell percentage was performed at least once every 6 months	AMA-PCPI NCQA	The AMA does not support removal of this measure. We believe it is premature to remove a measure based on a high-performance rate when the EP reporting rate within the PQRS program is low. Classifying a measure as having a high performance rate, when the total EP reporting rate is less than one-third of those eligible, may not provide an accurate picture of performance on any given measure. Additionally, if the rates among reporting EPs are close to 100 percent, it may be due to the very existence of the measure and removal of these measures from PQRS may result in a drop in performance and therefore quality of care.
AQA Adopted/ 173	Community/ Population Health	Preventive Care and Screening: Unhealthy Alcohol Use – Screening: Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use at least once within 24 months using a systematic screening method	AMA-PCPI	The AMA urges CMS to adopt the more comprehensive measure, "Unhealthy Alcohol Use: Screening & Brief Counseling," which the AMA-PCPI developed and has specified with the Substance Abuse & Mental Health Services Administration (SAMHSA) and submitted in the 2014 Call For Measures. Until a more comprehensive measure is incorporated into the PQRS program, aforementioned, we recommend this measure remain. This measure will be stewarded by AMA-PCPI for PQRS 2015. The measure description was updated for this measure.
0074/ 197	Effective Clinical Care	Coronary Artery Disease (CAD): Lipid Control: Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease (CAD) seen within a 12 month period who have a LDL-C result < 100 mg/dL OR patients who have a LDL-C result ≥ 100 mg/dL and have a documented plan of care to achieve LDL-C < 100 mg/dL, including at a minimum the prescription of a statin	AMA-PCPI ACCF/AHA	The AMA does not support the removal of this measure, as we are aware that ACCF/AHA (American College of Cardiology Foundation/American Heart Association) is actively working to update the measure, and it is currently undergoing peer review and public comment. We believe that the measure should be kept in the program and doing so would entail limited consequences, and still serves as a benchmark. The measure description has been updated.

NQF/ PQRS	NQS Domain	Measure Title and Description	Measure Steward	AMA Comments
0079/ 198	Effective Clinical Care	Heart Failure: Left Ventricular Ejection Fraction (LVEF) Assessment: Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) for whom the quantitative or qualitative results of a recent or prior (any time in the past) LVEF assessment is documented within a 12 month period	AMA-PCPI ACCF/AHA	The AMA does not support removal of this measure. We support the continued inclusion of this measure in the PQRS program. LVEF is a seemingly basic assessment; however, this assessment may not always be completed and it is necessary for determining treatment options for heart failure patients. The measure description has been updated for this measure.
N/A/ 231	Effective Clinical Care	Asthma: Tobacco Use: Screening - Ambulatory Care Setting: Percentage of patients aged 5 years and older with a diagnosis of asthma (or their primary caregiver) who were queried about tobacco use and exposure to second hand smoke within their home environment at least once during the one-year measurement period	AMA-PCPI NCQA	The AMA does not support the removal of this measure. This measure is appropriate and differs from existing measures because it addresses : 1) children whereas other measures only address the adult population; 2) the involvement of the caregiver in cases of pediatric exposure to environmental tobacco smoke; and 3) considerations related to second hand smoke and the home environment. The "Measure Steward" should be listed as the following: AMA-PCPI. The measure description has been updated.
N/A/ 232	Effective Clinical Care	Asthma: Tobacco Use: Intervention - Ambulatory Care Setting: Percentage of patients aged 5 years and older with a diagnosis of asthma who were identified as tobacco users (or their primary caregiver) who received tobacco cessation intervention at least once during the one-year measurement period	AMA-PCPI NCQA	The AMA does not support the removal of this measure. This measure is appropriate and differs from existing measures because it addresses: 1) children whereas other measures only address the adult population; 2) the involvement of the caregiver in cases of pediatric exposure to environmental tobacco smoke; and 3) considerations related to second hand smoke and the home environment. The "Measure Steward" should be listed as the following: AMA-PCPI. The measure description has been updated.
0643/ 243	Effective Clinical Care	Cardiac Rehabilitation Patient Referral from an Outpatient Setting: Percentage of patients evaluated in an outpatient setting who within the previous 12 months have experienced an acute myocardial infarction (MI), coronary artery bypass graft (CABG) surgery, a percutaneous coronary intervention (PCI), cardiac valve surgery, or cardiac transplantation, or who have chronic stable angina (CSA) and have not already participated in an early outpatient cardiac rehabilitation/secondary prevention (CR) program for the qualifying event/diagnosis who were referred to a CR program	ACCF AHA	The AMA does not support removal of this measure. While the clinical condition may initiate in the inpatient setting, the clinical process being measured is limited to the outpatient setting and would therefore add clinical value to outpatient care of the cardiac rehabilitation patient.
AQA Adopted/	Effective Clinical	Chronic Wound Care: Use of Wound Surface Culture Technique in Patients with	AMA-PCPI/ NCQA	The AMA does not support removal of this measure. We believe it is premature to remove a measure based on a high-performance rate when the EP reporting rate

NQF/ PQRS	NQS Domain	Measure Title and Description	Measure Steward	AMA Comments
245	Care	Chronic Skin Ulcers (Overuse Measure: Percentage of patient visits for those patients aged 18 years and older with a diagnosis of chronic skin ulcer without the use of a wound surface culture technique		within the PQRS program is low. Classifying a measure as having a high performance rate, when the total EP reporting rate is less than one-third of those eligible, may not provide an accurate picture of performance on any given measure. Additionally, if the rates among reporting EPs are close to 100 percent, it may be due to the very existence of the measure and removal of these measures from PQRS may result in a drop in performance and therefore quality of care. The "Measure Steward" should be listed as the following: ASPS/AMA-PCPI. The American Society of Plastic Surgeons (ASPS) will steward this measure for PQRS 2015.
AQA Adopted/ 246	Effective Clinical Care	Chronic Wound Care: Use of Wet to Dry Dressings in Patients with Chronic Skin Ulcers (Overuse Measure): Percentage of patient visits for those patients aged 18 years and older with a diagnosis of chronic skin ulcer without a prescription or recommendation to use wet to dry dressings	AMA-PCPI/ NCQA	The AMA does not support removal of this measure. We believe it is premature to remove a measure based on a high-performance rate when the EP reporting rate within the PQRS program is low. Classifying a measure as having a high performance rate, when the total EP reporting rate is less than one-third of those eligible, may not provide an accurate picture of performance on any given measure. Additionally, if the rates among reporting EPs are close to 100 percent, it may be due to the very existence of the measure and removal of these measures from PQRS may result in a drop in performance and therefore quality of care. The "Measure Steward" should be listed as the following: ASPS/AMA-PCPI. The ASPS will steward this measure for PQRS 2015.
AQA Adopted/ 247	Effective Clinical Care	Substance Use Disorders: Counseling Regarding Psychosocial and Pharmacologic Treatment Options for Alcohol Dependence: Percentage of patients aged 18 years and older with a diagnosis of current alcohol dependence who were counseled regarding psychosocial AND pharmacologic treatment options for alcohol dependence within the 12-month reporting period	AMA-PCPI/ NCQA	The AMA-PCPI does not support removal of this measure. We feel it is premature to remove a measure based on a high-performance rate when the EP reporting rate within the PQRS program is low. Classifying a measure as having a high performance rate, when the total EP reporting rate is less than one-third of those eligible, may not provide an accurate picture of performance on any given measure. Additionally, if the rates among reporting EPs are close to 100 percent, it may be due to the very existence of the measure and removal of these measures from PQRS may result in a drop in performance and therefore quality of care. The "Measure Steward" should be listed as the following: APA/AMA-PCPI. The APA will steward this measure for PQRS 2015.
AQA Adopted/ 248	Effective Clinical Care	Substance Use Disorders: Screening for Depression Among Patients with Substance Abuse or Dependence: Percentage of patients aged 18 years and older with a diagnosis of current substance abuse or dependence who were screened for depression within the 12-month reporting period	AMA-PCPI/ NCQA	The "Measure Steward" should be listed as the following: APA/AMA-PCPI. The APA will steward this measure for PQRS 2015.

NQF/ PQRS	NQS Domain	Measure Title and Description	Measure Steward	AMA Comments
N/A/ 276	Effective Clinical Care	Sleep Apnea: Assessment of Sleep Symptoms: Percentage of visits for patients aged 18 years and older with a diagnosis of obstructive sleep apnea that includes documentation of an assessment of sleep symptoms, including presence or absence of snoring and daytime sleepiness	AMA-PCPI/ NCQA	The "Measure Steward" should be listed as the following: AASM/AMA-PCPI. The American Academy of Sleep Medicine (AASM) will steward this measure for PQRS 2015.
N/A/ 277	Effective Clinical Care	Sleep Apnea: Severity Assessment at Initial Diagnosis: Percentage of patients aged 18 years and older with a diagnosis of obstructive sleep apnea who had an apnea hypopnea index (AHI) or a respiratory disturbance index (RDI) measured at the time of initial diagnosis	AMA-PCPI/ NCQA	The "Measure Steward" should be listed as the following: AASM/AMA-PCPI. The AASM will steward this measure for PQRS 2015.
N/A/ 278	Effective Clinical Care	Sleep Apnea: Positive Airway Pressure Therapy Prescribed: Percentage of patients aged 18 years and older with a diagnosis of moderate or severe obstructive sleep apnea who were prescribed positive airway pressure therapy	AMA-PCPI/ NCQA	The "Measure Steward" should be listed as the following: AASM/AMA-PCPI. The AASM will steward this measure for PQRS 2015.
N/A/ 279	Effective Clinical Care	Sleep Apnea: Assessment of Adherence to Positive Airway Pressure Therapy: Percentage of visits for patients aged 18 years and older with a diagnosis of obstructive sleep apnea who were prescribed positive airway pressure therapy who had documentation that adherence to positive airway pressure therapy was objectively measured	AMA-PCPI/ NCQA	The "Measure Steward" should be listed as the following: AASM/AMA-PCPI. The AASM will steward this measure for PQRS 2015.
N/A/ 335	Patient Safety	Maternity Care: Elective Delivery or Early Induction Without Medical Indication at ≥ 37 and < 39 Weeks (Overuse): Percentage of patients, regardless of age, who gave birth during a 12-month period who delivered a live singleton at ≥37 and < 39 weeks of gestation completed who had elective deliveries or early inductions without medical indication	AMA-PCPI	The AMA-PCPI will no longer be the steward for this measure as of 2015. No steward for this measure has been identified for the 2015 program year. The AMA-PCPI recommends the NQS domain for this measure be changed to "efficient use of healthcare resources" due to the fact that it is an overuse measure. The measure title has been updated for this measure.

NQF/ PQRS	NQS Domain	Measure Title and Description	Measure Steward	AMA Comments
N/A/ 336	Communication and Care Coordination	Maternity Care: Post-Partum Follow-Up and Care Coordination: Percentage of patients, regardless of age, who gave birth during a 12-month period who were seen for post-partum care within 8 weeks of giving birth who received a breast feeding evaluation and education, post-partum depression screening, post-partum glucose screening for gestational diabetes patients, and family and contraceptive planning	AMA-PCPI	The AMA-PCPI will no longer be the steward for this measure as of 2015. No steward for this measure has been identified for the 2015 program year.

APPENDIX E Comments on CMS Table 25 / Proposed Changes to Reporting Modalities for Measures Beginning 2015

NQF/ PQRS	CMS E-Measure ID	NQS Domain	Measure Title and Description	Measure Steward	AMA Comments
0067/ 6		Effective Clinical Care	Coronary Artery Disease (CAD): Antiplatelet Therapy: Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease (CAD) seen within a 12 month period who were prescribed aspirin or clopidogrel	AMA-PCPI ACCF AHA	The AMA encourages CMS to keep a variety of reporting options available, especially due to the fact that the majority of EPs still report via claims, despite CMS' indication that claims-based reporting allows for the most errors. The claims reporting option for PQRS 2014 offers many EPs an opportunity to avoid incurring additional costs of implementing a registry or EHR. This is a very important option for small and rural EPs, who may not have the resources to adopt either of those capabilities.
0086/ 12	143 v2	Effective Clinical Care	Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation: Percentage of patients aged 18 years and older with a diagnosis of primary open-angle glaucoma (POAG) who have an optic nerve head evaluation during one or more office visits within 12 months	AMA-PCPI NCQA	The AMA encourages CMS to keep a variety of reporting options available, especially due to the fact that the majority of EPs still report via claims, despite CMS' indication that claims-based reporting allows for the most errors. The claims reporting option for PQRS 2014 offers many EPs an opportunity to avoid incurring additional costs of implementing a registry or EHR. This is a very important option for small and rural EPs, who may not have the resources to adopt either of those capabilities.
0088/ 18	167 v2	Effective Clinical Care	Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy: Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed which included documentation of the level of severity of retinopathy and the presence or absence of macular edema during one or more office visits within 12 months	AMA-PCPI NCQA	The AMA encourages CMS to keep a variety of reporting options available, especially due to the fact that the majority of EPs still report via claims, despite CMS' indication that claims-based reporting allows for the most errors. The claims reporting option for PQRS 2014 offers many EPs an opportunity to avoid incurring additional costs of implementing a registry or EHR. This is a very important option for small and rural EPs, who may not have the resources to adopt either of those capabilities. Additionally, since CMS has placed an emphasis on registry reporting and the desire to shift the program towards that direction, the AMA does not support removal of the registry reporting option.
0089/ 19	142 v2	Effective Clinical Care	Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care: Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the ongoing care of the patient with diabetes mellitus regarding the findings of the macular or fundus exam at least once within 12 months	AMA-PCPI NCQA	The AMA encourages CMS to keep a variety of reporting options available, especially due to the fact that the majority of EPs still report via claims, despite CMS' indication that claims-based reporting allows for the most errors. The claims reporting option for PQRS 2014 offers many EPs an opportunity to avoid incurring additional costs of implementing a registry or EHR. This is a very important option for small and rural EPs, who may not have the resources to adopt either of those capabilities.

NQF/ PQRS	CMS E-Measure ID	NQS Domain	Measure Title and Description	Measure Steward	AMA Comments
0045/ 24		Communication and Care Coordination	Osteoporosis: Communication with the Physician Managing On-going Care Post-Fracture of Hip, Spine or Distal Radius for Men and Women Aged 50 Years and Older: Percentage of patients aged 50 years and older treated for a hip, spine or distal radial fracture with documentation of communication with the physician managing the patient's on-going care that a fracture occurred and that the patient was or should be tested or treated for osteoporosis	AMA-PCPI NCQA	The AMA encourages CMS to keep a variety of reporting options available, especially due to the fact that the majority of EPs still report via claims, despite CMS' indication that claims-based reporting allows for the most errors. The claims reporting option for PQRS 2014 offers many EPs an opportunity to avoid incurring additional costs of implementing a registry or EHR. This is a very important option for small and rural EPs, who may not have the resources to adopt either of those capabilities.
0046/ 39		Effective Clinical Care	Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older: Percentage of female patients aged 65 years and older who have a central dual-energy X-ray absorptiometry (DXA) measurement ordered or performed at least once since age 60 or pharmacologic therapy prescribed within 12 months	AMA-PCPI NCQA	The AMA encourages CMS to keep a variety of reporting options available, especially due to the fact that the majority of EPs still report via claims, despite CMS' indication that claims-based reporting allows for the most errors. The claims reporting option for PQRS 2014 offers many EPs an opportunity to avoid incurring additional costs of implementing a registry or EHR. This is a very important option for small and rural EPs, who may not have the resources to adopt either of those capabilities.
0048/ 40		Effective Clinical Care	Osteoporosis: Management Following Fracture of Hip, Spine or Distal Radius for Men and Women Aged 50 Years and Older: Percentage of patients aged 50 years and older with fracture of the hip, spine, or distal radius who had a central dual-energy X-ray absorptiometry (DXA) measurement ordered or performed or pharmacologic therapy prescribed	AMA-PCPI NCQA	The AMA encourages CMS to keep a variety of reporting options available, especially due to the fact that the majority of EPs still report via claims, despite CMS' indication that claims-based reporting allows for the most errors. The claims reporting option for PQRS 2014 offers many EPs an opportunity to avoid incurring additional costs of implementing a registry or EHR. This is a very important option for small and rural EPs, who may not have the resources to adopt either of those capabilities.
0097/ 46		Communication and Care Coordination	Medication Reconciliation: Percentage of patients aged 65 years and older discharged from any inpatient facility (e.g., hospital, skilled nursing facility, or rehabilitation facility) and seen within 30 days following discharge in the office by the physician, prescribing practitioner, registered nurse, or clinical pharmacist providing on-going care who had a reconciliation of the discharge medications with the current medication list in the outpatient medical record documented	AMA-PCPI NCQA	The AMA encourages CMS to keep a variety of reporting options available, especially due to the fact that the majority of EPs still report via claims, despite CMS' indication that claims-based reporting allows for the most errors. The claims reporting option for PQRS 2014 offers many EPs an opportunity to avoid incurring additional costs of implementing a registry or EHR. This is a very important option for small and rural EPs, who may not have the resources to adopt either of those capabilities. Additionally, this is proposed as a cross-cutting measure which means that it is relevant to a high number of specialties and EPs. Since this is a measure intended to be reported by a large number of EPs, the AMA believes it is important to keep a variety of reporting options available for these "broad" measures.

NQF/ PQRS	CMS E-Measure ID	NQS Domain	Measure Title and Description	Measure Steward	AMA Comments
0100/ 50		Person and Caregiver-Centered Experience and Outcomes	Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older: Percentage of female patients aged 65 years and older with a diagnosis of urinary incontinence with a documented plan of care for urinary incontinence at least once within 12 months	AMA-PCPI NCQA	The AMA encourages CMS to keep a variety of reporting options available, especially due to the fact that the majority of EPs still report via claims, despite CMS' indication that claims-based reporting allows for the most errors. The claims reporting option for PQRS 2014 offers many EPs an opportunity to avoid incurring additional costs of implementing a registry or EHR. This is a very important option for small and rural EPs, who may not have the resources to adopt either of those capabilities.
0090/ 54		Effective Clinical Care	Emergency Medicine: 12-Lead Electrocardiogram (ECG) Performed for Non-Traumatic Chest Pain: Percentage of patients aged 40 years and older with an emergency department discharge diagnosis of non-traumatic chest pain who had a 12-lead electrocardiogram (ECG) performed	AMA-PCPI NCQA	The AMA encourages CMS to keep a variety of reporting options available, especially due to the fact that the majority of EPs still report via claims, despite CMS' indication that claims-based reporting allows for the most errors. The claims reporting option for PQRS 2014 offers many EPs an opportunity to avoid incurring additional costs of implementing a registry or EHR. This is a very important option for small and rural EPs, who may not have the resources to adopt either of those capabilities. The "Measure Steward" should be listed as the following: AMA-PCPI.
0377/ 67		Effective Clinical Care	Hematology: Myelodysplastic Syndrome (MDS) and Acute Leukemias: Baseline Cytogenetic Testing Performed on Bone Marrow: Percentage of patients aged 18 years and older with a diagnosis of myelodysplastic syndrome (MDS) or an acute leukemia who had baseline cytogenetic testing performed on bone marrow	AMA-PCPI ASH	The AMA encourages CMS to keep a variety of reporting options available, especially due to the fact that the majority of EPs still report via claims, despite CMS' indication that claims-based reporting allows for the most errors. The claims reporting option for PQRS 2014 offers many EPs an opportunity to avoid incurring additional costs of implementing a registry or EHR. This is a very important option for small and rural EPs, who may not have the resources to adopt either of those capabilities.
0378/ 68		Effective Clinical Care	Hematology: Myelodysplastic Syndrome (MDS): Documentation of Iron Stores in Patients Receiving Erythropoietin Therapy: Percentage of patients aged 18 years and older with a diagnosis of myelodysplastic syndrome (MDS) who are receiving erythropoietin therapy with documentation of iron stores within 60 days prior to initiating erythropoietin therapy	AMA-PCPI ASH	The AMA encourages CMS to keep a variety of reporting options available, especially due to the fact that the majority of EPs still report via claims, despite CMS' indication that claims-based reporting allows for the most errors. The claims reporting option for PQRS 2014 offers many EPs an opportunity to avoid incurring additional costs of implementing a registry or EHR. This is a very important option for small and rural EPs, who may not have the resources to adopt either of those capabilities.

NQF/ PQRS	CMS E-Measure ID	NQS Domain	Measure Title and Description	Measure Steward	AMA Comments
0380/ 69		Effective Clinical Care	Hematology: Multiple Myeloma: Treatment with Bisphosphonates: Percentage of patients aged 18 years and older with a diagnosis of multiple myeloma, not in remission, who were prescribed or received intravenous bisphosphonate therapy within the 12-month reporting period	AMA-PCPI ASH	The AMA encourages CMS to keep a variety of reporting options available, especially due to the fact that the majority of EPs still report via claims, despite CMS' indication that claims-based reporting allows for the most errors. The claims reporting option for PQRS 2014 offers many EPs an opportunity to avoid incurring additional costs of implementing a registry or EHR. This is a very important option for small and rural EPs, who may not have the resources to adopt either of those capabilities.
0379/ 70		Effective Clinical Care	Hematology: Chronic Lymphocytic Leukemia (CLL): Baseline Flow Cytometry: Percentage of patients aged 18 years and older seen within a 12 month reporting period with a diagnosis of chronic lymphocytic leukemia (CLL) made at any time during or prior to the reporting period who had baseline flow cytometry studies performed and documented in the chart	AMA-PCPI ASH	The AMA encourages CMS to keep a variety of reporting options available, especially due to the fact that the majority of EPs still report via claims, despite CMS' indication that claims-based reporting allows for the most errors. The claims reporting option for PQRS 2014 offers many EPs an opportunity to avoid incurring additional costs of implementing a registry or EHR. This is a very important option for small and rural EPs, who may not have the resources to adopt either of those capabilities.
0387/ 71	140 v1	Effective Clinical Care	Breast Cancer: Hormonal Therapy for Stage IC - IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer: Percentage of female patients aged 18 years and older with Stage IC through IIIC, ER or PR positive breast cancer who were prescribed tamoxifen or aromatase inhibitor (AI) during the 12-month reporting period	AMA-PCPI ASCO NCCN	The AMA encourages CMS to keep a variety of reporting options available, especially due to the fact that the majority of EPs still report via claims, despite CMS' indication that claims-based reporting allows for the most errors. The claims reporting option for PQRS 2014 offers many EPs an opportunity to avoid incurring additional costs of implementing a registry or EHR. This is a very important option for small and rural EPs, who may not have the resources to adopt either of those capabilities.
0385/ 72	141 v3	Effective Clinical Care	Colon Cancer: Chemotherapy for AJCC Stage III Colon Cancer Patients: Percentage of patients aged 18 through 80 years with AJCC Stage III colon cancer who are referred for adjuvant chemotherapy, prescribed adjuvant chemotherapy, or have previously received adjuvant chemotherapy within the 12-month reporting period	AMA-PCPI ASCO NCCN	The AMA encourages CMS to keep a variety of reporting options available, especially due to the fact that the majority of EPs still report via claims, despite CMS' indication that claims-based reporting allows for the most errors. The claims reporting option for PQRS 2014 offers many EPs an opportunity to avoid incurring additional costs of implementing a registry or EHR. This is a very important option for small and rural EPs, who may not have the resources to adopt either of those capabilities.

NQF/ PQRS	CMS E-Measure ID	NQS Domain	Measure Title and Description	Measure Steward	AMA Comments
0395/ 84		Effective Clinical Care	Hepatitis C: Ribonucleic Acid (RNA) Testing Before Initiating Treatment: Percentage of patients aged 18 years and older with a diagnosis of chronic hepatitis C who started antiviral treatment within the 12 month reporting period for whom quantitative hepatitis C virus (HCV) RNA testing was performed within 12 months prior to initiation of antiviral treatment	AMA-PCPI	The AMA encourages CMS to keep a variety of reporting options available, especially due to the fact that the majority of EPs still report via claims, despite CMS' indication that claims-based reporting allows for the most errors. The claims reporting option for PQRS 2014 offers many EPs an opportunity to avoid incurring additional costs of implementing a registry or EHR. This is a very important option for small and rural EPs, who may not have the resources to adopt either of those capabilities. Additionally, since CMS has placed an emphasis on registry reporting and the desire to shift the program towards that direction, the AMA does not support removal of the registry reporting option. The "Measure Steward" should be listed as the following: AGA/AMA-PCPI.
0396/ 85		Effective Clinical Care	Hepatitis C: HCV Genotype Testing Prior to Treatment: Percentage of patients aged 18 years and older with a diagnosis of chronic hepatitis C who started antiviral treatment within the 12 month reporting period for whom hepatitis C virus (HCV) genotype testing was performed within 12 months prior to initiation of antiviral treatment	AMA-PCPI	The AMA encourages CMS to keep a variety of reporting options available, especially due to the fact that the majority of EPs still report via claims, despite CMS' indication that claims-based reporting allows for the most errors. The claims reporting option for PQRS 2014 offers many EPs an opportunity to avoid incurring additional costs of implementing a registry or EHR. This is a very important option for small and rural EPs, who may not have the resources to adopt either of those capabilities. Additionally, since CMS has placed an emphasis on registry reporting and the desire to shift the program towards that direction, the AMA does not support removal of the registry reporting option. The "Measure Steward" should be listed as the following: AGA/AMA-PCPI.
0398/ 87		Effective Clinical Care	Hepatitis C: Hepatitis C Virus (HCV) Ribonucleic Acid (RNA) Testing Between 4-12 Weeks After Initiation of Treatment: Percentage of patients aged 18 years and older with a diagnosis of chronic hepatitis C who are receiving antiviral treatment for whom quantitative hepatitis C virus (HCV) RNA testing was performed between 4-12 weeks after the initiation of antiviral treatment	AMA-PCPI	The AMA encourages CMS to keep a variety of reporting options available, especially due to the fact that the majority of EPs still report via claims, despite CMS' indication that claims-based reporting allows for the most errors. The claims reporting option for PQRS 2014 offers many EPs an opportunity to avoid incurring additional costs of implementing a registry or EHR. This is a very important option for small and rural EPs, who may not have the resources to adopt either of those capabilities. Additionally, since CMS has placed an emphasis on registry reporting and the desire to shift the program towards that direction, the AMA does not support removal of the registry reporting option. The "Measure Steward" should be listed as the following: AGA/AMA-PCPI.

NQF/ PQRS	CMS E-Measure ID	NQS Domain	Measure Title and Description	Measure Steward	AMA Comments
0389/ 102	129 v3	Efficiency and Cost Reduction	Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients: Percentage of patients, regardless of age, with a diagnosis of prostate cancer at low risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy who did not have a bone scan performed at any time since diagnosis of prostate cancer	AMA-PCPI	The AMA encourages CMS to keep a variety of reporting options available, especially due to the fact that the majority of EPs still report via claims, despite CMS' indication that claims-based reporting allows for the most errors. The claims reporting option for PQRS 2014 offers many EPs an opportunity to avoid incurring additional costs of implementing a registry or EHR. This is a very important option for small and rural EPs, who may not have the resources to adopt either of those capabilities.
0390/ 104		Effective Clinical Care	Prostate Cancer: Adjuvant Hormonal Therapy for High Risk Prostate Cancer Patients: Percentage of patients, regardless of age, with a diagnosis of prostate cancer at high or very high risk of recurrence receiving external beam radiotherapy to the prostate who were prescribed adjuvant hormonal therapy (GnRH [gonadotropin-releasing hormone] agonist or antagonist)	AMA-PCPI	The AMA encourages CMS to keep a variety of reporting options available, especially due to the fact that the majority of EPs still report via claims, despite CMS' indication that claims-based reporting allows for the most errors. The claims reporting option for PQRS 2014 offers many EPs an opportunity to avoid incurring additional costs of implementing a registry or EHR. This is a very important option for small and rural EPs, who may not have the resources to adopt either of those capabilities. The "Measure Steward" should be listed as the following: AUA/AMA-PCPI. The measure description has been updated.
0104/ 107	161 v2	Effective Clinical Care	Adult Major Depressive Disorder (MDD): Suicide Risk Assessment: Percentage of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified	AMA-PCPI	The AMA encourages CMS to keep a variety of reporting options available, especially due to the fact that the majority of EPs still report via claims, despite CMS' indication that claims-based reporting allows for the most errors. The claims reporting option for PQRS 2014 offers many EPs an opportunity to avoid incurring additional costs of implementing a registry or EHR. This is a very important option for small and rural EPs, who may not have the resources to adopt either of those capabilities. Additionally, since CMS has placed an emphasis on registry reporting and the desire to shift the program towards that direction, the AMA does not support removal of the registry reporting option.
1668/ 121		Effective Clinical Care	Adult Kidney Disease: Laboratory Testing (Lipid Profile): Percentage of patients aged 18 years and older with a diagnosis of chronic kidney disease (CKD) (stage 3, 4, or 5, not receiving Renal Replacement Therapy [RRT]) who had a fasting lipid profile performed at least once within a 12-month period	AMA-PCPI	The AMA encourages CMS to keep a variety of reporting options available, especially due to the fact that the majority of EPs still report via claims, despite CMS' indication that claims-based reporting allows for the most errors. The claims reporting option for PQRS 2014 offers many EPs an opportunity to avoid incurring additional costs of implementing a registry or EHR. This is a very important option for small and rural EPs, who may not have the resources to adopt either of those capabilities.

NQF/ PQRS	CMS E-Measure ID	NQS Domain	Measure Title and Description	Measure Steward	AMA Comments
					The "Measure Steward" should be listed as the following: RPA/AMA-PCPI.
AQA Adopted/ 122		Effective Clinical Care	Adult Kidney Disease: Blood Pressure Management: Percentage of patient visits for those patients aged 18 years and older with a diagnosis of chronic kidney disease (CKD) (stage 3, 4, or 5, not receiving Renal Replacement Therapy [RRT]) and proteinuria with a blood pressure < 130/80 mmHg OR ≥ 130/80 mmHg with a documented plan of care	AMA-PCPI	The AMA encourages CMS to keep a variety of reporting options available, especially due to the fact that the majority of EPs still report via claims, despite CMS' indication that claims-based reporting allows for the most errors. The claims reporting option for PQRS 2014 offers many EPs an opportunity to avoid incurring additional costs of implementing a registry or EHR. This is a very important option for small and rural EPs, who may not have the resources to adopt either of those capabilities. The "Measure Steward" should be listed as the following: RPA/AMA-PCPI.
0563/ 141		Communication and Care Coordination	Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of a Plan of Care: Percentage of patients aged 18 years and older with a diagnosis of primary open-angle glaucoma (POAG) whose glaucoma treatment has not failed (the most recent IOP was reduced by at least 15% from the pre- intervention level) OR if the most recent IOP was not reduced by at least 15% from the pre-intervention level, a plan of care was documented within 12 months	AMA-PCPI NCQA	The AMA encourages CMS to keep a variety of reporting options available, especially due to the fact that the majority of EPs still report via claims, despite CMS' indication that claims-based reporting allows for the most errors. The claims reporting option for PQRS 2014 offers many EPs an opportunity to avoid incurring additional costs of implementing a registry or EHR. This is a very important option for small and rural EPs, who may not have the resources to adopt either of those capabilities. The "Measure Steward" should be listed as the following: AAO/AMA-PCPI.
AQA Adopted/ 176		Effective Clinical Care	Rheumatoid Arthritis (RA): Tuberculosis Screening: Percentage of patients aged 18 years and older with a diagnosis of rheumatoid arthritis (RA) who have documentation of a tuberculosis (TB) screening performed and results interpreted within 6 months prior to receiving a first course of therapy using a biologic disease-modifying anti-rheumatic drug (DMARD)	AMA-PCPI	The AMA encourages CMS to keep a variety of reporting options available, especially due to the fact that the majority of EPs still report via claims, despite CMS' indication that claims-based reporting allows for the most errors. The claims reporting option for PQRS 2014 offers many EPs an opportunity to avoid incurring additional costs of implementing a registry or EHR. This is a very important option for small and rural EPs, who may not have the resources to adopt either of those capabilities. Additionally, since CMS has placed an emphasis on registry reporting and the desire to shift the program towards that direction, the AMA does not support removal of the registry reporting option. The "Measure Steward" should be listed as the following: ACR/AMA-PCPI (ACR is the American College of Rheumatology)

NQF/ PQRS	CMS E-Measure ID	NQS Domain	Measure Title and Description	Measure Steward	AMA Comments
AQA Adopted/ 177		Effective Clinical Care	Rheumatoid Arthritis (RA): Periodic Assessment of Disease Activity: Percentage of patients aged 18 years and older with a diagnosis of rheumatoid arthritis (RA) who have an assessment and classification of disease activity within 12 months	AMA-PCPI	The AMA encourages CMS to keep a variety of reporting options available, especially due to the fact that the majority of EPs still report via claims, despite CMS' indication that claims-based reporting allows for the most errors. The claims reporting option for PQRS 2014 offers many EPs an opportunity to avoid incurring additional costs of implementing a registry or EHR. This is a very important option for small and rural EPs, who may not have the resources to adopt either of those capabilities. Additionally, since CMS has placed an emphasis on registry reporting and the desire to shift the program towards that direction, the AMA does not support removal of the registry reporting option. The "Measure Steward" should be listed as the following: ACR/AMA-PCPI.
AQA Adopted/ 179		Effective Clinical Care	Rheumatoid Arthritis (RA): Assessment and Classification of Disease Prognosis: Percentage of patients aged 18 years and older with a diagnosis of rheumatoid arthritis (RA) who have an assessment and classification of disease prognosis at least once within 12 months	AMA-PCPI	The AMA encourages CMS to keep a variety of reporting options available, especially due to the fact that the majority of EPs still report via claims, despite CMS' indication that claims-based reporting allows for the most errors. The claims reporting option for PQRS 2014 offers many EPs an opportunity to avoid incurring additional costs of implementing a registry or EHR. This is a very important option for small and rural EPs, who may not have the resources to adopt either of those capabilities. Additionally, since CMS has placed an emphasis on registry reporting and the desire to shift the program towards that direction, the AMA does not support removal of the registry reporting option. The "Measure Steward" should be listed as the following: ACR/AMA-PCPI/
AQA Adopted/ 180		Effective Clinical Care	Rheumatoid Arthritis (RA): Glucocorticoid Management: Percentage of patients aged 18 years and older with a diagnosis of rheumatoid arthritis (RA) who have been assessed for glucocorticoid use and, for those on prolonged doses of prednisone ≥ 10 mg daily (or equivalent) with improvement or no change in disease activity, documentation of glucocorticoid management plan within 12 months	AMA-PCPI	The AMA encourages CMS to keep a variety of reporting options available, especially due to the fact that the majority of EPs still report via claims, despite CMS' indication that claims-based reporting allows for the most errors. The claims reporting option for PQRS 2014 offers many EPs an opportunity to avoid incurring additional costs of implementing a registry or EHR. This is a very important option for small and rural EPs, who may not have the resources to adopt either of those capabilities. Additionally, since CMS has placed an emphasis on registry reporting and the desire to shift the program towards that direction, the AMA does not support removal of the registry reporting option. The "Measure Steward" should be listed as the following: ACR/AMA-PCPI.

NQF/ PQRS	CMS E-Measure ID	NQS Domain	Measure Title and Description	Measure Steward	AMA Comments
0399/ 183		Community/ Population Health	Hepatitis C: Hepatitis A Vaccination in Patients with Hepatitis C Virus (HCV): Percentage of patients aged 18 years and older with a diagnosis of chronic hepatitis C who have received at least one injection of hepatitis A vaccine, or who have documented immunity to hepatitis A	AMA-PCPI	The AMA encourages CMS to keep a variety of reporting options available, especially due to the fact that the majority of EPs still report via claims, despite CMS' indication that claims-based reporting allows for the most errors. The claims reporting option for PQRS 2014 offers many EPs an opportunity to avoid incurring additional costs of implementing a registry or EHR. This is a very important option for small and rural EPs, who may not have the resources to adopt either of those capabilities. Additionally, since CMS has placed an emphasis on registry reporting and the desire to shift the program towards that direction, the AMA does not support removal of the registry reporting option. The "Measure Steward" should be listed as the following: AGA/AMA-PCPI.
0659/ 185		Communication and Care Coordination	Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use: Percentage of patients aged 18 years and older receiving a surveillance colonoscopy with a history of a prior adenomatous polyp(s) in previous colonoscopy findings, who had an interval of 3 or more years since their last colonoscopy	AMA-PCPI ASCO	The AMA encourages CMS to keep a variety of reporting options available, especially due to the fact that the majority of EPs still report via claims, despite CMS' indication that claims-based reporting allows for the most errors. The claims reporting option for PQRS 2014 offers many EPs an opportunity to avoid incurring additional costs of implementing a registry or EHR. This is a very important option for small and rural EPs, who may not have the resources to adopt either of those capabilities. The measure title has been updated. The "Measure Steward" should be listed as the following: AGA/ASGE/ACG/AMA-PCPI.
0386/ 194		Effective Clinical Care	Oncology: Cancer Stage Documented: Percentage of patients, regardless of age, with a diagnosis of cancer who are seen in the ambulatory setting who have a baseline American Joint Committee on Cancer (AJCC) cancer stage or documentation that the cancer is metastatic in the medical record at least once during the 12 month reporting period	AMA-PCPI NCQA	The AMA encourages CMS to keep a variety of reporting options available, especially due to the fact that the majority of EPs still report via claims, despite CMS' indication that claims-based reporting allows for the most errors. The claims reporting option for PQRS 2014 offers many EPs an opportunity to avoid incurring additional costs of implementing a registry or EHR. This is a very important option for small and rural EPs, who may not have the resources to adopt either of those capabilities. The "Measure Steward" should be listed as the following: AMA-PCPI/ASCO (the American Society for Clinical Oncology).

NQF/ PQRS	CMS E-Measure ID	NQS Domain	Measure Title and Description	Measure Steward	AMA Comments
0409/ 205		Effective Clinical Care	HIV/AIDS: Sexually Transmitted Disease Screening for Chlamydia, Gonorrhea, and Syphilis: Percentage of patients aged 13 years and older with a diagnosis of HIV/AIDS for whom chlamydia, gonorrhea and syphilis screenings were performed at least once since the diagnosis of HIV infection	AMA-PCPI	This measure was jointly developed by the AMA-PCPI and NCQA, similar to the other HIV measures. The "Measure Steward" should be listed as the following: NCQA/AMA-PCPI.
0658/ 320		Communication and Care Coordination	Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients: Percentage of patients aged 50 years and older receiving a screening colonoscopy without biopsy or polypectomy who had a recommended follow-up interval of at least 10 years for repeat colonoscopy documented in their colonoscopy report	AMA-PCPI	The AMA encourages CMS to keep a variety of reporting options available, especially due to the fact that the majority of EPs still report via claims, despite CMS' indication that claims-based reporting allows for the most errors. The claims reporting option for PQRS 2014 offers many EPs an opportunity to avoid incurring additional costs of implementing a registry or EHR. This is a very important option for small and rural EPs, who may not have the resources to adopt either of those capabilities. The "Measure Steward" should be listed as the following: AGA/ASGE/ACG/AMA-PCPI.
1525/ 326		Effective Clinical Care	Atrial Fibrillation and Atrial Flutter: Chronic Anticoagulation Therapy: Percentage of patients aged 18 years and older with a diagnosis of nonvalvular atrial fibrillation (AF) or atrial flutter whose assessment of the specified thromboembolic risk factors indicate one or more high-risk factors or more than one moderate risk factor, as determined by CHADS2 risk stratification, who are prescribed warfarin OR another oral anticoagulant drug that is FDA approved for the prevention of thromboembolism	AMA-PCPI ACCF AHA	The AMA encourages CMS to keep a variety of reporting options available, especially due to the fact that the majority of EPs still report via claims, despite CMS' indication that claims-based reporting allows for the most errors. The claims reporting option for PQRS 2014 offers many EPs an opportunity to avoid incurring additional costs of implementing a registry or EHR. This is a very important option for small and rural EPs, who may not have the resources to adopt either of those capabilities. The measure description has been updated.
N/A/ 327		Effective Clinical Care	Pediatric Kidney Disease: Adequacy of Volume Management: Percentage of calendar months within a 12-month period during which patients aged 17 years and younger with a diagnosis of End Stage Renal Disease (ESRD) undergoing maintenance hemodialysis in an outpatient dialysis facility have an assessment of the adequacy of volume management from a nephrologist	AMA-PCPI	The AMA encourages CMS to keep a variety of reporting options available, especially due to the fact that the majority of EPs still report via claims, despite CMS' indication that claims-based reporting allows for the most errors. The claims reporting option for PQRS 2014 offers many EPs an opportunity to avoid incurring additional costs of implementing a registry or EHR. This is a very important option for small and rural EPs, who may not have the resources to adopt either of those capabilities. The "Measure Steward" should be listed as the following: RPA/AMA-PCPI.

NQF/ PQRS	CMS E-Measure ID	NQS Domain	Measure Title and Description	Measure Steward	AMA Comments
1667/ 328		Effective Clinical Care	Pediatric Kidney Disease: ESRD Patients Receiving Dialysis: Hemoglobin Level < 10g/dL: Percentage of calendar months within a 12-month period during which patients aged 17 years and younger with a diagnosis of End Stage Renal Disease (ESRD) receiving hemodialysis or peritoneal dialysis have a hemoglobin level < 10 g/dL	AMA-PCPI	The AMA encourages CMS to keep a variety of reporting options available, especially due to the fact that the majority of EPs still report via claims, despite CMS' indication that claims-based reporting allows for the most errors. The claims reporting option for PQRS 2014 offers many EPs an opportunity to avoid incurring additional costs of implementing a registry or EHR. This is a very important option for small and rural EPs, who may not have the resources to adopt either of those capabilities. The "Measure Steward" should be listed as the following: RPA/AMA-PCPI.

APPENDIX F: Comments on CMS Tables 26-47 / Proposed Changes To Measures Groups Beginning 2015

Table #: Measures Group	AMA Comments
Table 26: Asthma	This measures group does not seem meaningful to have since there is only one measure that focuses on asthma, as the other asthma-specific measures have been proposed for removal (# 64, 231, and 232) beginning in 2015. If measures groups can be generic for all but one of the measures included in it, the number of measures groups that could then be created is so great the purpose of creating a measures group reporting option is lost.
Table 27: Acute Otitis Externa (AOE)	The AMA supports the proposal to add this measures group to the PQRS 2015 program.
Table 30: Chronic Obstructive Pulmonary Disorder (COPD)	The AMA does not support the proposed removal of the COPD measures group.
Table 33: Dementia	The AMA does not agree with the proposed addition of PQRS # 47 to the Dementia Measures Group. A measure specifically addressing palliative care and advance care planning for dementia patients was developed as a part of the Dementia Measurement Set by the AMA-PCPI titled, "Palliative Care Counseling and Advance Care Planning." We believe this measure would be more appropriate for inclusion in this measures group, as it also addresses end of life decision making. It has previously been submitted during a Call for Measures.
Table 45: Adult Sinusitis	The AMA supports the proposal to add this measures group to the PQRS 2015 program.
Table 46: Sleep Apnea	The "Measure Steward" for PQRS # 276-279 should be updated to "AASM/AMA-PCPI." The American Academy of Sleep Medicine will steward these measures for PQRS 2015.