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President and CEO

August 24, 2010

**BY COURIER**

Donald Berwick, M.D.  
Administrator  
Centers for Medicare & Medicaid Services  
*Attention: CMS-1503-P*  
Hubert H. Humphrey Building  
200 Independence Avenue, S.W., Room 445-G  
Washington, DC 20201

Re: Medicare Program; Payment Policies under the Physician Fee Schedule  
and Other Revisions to Part B for CY 2011 [CMS-1503-P]; 75 *Fed. Reg.*  
40040 (July 13, 2010)

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Dear Dr. Berwick:

The Federation of American Hospitals (FAH) is the national representative of nearly 1,000 investor-owned or managed community hospitals and health systems throughout the United States. Our members include teaching and non-teaching hospitals in urban and rural America, including inpatient rehabilitation, long-term acute care, cancer and psychiatric hospitals. We appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed rule (Proposed Rule or NPRM) regarding payment policies under the physician fee schedule and other revisions to Part B for CY 2011.

**II. C. 4. c. Proposed CY2011 Expansion of the MPPR Policy to Therapy Services**

**Background**

Medicare has a longstanding policy to reduce payment by 50 percent for the second and subsequent surgical procedures furnished to the same patient by the same physician on the same day, largely based on the presence of efficiencies in practice expense (PE) and physician work

in the pre-service and post-service period. Effective January 1, 2006 the Multiple Procedure Payment Reduction (MPPR) policy was extended to the technical component (TC) of certain diagnostic imaging procedures performed on contiguous areas of the body in a single session. This reduction is based on an assumption that for the second and subsequent imaging procedures there are some efficiencies in clinical labor, supplies, and equipment time.

### Proposal for CY 2011

CMS believes that therapy services are misvalued when multiple services are furnished to a patient in a single session because duplicate clinical labor and supplies are included in the practice expense inputs of the services furnished. In the proposed physician fee schedule regulation for 2011, CMS proposes to extend the MPPR policy to 46 "always therapy" services furnished to a patient on the same day. These services are designated "always therapy" services regardless of who furnishes them and always require therapy modifiers to be reported, specifically -GP (Services rendered under outpatient physical therapy plan of care); -GO (Services rendered under outpatient occupational therapy plan of care); or -GN (Services rendered under outpatient speech pathology plan of care).

The proposed MPPR policy for therapy services for CY 2011 includes the following:

- CMS proposes to apply a 50 percent payment reduction to the PE component of the second and subsequent therapy services for multiple therapy services furnished to a single patient in a single day. Full payment would be made for the service or unit with the highest PE relative value units (RVUs) and payment would be made at 50 percent of the PE RVUs for the second and subsequent procedures or units of the service. The work and malpractice components of the therapy service payment would not be reduced.
- CMS proposes to apply the proposed CY 2011 MPPR policy to services paid under the physician fee schedule (PFS) that are furnished in the office setting as well as services paid at the PFS rates that are furnished by outpatient hospitals, home health agencies, comprehensive outpatient rehabilitation facilities (CORFs), and other entities that are paid by Medicare for outpatient therapy services.
- CMS proposes to apply the 50 percent MPPR policy to the PE RVUs of subsequent therapy services provided to the same patient on the same day, rather than in the same session because CMS believes that beneficiaries typically have only one therapy session in a single day.
- CMS proposes to apply the policy to the "always therapy" services, regardless of whether the services are provided by one therapy discipline or multiple disciplines, for example, physical therapy, occupational therapy, or speech-language pathology.

### Impact of MPPR Proposal for Therapy Services

The proposed MPPR policy has the potential for a significant adverse impact on the delivery of therapy services. The most recent utilization data for the 46 therapy services furnished in the office setting and paid under the physician fee schedule is provided by CMS on the CMS website. The data indicate that these 46 codes accounted for \$2.5 billion in allowed charges and

91.7 million claims in CY 2011. The most recent utilization data for therapy services by outpatient hospitals, home health agencies, and CORFs is not provided on the CMS website.

The Regulatory Impact Analysis of the proposed rule indicates that the proposed MPPR policy would reduce payments to physical and occupational therapists by more than \$235 million or 11 percent of their total allowed charges. In order to maintain budget neutrality in the physician fee schedule, CMS proposes to redistribute the PFS savings back into other services paid under the PFS by increasing all PE RVUs by approximately one percent. CMS estimates that the proposal would reduce payments to providers for therapy services in settings such as skilled nursing facilities and hospital outpatient departments by 13 percent – and these reductions are not budget neutral. The total dollar impact of the proposal on hospital outpatient departments, home health agencies and CORFs is not provided in the proposed rule.

### CMS Rationale for Proposal

CMS believes the proposed therapy MPPR policy would provide more appropriate payment for therapy services that are commonly furnished together by taking into account the duplicative clinical labor activities and supplies in the practice expense inputs that CMS believes are not furnished more than once in a single day of therapy. CMS states that the following duplicate clinical labor activities are included in the practice expense inputs for these 46 codes:

- clean room/equipment;
- provide education/instruction/counseling/coordinating home care;
- greet patient/provide gowning;
- obtain measurements, for example, ROM/strength/edema; and,
- provide post-treatment patient assistance.

CMS states the most common duplicate supply item included in the practice expense input was the multispecialty visit pack.

CMS' examples of duplicated and unduplicated labor activities and supplies for two high volume sample therapy code pairs and the CMS estimates of potential clinically appropriate time and quantity reductions for multiple service sessions are displayed in Table 19 of the proposed rule.

### CMS Rationale is Unsound and Not Supported by Actual Data

CMS incorrectly assumes that duplicate clinical labor and supplies are included in the PE RVUs when multiple services are furnished to a patient in a single session. This basic assumption is incorrect because during the development of the PE RVUs for the therapy services the efficiencies that exist when multiple therapy services are provided in a single session were explicitly taken into account.

Although we do not have access to the files of the AMA/Specialty Society RVS Update Committee (RUC), it is our understanding that when the practice expense inputs for the therapy codes were developed, the "typical visit" was defined as a 45 minute visit during which the

patient receives two 15 minute therapeutic procedures (e.g., code 97110 Therapeutic exercises to develop strength and endurance, etc. and code 97112 Neuromuscular reeducation of movement, balance, coordination, etc.) and a modality (e.g., code 97032 manual electrical stimulation). In general, the clinical activities for the activities that CMS considers duplicative were halved for the therapeutic procedures and set at zero for the modalities.

We also understand that concerns about duplication in practice expense of the therapy codes were recently discussed by the RUC. Following review of the practice expense inputs and the history described above, it was concluded by this multi-specialty panel of practicing physicians and other health professionals that the current PE RVUs are adjusted appropriately to reflect the typical encounter of two therapeutic procedures and one modality during a single 45 minute session. In the proposed rule, CMS seems to acknowledge this history but goes on to suggest these adjustments were insufficient and that a session of two therapeutic procedures and one modality is not “typical” by stating: “In addition, we note that the CY 2009 PFS claims data show that when multiple therapy services are billed on a claim for the same date of service, the median number is four services per day.” We do not believe it is appropriate to calculate a median of the number of therapy claims by excluding claims with a single service, as CMS has done, and we do not believe that CMS has provided persuasive evidence that the therapy codes are misvalued.

The table below includes the code pairs in the first CMS example of “duplicative” inputs that was included in the proposed rule. In addition to the times that CMS listed with the codes, we have listed the standard times associated with these activities to prove that a 50 percent reduction has already been built into the values for the codes.

The standard times were based on the times for identical or comparable activities associated with code 99213, a mid-level office visit that is the most frequently billed service under the physician fee schedule. Each activity listed in the table is assigned a number. If the activity is identical for both 99213 and the therapy codes, the activity is not split into components. Where the activities are comparable but not identical, the activity is split into components a, b, and possibly c. For example, the activities for 99213 include obtaining vital signs but do not include obtaining measurements such as ROM and strength. To avoid duplication of time, the five (5) minutes associated with obtaining vital signs for code 99213 were divided between the two therapy activities with 1.5 minutes for vital signs and one (1) minute for obtaining measurements. Thus the total time of the comparable therapy activities (5 minutes) equals the time of obtaining vital signs for 99213 (5 minutes).

Example 1: CPT code 97112 (Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and /or proprioception for sitting and/or standing activities) and CPT code 97110 (Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility).

| Labor Task Description                                       | Standard Time (based on 99213, a 15 minute office visit) | Code A 97112 Labor Task Time | Code B 97110 Labor Task Time |
|--------------------------------------------------------------|----------------------------------------------------------|------------------------------|------------------------------|
| 1. Clean room/equipment                                      | 2                                                        | 1                            | 1                            |
| 2. Education/instruction/counseling/ coordination home care  | 5                                                        | 2.5                          | 2.5                          |
| 3. Greet patient/provide gowning                             | 3                                                        | 1.5                          | 1.5                          |
| 4a. Obtain vital signs                                       | 5                                                        | 1.5                          | 1.5                          |
| 4b. Obtain measurements, eg, ROM/strength/edema              | 0                                                        | 1                            | 1                            |
| 5a. Phone calls between visits with patient, family          | 5                                                        | 1                            | 1                            |
| 5b. Post treatment patient assistance                        | 0                                                        | 1                            | 1                            |
| 6a. Review history, systems, and medications                 | 6                                                        | 0                            | 0                            |
| 6b. Review/read documentation, plan of care, treatment goals | 0                                                        | 1.5                          | 1.5                          |
| 6c. Verify/Coordinate availability of resources/equip        | 0                                                        | 1.5                          | 1.5                          |
| Total time                                                   | 26                                                       | 12.5                         | 12.5                         |

Regarding supplies, the table in the proposed rule clearly indicates that the \$1.14 cost of the most expensive supply (multispecialty pack) already has been divided evenly between the two codes.

#### CMS Proposal Fails to Consider the Pattern of Therapy Delivery in Provider Settings

The CMS proposal is focused on the delivery of therapy services in the office setting and fails to consider that the pattern of delivery of therapy services in provider settings is different. Based on an analysis of claims that was limited to claims from practitioners furnishing therapy services in their offices, CMS proposes to:

- apply the 50 percent MPPR policy to the PE RVUs of subsequent therapy services

provided to the same patient on the same day, rather than in the same session because CMS believes that beneficiaries typically have only one therapy session in a single day.

- apply the policy to all "always therapy" services, regardless of whether the services are provided by one therapy discipline or multiple disciplines, for example, physical therapy, occupational therapy, or speech-language pathology.

These aspects of the proposed MPPR policy are completely inconsistent with the delivery of therapy services in a provider setting. For example, in a skilled nursing facility and to a lesser extent in hospital outpatient departments, it is fairly common for patients to receive therapy from different practitioners on the same day. For example, a stroke patient might receive help with gait training in the morning from a physical therapist and speech therapy in the afternoon from a speech pathologist. Clearly, activities such as greeting the patient are appropriately duplicated in such circumstances.

The failure of CMS to consider this pattern of delivery is significant since delivery of physical therapy occurs far less often in an office setting than in a provider setting. Based on analysis of 2007 claims data conducted by CMS contractor Research Triangle Institute, the private practice setting and physician office setting account for 35.9 percent of the outpatient therapy expenditures. The remaining 65 percent of expenditures for outpatient therapy services are from hospital, skilled nursing facility, outpatient rehabilitation facility, home health and CORF settings. Table 8 (below) extracted from the RTI 2007 Medicare claims analysis shows the spending for services in the different therapy settings.

| Table 8: CY 2007 Outpatient Therapy Expenditures by Setting |             |                 |                         |
|-------------------------------------------------------------|-------------|-----------------|-------------------------|
| Setting                                                     | Claim Lines | Paid            | Percent of Paid Dollars |
| All                                                         | 140,634,124 | \$4,376,866,295 | 100.0%                  |
| Hospital                                                    | 22,066,160  | \$767,214,932   | 17.5%                   |
| SNF                                                         | 41,919,516  | \$1,384,510,150 | 31.6%                   |
| CORF                                                        | 4,764,357   | \$127,270,223   | 2.9%                    |
| ORF                                                         | 17,599,266  | \$522,738,267   | 11.9%                   |
| HHA                                                         | 70,269      | \$2,267,251     | 0.1%                    |
| Physical therapist in private practice                      | 42,000,657  | \$1,241,335,610 | 28.4%                   |
| Occupational therapist in private practice                  | 2,271,450   | \$75,871,554    | 1.7%                    |
| Physician                                                   | 9,859,356   | \$253,521,101   | 5.8%                    |
| Nurse practitioner                                          | 86,913      | \$2,137,208     | 0.0%                    |

The FAH strongly believes that it is inappropriate to determine a median number of units of therapy services in an office setting and then propose a major policy that is based on settings in which only 36 percent of the spending occurs and to assume that a private practice setting represents and reflects the same practice patterns as a provider setting.

### Recommendation

The FAH recommends that CMS withdraw the proposed MPPR policy for therapy services. The proposed policy attempts to address a perceived duplication of services that has already been accounted for in the development of the PE RVUs and therefore is completely unnecessary. In addition, it is based on an analysis of claims from the office setting that account for only 36 percent of all expenditures for therapy services. Finally, it assumes a pattern of treatment delivery that is not consistent with treatment delivery in the provider setting.

At a minimum, the proposal should be withdrawn for CY 2011 while CMS analyzes all appropriate data, including data specific to provider settings, with the assistance of all stakeholders in the therapy community. It is possible that there may be limited circumstances under which a reduced payment might be appropriate but those circumstances have not been identified and the appropriate reduction in payment has yet to be determined based on actual data. A proposal could then be presented in a future proposed rule and the public could be provided the opportunity to submit comments for consideration by CMS in the formulation of a final rule. The FAH would be pleased to participate in such a process. Nonetheless, we are hopeful that CMS will be persuaded by these comments and the comments of other stakeholders that the CY 2011 proposal should be permanently withdrawn.

## **V. Provisions of the Patient Protection and Affordable Care Act of 2010 (ACA)**

### ***B.5.d. Cost and Quality Measures and Compositing Methods***

The FAH appreciates the CMS discussion in the Proposed Rule of issues related to future consideration and implementation of Section 3007 of the Affordable Care Act (ACA). In particular, CMS notes the requirement in Section 3007 to pay physicians differentially based on a modifier derived with composites of both quality and cost measures and the need to develop methodologies that may also produce a single score. The FAH appreciates that CMS states in the Proposed Rule that it will use rule-making to further define changes to the Physician Resource Use Measurement & Reporting (RUR) Program. We urge CMS to conduct listening sessions on various methodologies under consideration for developing composites and that each phase of the process be transparent with plenty of opportunity for public comment. We agree with CMS that the development of composites is a complex and highly volatile area of quality measurement complicated by the fact that the further away a derived score is from the underlying data, the more difficult it is to interpret the meaning of the score.

The National Strategy for Quality Improvement included in ACA defines a program in Section 3014 that requires the Secretary to seek input from a defined multi-stakeholder group on the use of quality and efficiency measures in a variety of payment programs. The composite measures

described above should be reviewed by the multi-stakeholder consultative partnership defined in Section 3014 prior to any adoption into the physician payment program.

***T. Section 6003: Disclosure Requirements for In-Office Ancillary Services  
Exception to the Prohibition on Physician Self-Referral for Certain Imaging  
Services***

The Proposed Rule implements Section 6003 of ACA, which requires the creation of a new disclosure requirement for the in-office ancillary services exception to the prohibition on self-referral. The FAH supports this new disclosure policy, as it is consistent with other applicable patient protection disclosure requirements related to physician ownership of facilities to which physician-owners may refer Medicare patients for designated health services (DHS).

ACA Section 6003 provides that, with respect for referrals for magnetic resonance imaging (MRI), computed topography (CT), positron emission topography (PET), and any other DHS specified under Section 1877(h)(6)(D) that the Secretary determines appropriate, a requirement must be promulgated that the referring physician must inform a patient in writing at the time of the referral that the patient may obtain the services from a person other than the referring physician or someone in the physician's group practice and provide the patient with a list of suppliers who furnish the service in the area in which the patient resides.

The FAH submits comments on two points for which CMS requests input. First, CMS indicates that it is not inclined to expand the disclosure requirement beyond MRI, CT, and PET referrals, but solicits comments on whether other services should be included and why. We urge CMS to fully exercise the authority granted by the ACA and apply the disclosure requirement to all radiology services covered by Section 1877(h)(6)(D). This disclosure requirement benefits Medicare beneficiaries through greater transparency regarding their freedom to choose a supplier of medical services. Thus, we see no reasonable basis to draw a distinction between MRI, CT, and PET referrals and referrals for other radiology services under a policy intended to benefit patients in this way. Conversely, the burden on the referring physicians would not be materially different if the list of affected imaging services is expanded to cover all radiology services, as it would only entail expanding the list that will serve as the notice to patients.

As part of the disclosure, Section 6003 of ACA requires the referring physician to provide a patient with a written list of "suppliers (as defined in Section 1861(d))" that can alternatively provide the medical services for which the patient is being referred. Section 1861(d) defines "suppliers" as "a physician or other practitioner, a facility, or other entity (other than a provider of services) that furnishes items or services under this title." CMS proposes that the written list of suppliers exclude providers of services, but solicits comments regarding whether including providers of services on the written notice would benefit patients.

The FAH urges CMS to require that hospitals be included on the written list of alternative suppliers. First and foremost, patients would be well served by receiving an all inclusive list with alternative sites of services that may be conveniently located for them or may offer a facility in which the patient has received other services and is highly satisfied. A community hospital may clearly fit this bill. Second, technically speaking, the hospital's services provided in this

context would be outpatient services covered under Medicare Part B, and thus synonymous with the care rendered by “suppliers” that CMS is focused on. Thus, if the true focus of this policy is on transparency for patients and allowing them ready access to alternative sites of care in response to potential self-referral concerns, including nearby hospital outpatient imaging departments on the written list is very important.

## **VI. Other Provisions of the Proposed Regulation**

### ***C. Clinical Laboratory Fee Schedule: Signature on Requisition***

In the Proposed Rule, CMS proposes to eliminate confusion between requisitions and written orders for diagnostic laboratory tests by requiring signatures on both documents by the ordering physician or non-physician practitioner (NPP) for clinical laboratory tests paid on the basis of the Clinical Laboratory Fee Schedule (CLFS). This would be an expansion of the current requirements, which require physician signatures on written orders only, and not requisitions, for such tests.

In 2001, CMS amended 42 C.F.R. § 410.32 (Section 410.32) to more explicitly state the requirements for ordering diagnostic x-rays, diagnostic laboratory tests, and other diagnostic tests. Specifically, CMS amended Section 410.32(a) to require that “[a]ll diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests must be ordered by the physician who is treating the beneficiary,” and further that the physician or qualified NPP “who orders the services must maintain documentation of medical necessity in the beneficiary's medical record.”

In the preamble discussions to the proposed rule and the November 23, 2001 final rule (65 *Fed. Reg.* 13089 and 66 *Fed. Reg.* 58802, respectively), CMS noted that “[w]hile the signature of a physician on a requisition is one way of documenting that the treating physician ordered the test, it is not the only permissible way of documenting that the test has been ordered.” It was further stated that CMS would publish an instruction to Medicare contractors clarifying that the ordering physician did not have to sign the requisition for a clinical diagnostic laboratory test. In its March 5, 2002 transmittal, the manual instructions noted that “[n]o signature is required on orders for clinical diagnostic services paid on the basis of the physician fee schedule or for physician pathology services.” Subsequently, CMS issued Program Transmittal 94, Change Request 6100, on August 29, 2008, for the purpose of updating the Benefit Policy Manual (BPM) to incorporate this language, which was previously contained in section 15021 of the Medicare Carriers Manual.

For diagnostic laboratory test orders, the preamble discussions referenced above “implicitly left in place the existing requirements for a written order to be signed by the ordering physician or NPP for clinical diagnostic laboratory tests, as well as other types of diagnostic tests.” (75 *Fed. Reg.* 40161).

In the CY 2010 PFS proposed rule, CMS solicited public comments in an attempt to resolve any existing confusion about the distinction between an order and a requisition (74 *Fed. Reg.* 33642). However, during the proposed and final rulemaking process for CY 2010, CMS received numerous comments expressing continued confusion about the distinction between an order and a requisition (See 74 *Fed. Reg.* 61930-32 for a complete discussion of the comments received

and responses to these issues). To address this issue, CMS now proposes to eliminate the distinction between requisitions and orders altogether, and to require a physician's or NPP's signature on requisitions for clinical diagnostic laboratory tests paid on the basis of the CLFS.

The FAH believes that requiring a physician's or NPP's signature on requisitions is not an ideal way to clear up confusion between requisitions and orders, and that it will pose extreme administrative and practical burdens on both providers of laboratory tests, and on physicians. For the reasons discussed below, the FAH strongly encourages CMS to consider alternate means of distinguishing requisitions and orders, rather than requiring physician or NPP signatures on both documents.

The FAH understands and appreciates CMS' willingness to create a "less confusing process" that would eliminate uncertainty over whether a document is a requisition (which does not require a physician signature) or an order (which does require a physician signature). (*See 75 Fed. Reg. 40162*). However, to require two signatures, and indeed a signature that was not previously required, is not appropriate. This is the case particularly as CMS' original, and appropriate, decision that a physician's signature is not the only way to document that the treating physician ordered a test was the result of the November 23, 2001 final rule preceded by a negotiated rulemaking session involving 18 healthcare and laboratory organizations and stakeholders. While it is important to address the confusion between orders and requisitions for laboratory tests, CMS can do so without abandoning a long standing rule developed with industry input. Indeed, CMS could simply address the distinction between the documents through amendments to manuals providing further refinements.

Requiring physician signatures on requisitions as well as orders would double the recordkeeping requirements in physician offices (since both signed documents would have to be kept on file). However, because the Proposed Rule provides neither incentives for compliance nor consequences for noncompliance, enforcement of this rule by independent labs may be difficult and impractical. Further, the consequences of noncompliance could place laboratories in a difficult position; because it is common practice to perform laboratory tests immediately - particularly if such test is an emergency - laboratories are left with difficult choices if they are presented with an unsigned requisition. If they wait for a physician signature before performing a test, are they responsible for potential harm to a patient? Is it the laboratory's duty to follow-up with a physician until a signature is obtained on an unsigned requisition, and, if so, what procedures should they use for such follow up? Because prompt laboratory testing can be crucial to patient care, the FAH urges CMS to reconsider the signature requirement in the Proposed Rule, which could impede the ability of facilities to provide quality care to patients.

For the reasons discussed above, the FAH feels very strongly that the Proposed Rule requiring physician or NPP signatures on requisitions is not strong public policy, and, in extreme cases, could prevent physicians and laboratories from providing the highest level of care to patients.

**F. Issues Related to the Medicare Improvements for Patients and Providers Act of 2008 (MIPAA)**

***1.h.2. Other Considerations for Measures Proposed for Inclusion in the 2011 PQRI.***

The CMS seeks comment on a variety of proposals for selecting measures for inclusion in the Physician Quality Reporting Initiative (PQRI) program. As stated above, the ACA provides an important and robust framework for the use of NQF-endorsed measures in any number of the federal quality reporting program. The FAH strongly supports Section 3011 of ACA, which directs the Secretary to establish a National Strategy to improve the delivery of health care services, patient health outcomes, and population health. We recognize that the Secretary is already undertaking steps to develop the plan and to report it by the statutory deadline of January 2011. We urge CMS to utilize the National Strategy, which we expect will lay out a framework and priorities, in developing more detailed plans for specific programs such as PQRI and that the future proposed PQRI measures will be consistent with the overall National Strategy. As with hospitals, the physicians we work with find advance notice and predictability in the quality reporting and payment programs to be necessary for budgeting and planning resource use. Physicians need sufficient notice to develop plans and internal strategies for implementing new measures and reporting mechanisms, which is extremely challenging in a time of limited financial resources. Physicians must also plan for and deploy enhanced data collection methodologies and engage in staff training to effectively report quality data collection and analysis. The FAH believes planning for future years in the PQRI program and subsequent quality measurement, payment and reporting programs must be informed by the agreed to Secretarial strategic plan and priorities. We recognize the timing of this proposed CY 2011 physician payment regulation and the passage of the Affordable Care Act may not have permitted coordination, but we believe such coordination should take place for quality programs beyond 2011.

In addition, we urge focused evaluation of the current measures being reported and the quality improvement that comes from public reporting. The addition of new quality measures for quality reporting and improvement should be calibrated and focused to minimize burden to physicians and to truly improve patient care. The data generated from early years of PQRI should inform quality improvement and public reporting in future years. Focus on critical issues will drive greater improvement more quickly.

We appreciate CMS encouraging the use of measures that may be derived from the electronic health record (EHR), for those physicians who have implemented them at this time. However, many current quality measures are not specified for electronic reporting, and additional resources will be needed to work with measure developers to re-specify measures to be effectively collected via EHRs. Further, the ability to gather quality and cost data for comparison at the physician practice level is largely dependent on the sophistication of information systems and practice administration. Quality reporting, even when supported by EHRs, still requires a tremendous commitment of resources within the practice to ensure that the data gathered can be used to drive meaningful quality improvement. The FAH has long encouraged CMS to be

mindful of the resources required to translate quality data into improved provider performance and ensure an appropriate phasing-in of new measures into the current quality reporting programs.

***F.1.k. Public Reporting of PQRI Data***

The FAH has long supported public reporting of quality measures. The transparency provided with the display of well-founded measures and accurate data is helpful to clinicians, providers and to patients and their families. However, care must be taken to ensure that the data is accurate, validated and easily understood. CMS proposes to phase-in a physician web-site beginning in January 2011 with the listing of physicians and group practices. The FAH encourages CMS to permit physicians the opportunity to preview the information prior to public posting, much like the preview period for Hospital Compare. In addition, and particularly during this first phase, physicians should have the opportunity to make changes prior to public reporting should the information be incorrect.

The FAH commends CMS for continuing to work toward display of physician quality information, and urges CMS do so paying close attention to the integrity of the data and incorporating a preview period for physicians and group practices to review the quality data. Any composite scores to be developed for data display must be submitted to the National Quality Forum prior to their deployment on the physician compare web site. We also urge robust consumer testing to ensure that the data being reported is understood by patients and their families and care givers. Quality measurement data is a powerful tool, but easily can be misinterpreted unless the message is clear and well-crafted. If poorly constructed, the data could unintentionally direct patients to one provider over another. The consumer testing should be conducted in a variety of markets to ensure that patients and their care givers can appropriately interpret the information being displayed on the public web site. The FAH looks forward to reviewing additional future plans for a physician compare web site.

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The FAH appreciates the opportunity to comment on the Proposed Rule. If you have any questions about our comments or need further information, please contact me or Jeff Micklos of my staff at (202) 624-1500.

Sincerely,

