American Heart Association | American Stroke Association

September 6, 2013

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1600-P
PO Box 8013
Baltimore, MD 21244-1850

Re: CMS-1600-P

Dear Sir/Madam:

On behalf of the American Heart Association (AHA), including the American Stroke Association (ASA) and over 22.5 million AHA and ASA volunteers and supporters, we appreciate the opportunity to provide comments in response to the Centers for Medicare and Medicaid Services' (CMS) proposed revisions to the Physician Fee Schedule for 2014. Our comments focus on the following five areas:

- Medicare telehealth services
- Complex chronic care management services
- Physician Compare website
- Physician payment, efficiency, and quality improvements – PQRS
- Proposed PQRS quality measures

Medicare Telehealth Services

AHA strongly supports the Agency's proposal to modify one of the geographic criteria used to identify eligible telehealth originating sites. Under the existing requirements, entities located within rural health professional shortage areas (HPSAs) may qualify as originating sites; however, "rural" HPSAs may not be located within a Metropolitan Statistical Area (MSA). According to the proposed rule, CMS plans to expand the definition of "rural" to include rural census tracts. This change would allow entities in rural HPSAs – regardless of whether or not they are located within a MSA – to qualify as a telehealth originating site. As CMS notes in the proposed rule, this change should expand the number of entities that can qualify as originating sites and increase access to health care services for Medicare beneficiaries located in rural areas.

AHA appreciates the Agency's effort to increase the number of sites that will qualify as a telehealth originating site. We've found that telehealth in the treatment of stroke – also known as telestroke – has been tremendously helpful in improving access to high quality stroke care. Because every minute matters when treating

stroke, the recommended treatment for acute stroke must begin as soon as possible after symptom onset to be most effective and reduce the risk of resulting disabilities, but no longer than within 4.5 hours of the onset of stroke signs or symptoms. There are, however, a number of barriers that prevent patients from receiving treatment within this critical timeframe, including long distances to tertiary care hospitals, a shortage of neurologists, and hospitals that aren't able to provide around the clock on-site call coverage. As a result of these and other barriers, only a small fraction (3 to 5%) of patients receive the treatment recommended by the latest scientific guidelines for acute stroke. Fortunately, telehealth can help overcome these barriers and improve patient access to recommended stroke treatments in rural and other "neurologically underserved" areas.

Thus, we are encouraged that the Agency's proposal will help remove some of these barriers by expanding access to telehealth services in a greater number of rural areas. But we remain concerned that reimbursement for telehealth is limited to originating sites that meet the geographic criteria or were participating in a federal telehealth demonstration project as of December 31, 2000. Medicare should reimburse for telehealth services that originate in urban and suburban areas, as well as in rural areas. Although many areas not served or underserved by neurologists and other specialists are rural, many other areas of the country – including some urban and suburban areas – do not have appropriate access to acute stroke care. There are roughly four neurologists per 100,000 people in the United States treating the nearly 800,000 new or recurrent strokes that occur each year. In 2002, 77% of U.S. counties did not have a hospital with neurological services. Telestroke has proven to be an effective means of helping provide high-quality stroke care in areas underserved by neurologists, including in New York, Massachusetts, and many other regions. However, the Medicare policy of limiting reimbursement for telehealth services to those originating in rural areas has hampered the development of sufficient stroke consultation coverage.

To remove these remaining barriers and facilitate appropriate care regardless of the patient's location, we encourage CMS to consider eliminating the rural originating site requirement altogether. Patients in rural, suburban, and urban areas should all have access to the highest quality of care. Telehealth should be an option to provide that care for those disease states, like stroke, where the evidence supports a benefit.

Complex Chronic Care Management Services

AHA supports the Agency's proposal to create a new HCPCS G-code to better account for the provision of complex chronic care management services. As we stated in our comments on last year's Physician Fee Schedule proposed rule, in order to support adequate and appropriate care coordination for patients, there must be a way for physicians on both sides of the care transition (inpatient and primary care/community physician) to account for the often extensive set of services they provide, through the use of a billing code.

We also applaud the Agency's alignment of these new codes with other programs. For example, we are pleased to see that as a standard for furnishing complex chronic condition services, the practice must be using a certified electronic health record as part of the meaningful use program. With so much activity underway, it is important that these programs are aligned so they may build off of one another and have the greatest impact.

Physician Compare Website

According to the proposed rule, CMS plans to expand the number of quality measures posted on the Physician Compare website over the next several years. CMS intends to start in 2014 by publicly reporting performance on all measures collected through the Group Practice Reporting Option (GPRO) web interface by groups participating in the Physician Quality Reporting System (PQRS). CMS will further expand this to include measures that groups report via registries and electronic health records no earlier than 2015.

AHA fully supports the inclusion of the additional GPRO measures identified by CMS for PQRS GPRO reporting at the physician group level. We agree there is value in publicly posting data at the group practice level. Group practices tend to have a sufficient volume of patients that may make it feasible to benchmark care in one practice compared to another practice. Additionally, it is easier to identify a core set of measures on which to gauge a group practice's overall rate of performance.

We are, however, very concerned with the Agency's proposal to post individual physician level data on the Physician Compare website. We are concerned that it may not be feasible to accurately represent a physician's performance, because at the individual physician/eligible professional level, there is not always an adequate sample size to make valid comparisons even if composite measures are employed or commonly reported measures such as the GPRO set are used as the basis for reporting. In addition, there are problems with the attribution of process of care measures to a single physician/eligible professional. Multiple physicians can be involved in the treatment of a patient, especially patients with a chronic disease. For example, in the case of heart failure, it is not uncommon for a patient to see 10 or more physicians over the course of the year. Each of these physicians could be seen as being responsible for the patient and it is unclear which physician would get credit for meeting one of the measures (e.g., prescribing a beta blocker) and who would be penalized if a measure was missed (e.g., if tobacco counseling was not offered). In these situations, it can be difficult to assess who ultimately is responsible for the care of that patient when evaluating a specific measure.

Furthermore, having this information publicly reported could be detrimental to patient care in areas where there are large numbers of patients with low socio-economic status and low literacy rates. Providers would have an incentive to turn away patients with low health literacy, inadequate financial resources to afford treatment, and ethnic groups traditionally subject to healthcare inequities in order to improve their process measure performance. The possibility that providers will deselect high risk populations to maintain high scores on publicly reported websites should be of real concern to CMS. While CMS may try to include risk adjusted measures or other mechanisms to account for these concerns, we do not believe that will sufficiently reduce the veiled incentive to deselect patients as there is no way at the individual practitioner level to create a fair risk model. For these reasons, we strongly urge CMS to limit the publication of measure data to group practices until there is sufficient experience and data to determine what measures, if any, can be reported at the individual practitioner level with relative certainty that the information being portrayed is accurate.

We have similar concerns with the Agency's plan to publicly report performance rates on measures in the PQRS Cardiovascular Prevention measures group at the individual physician level. We understand that this proposal was made in support of the Million Hearts Initiative. AHA has been a partner of the Million Hearts Initiative since the inception of the campaign and we believe that the goals of the

initiative are critical to furthering prevention of cardiovascular disease. However, as with the measures above, we feel that any public reporting of measures on the individual physician level can result in unintended consequences. Thus, we encourage CMS to limit public reporting of these measures to the practice group level.

Physician Payment, Efficiency, and Quality Improvements – PQRS

In this section of the proposed rule, CMS discusses a new reporting option which would allow individual eligible professionals to satisfy the PQRS beginning in 2014 based on satisfactory participation in a qualified clinical data registry. AHA generally supports this new reporting option; however, we have a number of questions about the requirements a clinical data registry must meet in order to "qualify" as capable of submitting data on behalf of an eligible participant. Our questions follow below.

- According to the proposed rule, when determining whether an entity should be considered a qualified clinical data registry, CMS will consider whether the entity "requires the submission of data from participants with respect to multiple payers". AHA's Get With The Guidelines (GWTG) programs collect data from other payers besides Medicare. However, from the language included in this proposed rule, we are uncertain if CMS would require that the data be broken out by different payer types or if categories such as Medicare, Medicaid, and Other payers would suffice. We request clarification from the Agency on what is intended by this statement.

- Qualified registries are to "provide timely feedback at least quarterly so eligible professionals could view their reporting at least 4 times during the yearly reporting period." Certain registries such as GWTG have the ability to allow users to generate reports on an "on demand" basis. If, the registry is capable of allowing the user to generate reports as often as they like, would it be acceptable if the registry sent the eligible professional a reminder to generate their quarterly reports, or would the registry have to generate a printable version for the provider once every quarter?

- To qualify "the entity must report, on behalf of its individual eligible professional participants, a minimum of 9 measures that cross 3 National Quality Strategy domains." AHA agrees that there is value with ensuring that measures cut across the National Quality Strategy domains. However, we request clarification on what type of process CMS would use to evaluate if a measure falls within a given domain. In some instances there are measures that may potentially fall into two domains. In other instances medical professionals may feel that a measure falls within one domain, but others could potentially disagree. We ask for additional clarification on this language.

- The rule states that "an eligible professional must report for each measure 50% of [the professional's] eligible patients." We request clarification from CMS on this requirement. In cases where a physician's practice is limited to one hospital, it is feasible to calculate whether the data represents 50% of the eligible patients. If a physician, however, has privileges at multiple hospitals, it becomes more difficult to assess the total number of patients treated by the physician. We therefore request clarification on how registries should deal with those physicians who practice at multiple sites.

Thank you again for the opportunity to submit comments. If you have any questions or need any additional information, please do not hesitate to contact a member of AHA's staff. For questions related to telehealth, please contact Susan Bishop, Senior Regulatory Affairs Advisor, at (202) 785-7908 or susan.k.bishop@heart.org. For questions on the Physician Compare website or the PQRS, please contact Penelope Solis, Healthcare Quality Manager, at (202) 423-3124 or penelope.solis@heart.org.

Sincerely,

Mariell Jessup, MD, FAHA
President
American Heart Association