AMA
AMERICAN MEDICAL ASSOCIATION

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May 25, 2012

The Honorable Dave Camp
Chairman
Committee on Ways and Means
1102 Longworth House Office Building
Washington, DC 20515-6115

The Honorable Wally Herger
Chairman
Committee on Ways and Means
Subcommittee on Health
1102 Longworth House Office Building
Washington, DC 20515-6115

Dear Chairman Camp and Chairman Herger:

The American Medical Association (AMA) is pleased to respond to the Committee on Ways and Means letter of April 27, 2011, requesting our comments on alternative payment models to the current Medicare physician payment system and flawed sustainable growth rate (SGR) that will improve health outcomes and efficiency in the Medicare program. We appreciate the Committee's continued focus on developing a permanent, sustainable solution and welcome the opportunity to provide you with our ideas.

We are eager to continue to work with Congress to lay the ground work for reform. Below are key highlights and recommendations for transitioning to alternative payment models. Our more detailed comments on the Committee's questions set forth in your April 27th letter are attached.

Rewarding Quality and Efficiency

There are a number of strategies the AMA and physician community support that could simultaneously reduce growth in costs and improve patient outcomes.

Innovative payment models can give physicians the resources and flexibility to re-design care to keep patients healthier, better manage chronic conditions, improve care coordination, reduce duplication of services, and prevent avoidable admissions, and do so in ways that will control costs for the Medicare program. As discussed below, a number of these innovative payment models are being developed, and results will be evaluated over time for purposes of promoting successful "best practices," refining elements that need improvement, and discarding elements that do not prove to be effective.

For Medicare's physician payment system to move in this direction, there needs to be a transition period with opportunities for physicians to move into innovative payment and delivery models in ways that enable them to gain skills and experience in taking accountability for improving care and lowering growth in costs.

- **To enable all physicians to participate in efforts to improve care for beneficiaries and generate savings for the Medicare program, Congress should ensure that a full menu of innovations is available during this transition. This menu should go beyond shared savings and accountable care organizations (ACOs) based on total costs, and should also include innovations such as bundled payments, performance-based payments, global and condition-specific payment systems, warranties for care, and medical homes.**

- To date, those wishing to participate in new Medicare payment and delivery reform pilots have had to respond to requests for applications made available on a one-time basis with a short turnaround time. It is difficult to plan ahead for these announcements and organize the projects and resources necessary for a successful proposal. **Going forward, opportunities to engage in new models need to be available on an ongoing basis so physicians can plan for the needed changes and join as they become ready.**

- **The Centers for Medicare and Medicaid Services (CMS) must also have adequate funding and infrastructure to ensure the agency can fully engage in these transition efforts on an effective, timely, and efficient basis. This is necessary to bridge current gaps, such as providing timely incentive payments and real time data to physicians.**

The AMA has actively assisted in transitioning to an alternative payment system through developing and facilitating the use of quality and outcome measures.

- **The AMA-convened Physician Consortium for Performance Improvement™ (PCPI®), which brings together over 170 members, including all disciplines of medicine and multi-stakeholder organizations, has developed and made publicly available more than 280 clinical performance measures and specifications, covering 46 clinical areas that account for a substantial portion of Medicare services and spending.** Many PCPI measures have already been adopted in both the public and private sectors, including the Physician Quality Reporting System (PQRS) and the Electronic Health Record (EHR) Incentive Program, United Healthcare and Highmark BlueCross BlueShield, and the American Board of Internal Medicine.

- PCPI measures already include several outcome measures, and ongoing PCPI projects are placing greater emphasis on the need for more clinical and patient-reported outcome measures, including measures of clinical outcomes as well as patient-reported outcomes. AMA staff to the PCPI are currently in discussion with PCPI physician leaders to

prioritize topics for drafting new outcome measures and to determine the PCPI role in promoting widespread use of outcome measures that are already available.

- The PCPI has also established an advisory group focusing on efficiency and cost of care, which developed two white papers on a framework for measuring health care efficiency, which aligns quality measurement and costs of care.

- The AMA is initiating focusing on tracking and improvement of outcomes. Our work toward improving health outcomes will build on and complement the work of the PCPI. AMA efforts in this area will seek to demonstrate improvements in clinical and patient-reported outcomes, reduce unexplained variation, assure health equity, advance the quality and safety of health care and contribute to the appropriate use of finite health care resources.

- AMA has developed internal, core teams to advance our work in improving health outcomes, reducing unexplained variation, assuring health equity, advancing the quality and safety of health care and contributing to the appropriate use of finite health care resources.

The AMA is actively involved in developing and supporting clinical improvement activities to help the physician community effectively participate in these activities.

The AMA is working to ensure that physicians are fully informed of new clinical improvement activities and enabled to adopt such improvements:

- **In June 2011, the AMA formed the Innovators Committee, an advisory group of physicians with hands-on experience in the development, management, and operation of innovative delivery and payment models. The initial group of Innovators has already identified several novel approaches to improving care delivery.**

- Cloud-based data sharing systems offer the potential to achieve significant quality and efficiency gains for a fraction of the cost of integrated EHRs. A group in Massachusetts has applied cloud-based data sharing and other infrastructure support services to smooth its physicians' transition to global payment models. Most significantly, patients' covered under these new models have realized further improvements in quality and efficiency compared to their unmanaged counterparts.

- We also highlight the Virginia Cardiac Surgery Quality Initiative. This program, which represents 17 hospitals and 13 cardiac surgical practices providing 99 percent of the open-heart procedures in the Commonwealth, has achieved dramatic reductions in complications and costs of cardiac surgery for cardiac patients.

- The AMA is involved in a project, led by Brandeis University, to define and measure episodes of care that capture the vast majority of Medicare payments and include quality as well as cost data. The results of this project are in part aimed at informing Medicare regarding transitions toward innovative approaches, such as bundled payments and ACOs, that require the aggregation of services and costs into larger units of care.

- The AMA joined the Colorado Medical Society (CMS) and UnitedHealth Group (UHG) to create the Colorado Collaborative Quality Improvement Project (CCQIP). The CCQIP provided Colorado physicians with data and physician specialty society-derived clinical guidance to identify ways to improve outcomes in health quality and reduce cost. This project is in its initial stages, and beginning in July 2012, the CCQIP will begin collecting and distributing data on cholesystectomies performed by participating surgeons to determine the pilot results and size of any shared savings pool.

- To support physician practices in their 2012 participation in the Medicare Physician Quality Reporting Initiative (PQRS), the AMA has developed and posted participation tools for both individual measures and measures groups on our website.

- Following a series of meetings with leaders in patient safety in 2010, the AMA Center for Patient Safety produced tools and resources that can improve ambulatory safety.

- The AMA has been working to develop Guidelines for Reporting Physician Data (Reporting Guidelines) to increase physician understanding and use of their data for practice improvement. The AMA will formally release the Reporting Guidelines during our Annual Meeting in June, including a list of all supporting stakeholders.

Alternative Payment Models

There are numerous opportunities underway for quality-enhancing alternatives to fee-for-service.

Multi-payer initiatives hold much promise when Medicare and private payers align their programs so that physicians can implement reforms in the way they deliver care to all their patients, with a consistent set of financial incentives and quality metrics.

- Regional Health Improvement Collaboratives bring together stakeholders in a community and provide the data and technical assistance these stakeholders need to design and implement better payment and delivery systems that are customized to the needs of their communities.

- **We recommend that private sector models benefit from having the Medicare program either join in with the private payers or be launched as Medicare initiatives. Examples include:**

- A multi-payer medical home initiative co-sponsored by a regional collaborative, the Puget Sound Health Alliance, and the Washington State Health Care Authority.

- The Geisinger Health System's ProvenCare program, which is focused on improving quality of care and provides a bundled payment with a warranty that covers all related pre-admission care, inpatient physician and hospital services, related post-acute care and care for any related complications or readmissions for an entire 90-day period.

- The Alternative Quality Contract global payment program developed by Blue Cross Blue Shield (BCBS) of Massachusetts. A single payment amount is established to cover all costs of care for a population of patients, with adjustments for types and severity of conditions, along with annual bonuses based on the quality of care delivered.

Patient Involvement and Regulatory Relief

The AMA actively assists physicians in encouraging beneficiaries to seek appropriate, high-value health care services.

Physicians should educate patients about healthy behaviors, and help them understand the importance of managing chronic conditions as prescribed. Reducing the burden of preventable disease is a key strategy to containing health care costs. **The AMA supports the training of physicians in addressing patient lifestyle behaviors, and urges Congress to ensure that Medicare covers routine lifestyle evaluation and counseling by physicians. Private payers need to cover these services as well.** The AMA has several initiatives to help physicians help patients make healthier choices, including the following:

- The Healthier Life Steps™ program, which provides a tool-kit that patients can use while they work with their physicians to move toward a healthier lifestyle.

- An online training module to help physicians counsel their patients on healthy eating habits.

- "Weigh What Matters," a free online App that encourages patients to consult with their physicians to establish personal health goals for three categories (weight, eating and activity).

Administrative and regulatory barriers for fundamental delivery system reform must be removed.

There are a number of existing laws and regulations that need to be adapted to better facilitate fundamental delivery reform, instead of acting as a barrier to reform. Examples are as follows:

- **Congress should act to waive the program integrity laws and regulations for physicians who seek to engage in and lead innovative delivery models that promote quality, increase coordination, and reduce costs.** These laws include the Ethics in Patient Referrals Act (or "Stark law"), the federal anti-kickback statute, the civil monetary penalties law prohibiting hospital payments to physicians to reduce or limit services (gain-sharing CMP), and the CMP prohibiting beneficiary inducements. Congress should model these waivers on the flexible approach taken by CMS/Office of Inspector General (OIG) for the Medicare Shared Savings Program (MSSP). Congress should also act to make the current waivers for EHRs permanent, instead of allowing them to expire in 2013.

- While the Federal Trade Commission (FTC)-Department of Justice (DOJ) MSSP statement is helpful, it is a new policy and we have yet to see to what extent its enforcement by the FTC and DOJ will enable or deter innovative physician-led models. Physicians who do not participate in the MSSP but are pursuing innovative contracting arrangements with payers are still subject to antitrust enforcement that is highly suspicious of physician arrangements. **The AMA urges Congress going forward to ensure that antitrust laws and enforcement are not barriers to physician-led models.**

- Hospital and insurer consolidation also present barriers to physician-led delivery reform. **Congress must ensure that physicians who seek to lead and engage in new models of care are not precluded from having a meaningful market presence by hospitals and insurers who have achieved an anticompetitive, dominant market share.**

- **Significant changes be made to the proposed Medicare meaningful use EHR incentive program as we move into Stage 2. These changes are needed to increase physician participation in the program.** Needed changes include: a comprehensive survey of Stage 1 to determine what works and what improvements are needed for Stage 2; refinement of Stage 2 measures; and program flexibility to accommodate all specialists and their varying practice patterns and patient populations, including allowing physicians to opt-out of a certain number of measures.

- **Congress should also act to ensure that CMS discontinues its proposals to "back-date" the meaningful use, electronic prescribing, and PQRS penalty programs, along with the value-based modifier.** Under this policy, CMS is imposing penalties in a year or two prior to the year of the penalty specified in the law. CMS has essentially

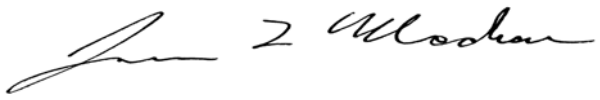
pushed up deadlines for participation by up to two years due to its own administrative issues. This will unfairly subject a significant number of physicians to financial penalties and slow down EHR adoption and implementation rates.

- **The AMA also urges Congress to pass H.R. 816, the "Provider Shield Act." H.R. 816 makes it clear that health care providers would be shielded from liability exposure resulting from national care and practice standards or guidelines. In addition, the bill preserves state medical and product liability laws.**

- **The AMA recommends: (1) that the Health Insurance Portability and Accountability Act's (HIPAA) Transaction and Code Set (TCS) rule and other HIPAA administrative simplification provisions be revised as necessary to ensure the simplification and timely disclosure of all information necessary for determining patient and payer financial responsibilities at the point of care; and (2) that the Medicare National Correct Coding Initiative (NCCI) should be the starting point for the development of a national claims edit standard.**

The AMA appreciates the opportunity to provide our comments on these critical matters, and we look forward to working with the Committee to repeal the flawed SGR formula and assist in the transition to a new health care payment and delivery system that provides more coordinated and efficient care that improves health outcomes and slows the growth of costs in the Medicare program. Attached are our more detailed comments for each of the specific questions asked by the Committee.

Sincerely,



James L. Madara, MD

Attachments
cc:

The Honorable Adrian Smith
The Honorable Lynn Jenkins, CPA
The Honorable Kenny Marchant
The Honorable Diane Black
The Honorable Aaron Schock
The Honorable Erik Paulsen
The Honorable Rick Berg
The Honorable Tom Reed
The Honorable Sam Johnson
The Honorable Kevin Brady
The Honorable Paul Ryan
The Honorable Devin Nunes
The Honorable Pat Tiberi
The Honorable Geoff Davis
The Honorable Dave G. Reichert
The Honorable Charles Boustany, Jr., MD
The Honorable Peter J. Roskam
The Honorable Jim Gerlach
The Honorable Tom Price, MD
The Honorable Vern Buchanan

Attachment I

AMA Responses to Specific Questions Asked by the Ways and Means Committee:

Rewarding Quality and Efficiency

1. How does your organization think quality, efficiency, and patient outcomes should be incorporated into the Medicare physician payment system?

Strategies to Reduce Cost Growth and Improve Patient Outcomes

There are a number of strategies that physicians support that could simultaneously reduce growth in costs and improve patient outcomes. Keeping patients healthy, for example, is better for both quality and costs than treating them after they become sick. Similarly, it costs the Medicare program less when patients' chronic conditions are managed through services provided by a physician's office compared to an emergency room visit or hospital admission. When patients do have to be hospitalized, it costs less to treat them appropriately than to treat avoidable complications. After discharge, Medicare spends less and patients are better off if they recover successfully either at home or in other post-acute settings.

The AMA supports innovative payment models that would give physicians the resources and flexibility to re-design care to keep patients healthier, better manage chronic conditions, improve care coordination, reduce duplication of services, and prevent avoidable admissions, and to do so in ways that will control costs for the Medicare program. For Medicare's physician payment system to move in this direction, there needs to be a transition period with opportunities for physicians to move into innovative payment and delivery models in ways that enable them to gain skills and experience in taking accountability for improving care and lowering growth in costs. Physicians should have opportunities to help design an array of innovations and choose those that best fit their specialty, practice, patient population, capabilities, market, partners, and resources.

The transition period should be used to develop new approaches and provide physicians with the time and support needed to transition into them. Milestones could be established so that progress in transitioning to the new models can be measured. Physicians currently face a number of challenges to widespread adoption of these innovative payment models. For example, although it is clear that it is more efficient and less risky for multiple physicians to work together to implement new payment models, as discussed further below, antitrust enforcement prevents physicians from jointly contracting with private payers around promising new payment models. Even though physicians can help hospitals lower their costs, prohibitions on gain-sharing make it difficult to implement bundled payments and other ways of enabling physicians to share in these savings with hospitals and payers. These and similar regulatory, legal and financial barriers to promising models need to be addressed. In addition, government and private payers

should offer aligned payment policy incentives.

To enable all physicians to participate in efforts to improve care for beneficiaries and generate savings for the Medicare program, a full menu of innovations should be available during this transition, not just shared savings and ACOs based on total costs, but bundled payments, performance-based payments, global and condition-specific payment systems, warranties for care, and medical homes. **To date, those wishing to participate in new Medicare payment and delivery reform pilots have had to respond to requests for applications made available on a one-time basis with a short turnaround time. It is difficult to plan ahead for these announcements and organize the projects and resources necessary for a successful proposal. Going forward, opportunities to engage in new models need to be available on an ongoing basis so physicians can plan for the needed changes and join as they become ready.** In addition, Medicare and private payer claims data needs to be provided to physicians in a timely, easy-to-use way that allows them to identify opportunities to improve care and monitor their performance. Ultimately, after there has been more experience with these new models, federal policy should promote widespread diffusion of payment and delivery innovations that improve care and lower costs.

Value-Based Initiatives

As we transition to the use of value-based payment initiatives in the Medicare program, it is critical that certain elements be integral to these types of programs, including such factors as: physician development of quality measures; appropriate use of quality data; effective educational efforts to help ensure that physicians can easily and properly report data under the program; the ability for physicians to verify the data that is used in developing a physician rating under a quality program; physician appeal rights with regard to various aspects of the program; use of effective risk adjustment and attribution methodologies; and a stable physician payment structure. CMS also must have adequate funding and infrastructure to ensure the agency can fully engage in these efforts on an effective and efficient basis. This is necessary to bridge the current gap in providing timely incentive payments and real time data to physicians.

2. To what extent has your organization developed and/or facilitated the use of:

a. Quality and outcome measures?

The AMA has dedicated significant time and resources to develop, test, and implement clinically relevant quality measures. Founded in 2000, the AMA-convened PCPI brings together all disciplines of medicine to work along side other organizations and stakeholders to identify areas for improvement, review evidence, develop clinically relevant, patient-centered measurements, test measurements in practice, provide clinical coding and specifications to incorporate those measurements into EHRs and continually evaluate progress toward national goals. The over 170 members of the PCPI include virtually all national medical specialty and state medical societies; 13 health care professional organizations (non-MDs/DOs); the Council of Medical Specialty Societies;

the American Board of Medical Specialties and member boards; experts in methodology and data collection; the Agency for Healthcare Research and Quality (AHRQ); CMS; and private health plans. Moreover, the PCPI is advised by a Patient/Consumer/Purchaser Panel. This diverse membership provides a gateway to highlight problem areas, share solutions and spread best practices across the health care community.

The PCPI maintains a transparent, multi-stakeholder approach to developing and maintaining performance measures, and has developed and made publicly available more than 280 clinical performance measures and specifications, covering 46 clinical areas. PCPI measures account for conditions covering a substantial portion of Medicare services and spending. A complete list of all PCPI-developed quality measures can be found at: www.physicianconsortium.org.

Many measures developed by PCPI have already been adopted in both the public and private sectors. Roughly 57 percent (57%) of measures in the CMS 2011 PQRS and 45 percent (45%) of measures in the Stage 1 EHR Incentive Program were developed by the PCPI. The PCPI has also partnered with the National Quality Forum and National Committee for Quality Assurance (NCQA) to help re-specify quality measures for electronic medical record capture. Private entities, including health plans such as United Healthcare and Highmark BlueCross BlueShield and the American Board of Internal Medicine, also are using PCPI measures.

Outcome and Efficiency Measures

Many of the PCPI measures developed thus far are process measures, including measures for numerous chronic care conditions, as well as preventive care and screening measures, and appropriate use and overuse measures. Although the PCPI measure portfolio already includes several outcome measures for individual clinical topics, ongoing PCPI projects are placing greater emphasis on the need for a more robust set of outcome measures, including measures of clinical outcomes as well as patient-reported outcomes. AMA staff to the PCPI are currently in discussions with PCPI physician leaders to prioritize topics for drafting new outcome measures and to determine the PCPI role in promoting widespread use of outcome measures that are already available.

Both patient and health professional experiences of care delivery have also been recognized as important outcomes, and the AMA's C-CAT is in line to be among the first set of disparities measures endorsed by the NQF. The 9 C-CAT scores reflect composites of patient and staff reports of structures, processes and outcomes that, taken together, comprise validated measures of the communication climate in a health care organization. The C-CAT is one way the AMA's attention to outcomes, patient engagement, safe communication, and health disparities are being brought together to create tools that can measure and improve the environment in which care is delivered.

In addition, the AMA understands that measures need to be expanded to encourage efficiency. It is important to recognize that efficiency must account for both cost and quality of care. The PCPI established an advisory group on efficiency and cost of care to

respond to the increasing salience of efficiency and cost of care. The advisory group developed two white papers on a framework for measuring health care efficiency, which aligns quality measurement and costs of care. The AMA is also part of a project team being led by Brandeis University developing episodes of care and multidimensional efficiency measurement incorporating quality of care, as discussed further below.

Quality Measure Testing Networks

The PCPI has formed two measure testing measurement networks. The first is the "Testing and Prototyping Quality measures in EHRs Network," referred to as TPQeNet. This network is utilized to test quality measures for reliability and validity using several EHR systems. The second network is the "Physician Quality Reporting System Academic Testing Network." This network is focusing on the testing of claims-based quality measures at various practice sites, with an emphasis on claims based measures in the CMS PQRS program. In 2011, the PCPI completed 13 testing projects and submitted testing results to NQF for 21 measure sets.

b. Evidence-based guidelines?

The measure development methodology of the PCPI is based on the principles of evidence-based medicine, the practice of which involves the integration of individual clinical expertise with the best available clinical evidence from systematic research. Research evidence is typically reviewed in clinical practice guidelines and synthesized into clinical recommendations, from which "evidence-based" performance measures are derived. In June 2009, the PCPI issued a position statement on the "Evidence Base Required for Measures Development" (http://www.ama-assn.org/resources/doc/cqi/pcpi-evidence-based-statement.pdf). The PCPI Position Statement describes evidence base criteria for clinical practice guidelines, which are highly consistent with the IOM study released last year that described eight standards for developing rigorous, trustworthy clinical practice guidelines. Since the quality of the research evidence available for each clinical topic and the process for developing clinical recommendations from the evidence are extremely variable, by disseminating the criteria described in the Position Statement, the PCPI seeks to promote greater consistency and rigor in guideline development methodology and facilitate the current measure development process for PCPI work groups.

c. Patient registries?

Patient registries can be powerful tools for outcomes measurement. Several hundred patient registries exist in the United States across many medical conditions and procedures. Several individuals and organizations, including the federal government, have asked what more might be done to advance and sustain patient registries in the US. To build on this momentum, the PCPI has brought together a number of stakeholders to consider the establishment of a National Quality Registry Network (NQRN), a voluntary coordinating network of individual registries. The NQRN would not compete with or be redundant to any individual registry. Rather, the activities of the NQRN would amplify the impact of individual registries through coordination and sharing.

Specifically, the development of an NQRN could: (i) broaden the power and impact of registries through shared services and strategies; (ii) accelerate the development of new registries; (iii) enable health system transformation by facilitating use of registry data for shared decision-making and comparison of clinical outcomes across care delivery sites, organizations and regions.

d. Continuous quality improvement programs or strategies?
(See question three below)

e. Electronic health records?
(See response on EHRs below under section entitled "Patient Involvement and Regulatory Relief, question 2 on "Administrative and Regulatory Burdens")

3. **What clinical improvement activities have been developed and are supported by your organization or have otherwise been used effectively by your members?**
4. **Have non-Medicare payers recognized or rewarded these clinical improvement activities? If so, how?**
5. **Is there anything else your organization would like to share with the Committee on how to reward physicians for high quality, efficiency, and patient outcomes?**

(Our responses to questions 3, 4, and 5 above are combined in the following comments.)

The AMA is actively promoting additional ways to improve the quality and efficiency of patient care. As a membership organization and convener, the AMA is uniquely qualified to provide information and education to physicians. The AMA is working to ensure that physicians are fully informed of new clinical improvement activities and enabled to adopt such improvements. To that end, we have undertaken an aggressive education and dissemination effort for physicians.

<u>AMA Innovators Committee</u>

In June 2011, the AMA formed the Innovators Committee, an advisory group of physicians with hands-on experience in the development, management, and operation of innovative delivery and payment models. The initial group of Innovators has already identified several novel approaches to improving care delivery.

For example, cloud-based data sharing systems offer the potential to achieve significant quality and efficiency gains for a fraction of the cost of integrated EHRs. A group in Massachusetts has applied cloud-based data sharing and other infrastructure support services to smooth its physicians' transition to global payment models. Most significantly, patients covered under these new models have realized further improvements in quality and efficiency compared to their unmanaged counterparts.

We also highlight the Virginia Cardiac Surgery Quality Initiative. This program, which represents 17 hospitals and 13 cardiac surgical practices providing 99 percent of the

open-heart procedures in the Commonwealth, has achieved dramatic reductions in complications and costs of cardiac surgery for cardiac patients.

Defining and Measuring Episodes of Care

The AMA is involved in a project, which is being led by Brandeis University, to define and measure episodes of care that capture the vast majority of Medicare payments and include quality as well as cost data. The results of this project are in part aimed at informing Medicare regarding transitions toward innovative approaches, such as bundled payments and ACOs, that require the aggregation of services and costs into larger units of care. In so far as aggregated cost and quality data are shared with physicians in resource use reports or through other mechanisms, this project also may offer a significant clinical improvement opportunity. The AMA brings the significant clinical and measurement expertise to this project necessary to ensure that the service and cost inputs underpinning each episode are appropriate, which fosters physician credibility.

Chronic Care Coordination Workgroup (C3W)

The AMA's CPT Editorial Panel and the AMA/Specialty Society RVS Update Committee (RUC) created a Chronic Care Coordination Workgroup (C3W) to recommend new codes and values to better recognize and pay physicians for care coordination. On October 3, 2011, and again on March 12, 2012, the RUC sent letters to CMS urging the agency to consider payment for telephone calls, team conferences, patient education, and anticoagulant management. To date, CMS has not adopted these requests. The C3W also recommended that the CPT Editorial Panel create new coding mechanisms for care transition from the hospital to the community and to describe care management for the complex chronically ill patients. The Editorial Panel developed a new coding structure for these services last week and the RUC will review resource costs in October 2012. Recommended codes and cost information will be available to the Medicare program to begin payment for these services on January 1, 2013.

Colorado Collaborative Quality Improvement Project

The AMA joined with the Colorado Medical Society (CMS) and UnitedHealth Group (UHG) to create the Colorado Collaborative Quality Improvement Project (CCQIP), a collaborative effort inspired by studies demonstrating the potential value of providing detailed, benchmarked claims data to enable physicians to evaluate that data, identify high cost variations, and implement practice modifications to achieve cost savings while maintaining or even improving quality. CCQIP provided Colorado physicians with actionable, relevant, and trustworthy data that were used in conjunction with physician specialty society-derived clinical guidance to identify ways to improve outcomes in health quality and reduce cost.

Cholecystectomies were chosen as the subject for the initial project because the data revealed that there are three primary drivers of cost and clinical variation in performing this surgery: place of service; length of hospital stay; and the use of intra-operative

cholangiography. Colorado surgeons will be educated about the role of these cost/variation drivers and their appropriate use and any resulting savings will be shared between participating surgeons and UnitedHealthcare. CCQIP is currently running the most recent data on UHG cholesystectomy patients to establish benchmarks for the program. Printed materials and presentations will be used in a June campaign to enroll Colorado surgeons into this one year pilot. Beginning July 2012, CCQIP will begin collecting and distributing data on cholesystectomies performed by participating surgeons to determine the pilot results and size of any shared savings pool.

AMA PQRS Participation Tools

To support physician practices in their 2012 participation in the Medicare Physician Quality Reporting Initiative (PQRS), the AMA has developed and posted participation tools for both individual measures and measures groups on its website. These tools are available at www.ama-assn.org/go/PQRS, and continue to be promoted to the Federation of Medicine through various AMA-sanctioned communication channels.

Patient Safety

Following a series of meetings with leaders in patient safety in 2010, the AMA Center for Patient Safety turned its focus to producing tools and resources that can improve ambulatory safety, including a comprehensive compilation of research on ambulatory safety (http://www.ama-assn.org/resources/doc/ethics/research-ambulatory-patient-safety.pdf); a focus on medication management in the ambulatory setting (using both traditional and electronic tools to support medication reconciliation: http://www.ama-assn.org/ama/pub/about-ama/apps/my-medications.page; and a forthcoming expert panel report on the core responsibilities of ambulatory practices in supporting safe care transitions, which provides a unique new framework that will bring ambulatory practices to the front of the national conversation about care transitions and readmissions.

AMA Guidelines for Reporting Physician Data

Physicians often receive disparate quality and cost reports from different profiling entities, making it difficult to use the information constructively to help improve patient care and lower health care costs. To improve the usefulness of these reports, the AMA convened a workgroup comprised of medical state and specialty representatives. Together with private health plans and CMS, this workgroup was able to identify opportunities for standardizing quality and cost reports. The AMA Guidelines for Reporting Physician Data (Reporting Guidelines) are a direct product of these discussions. While we understand that physician profiling entities may be unable to immediately implement all aspects of these Reporting Guidelines, we are urging multiple stakeholder groups (payers, purchasers, consumers, and providers) to support their intended purpose of increasing physician understanding and use of their data for practice improvement. In addition, we are encouraging various stakeholders to implement as many of the Reporting Guideline concepts as possible into their own physician data reporting systems.

The AMA will formally release the Reporting Guidelines during our Annual Meeting in June, including a list of all organizations that publicly support this opportunity to advance physician data usage which is integral to improving the health of, and the provision of effective healthcare to, all Americans.

Alternative Payment Models

1. **Are there quality-enhancing alternatives to fee-for-service, such as bundled payments and shared savings models that your members have experience with or are developing with private payers?**
    a. **If so, what are the pros and cons of such approaches?**
    b. **If not, are there alternatives to fee-for-service that are relevant and feasible for your members?**

As discussed in response to question #1 under "Rewarding Quality and Efficiency," the AMA supports physician involvement in a number of innovative payment models. Congress has authorized multiple demonstrations of bundled and shared savings arrangements over the years, such as the Physician Group Practice demonstration authorized by the Benefits Improvement and Protection Act of 2000, the Acute Care Episode demonstration authorized by the Medicare Modernization Act of 2003, the Gains-haring demonstration authorized by the Deficit Reduction Act of 2005 and the Patient-Centered Medical Home demonstration authorized by the Tax Relief and Health Care Act of 2006. These demonstrations have played a key role in promoting testing of these concepts in both Medicare and the private sector. The Center for Medicare and Medicaid Innovation (CMMI) is allowing additional pilot programs to be launched that build upon these early innovations.

The AMA believes these pilots hold a great deal of promise for increasing physicians' knowledge and experience with such programs. Some of the most promising programs, in our view, are multi-payer initiatives in which Medicare and private payers align their programs so that physicians can implement reforms in the way they deliver care to all their patients, with a consistent set of financial incentives and quality metrics. Some examples are projects involving Regional Health Improvement Collaboratives that bring together all of the stakeholders in a community – payers, employers, physicians, hospitals and patients – to pursue reforms aimed at improving population health. These collaboratives are working to provide the data and technical assistance these stakeholders need to design and implement better payment and delivery systems customized to the needs of their communities.

We are also working with medical specialties to identify additional models that would expand on available models and make it possible for more of their members to participate in value-enhancing innovations. There are several examples of models in the private sector, however, that we believe would benefit from having the Medicare program either join in with the private payers or launched as Medicare initiatives.

One example is a multi-payer medical home initiative co-sponsored by a regional collaborative, the Puget Sound Health Alliance, and the Washington State Health Care Authority. This initiative blends elements of medical home payment programs and the concept of the ACO in a way that is feasible for small primary care practices to implement. Under the program, participating primary care practices in Washington State receive greater resources to help their patients, and in return they accept accountability for helping patients avoid unnecessary emergency room visits and hospitalizations. Seven health plans and 12 practices are involved covering 25,000 patients. The practices are accountable for achieving targeted savings. Success can earn them additional compensation or they can forfeit some of the care management fee if they fall short.

Another example is the Geisinger Health System's ProvenCare program. ProvenCare is focused on improving quality of care and provides a bundled payment with a warranty that covers all related pre-admission care, inpatient physician and hospital services, related post-acute care and care for any related complications or readmissions for an entire 90-day period. The conditions for which ProvenCare is currently offered are: cardiac bypass surgery, cardiac stents, cataract surgery, total hip replacement, bariatric surgery, perinatal care, low back pain, treatment of chronic kidney disease.

A third example is the global payment program, called the Alternative Quality Contract, developed by Blue Cross Blue Shield (BCBS) of Massachusetts. A single payment amount is established to cover all costs of care for a population of patients. The global payment is adjusted up or down based on the types and severity of conditions the patients have, and payments are increased by annual bonuses based on the quality of care delivered. BCBS actually still pays individual physicians in the program on a fee-for-service basis, but their payment rates are adjusted up or down to keep total costs within the global payment amount. More detail on these types of programs is available in Section III of the AMA's report *Pathways for Physician Success Under Healthcare Payment and Delivery Reforms* and in *Transitioning to Accountable Care*, a free report from the Center for Healthcare Quality and Payment Reform at:

http://www.chqpr.org/downloads/TransitioningtoAccountableCare.pdf.

Patient Involvement and Regulatory Relief

1. How does your organization think physicians can encourage beneficiaries to seek appropriate, high-value health care services?

A strong, uninterrupted relationship between a patient and physician provides an important opportunity for physicians to work with their patients to choose the most appropriate health care services. Physicians can help patients understand how their choices and behaviors affect their health and the potential for more intensive health care interventions in the future. Physicians should educate patients about healthy behaviors, and help them understand the importance of managing chronic conditions as prescribed. Reducing the burden of preventable disease is a key strategy to containing health care costs. This can be accomplished by: working with patients to reduce risk factors for disease and prevent the onset of chronic illness; improving patient compliance with medications and preventive care recommendations; encouraging improved nutrition and physical activity; preventing injury due to accidents and violence; and conducting public health campaigns. To this end, the AMA supports the training of physicians in addressing patient lifestyle behaviors. Training should address how to evaluate patient lifestyle behaviors, provide effective counseling, and refer patients for more in-depth assistance. However, routine lifestyle evaluation and counseling by physicians needs to be supported through adequate insurance payment and coverage. Private and public plans also need to ensure that plan enrollees have access to physicians who will provide these essential services. First-dollar coverage for evidence-based prevention and wellness services and benefits will help ensure patients have access to necessary preventive services. In addition, the AMA believes that physicians have an important, integral role to play in the design of reward-based workplace incentive programs to encourage patients to adopt healthy lifestyles: such programs should be designed with input from physicians, and should be integrated into an ongoing risk-reduction and behavior change program to encourage and support long-term changes in patient habits and behaviors.

The AMA has several initiatives to help physicians help patients make healthier choices, including the following:

- The Healthier Life Steps™ program, which provides a tool-kit that patients can use while they work with their physicians to move toward a healthier lifestyle;
- An online training module to help physicians counsel their patients on healthy eating habits; and
- "Weigh What Matters," a free online App that encourages patients to consult with their physicians to establish personal health goals for three categories: weight, eating and activity.

With regard to more acute medical decisions, patients are better able to select high-value services if they are well-informed about the clinical, financial, and personal implications of their treatment options. The voluntary use of shared decision-making processes and patient decision aids can help patients integrate clinical information (*e.g.*, diagnosis,

treatment options, and likely outcomes) with their individual preferences and priorities, which can, in turn, help physicians more effectively guide individual patients to the most appropriate treatments. However, it is critical that patients and physicians have timely access to information that will help them evaluate the relative costs and benefits of a given service. Information about treatment costs and insurance coverage details, clinical information about potential outcomes or side effects, and data from comparative effectiveness research that can help physicians educate patients about the relative effectiveness of treatment alternatives must be available at the point of service to help facilitate discussions about selecting appropriate health care services.

2. Are there administrative and regulatory burdens that your organization sees as barriers to fundamental delivery system reform? If so, please describe.

Medicare Silos

Advancements in medicine have led to an increasing number of services being delivered in physician offices, rather than in a hospital setting. In addition, reducing hospitalizations, through more efficient and coordinated care delivery outside of the hospital setting, is a key component of delivery system reform. Unfortunately, the payment rules under Medicare Part A and Medicare Part B have not adapted to the increased use of physician services vs. hospital services. While more services provided in physicians offices can help avoid costly hospitalizations and readmissions, this increases Medicare Part B spending under the flawed SGR physician payment formula, which then drives untenable cuts in payments for physicians services. This imbalance creates disincentives for physicians who are working hard to provide the most effective, and efficient care for their patients.

The AMA, therefore, recommends that Congress ensure physicians are able to choose from a full menu of innovations that cut across Medicare silos. As discussed under the section on "Rewarding Quality and Efficiency," opportunities to engage in new models need to be available on an ongoing basis so physicians can plan for the needed changes and join as they become ready.

Program Integrity Law Barriers

Confusion regarding the applicability of the federal program integrity laws to innovative payment and delivery arrangements is a barrier to fundamental delivery reform. These laws include the "Stark law," the federal anti-kickback statute, the civil monetary penalties law prohibiting hospital payments to physicians to reduce or limit services (*i.e.*, gainsharing CMP), and the CMP prohibiting beneficiary inducements. In the context of fee-for-service payment, the program integrity laws can serve as a necessary check on inappropriate financial arrangements. However, as physicians seek to engage in innovative payment and delivery arrangements (*e.g.*, bundling, gainsharing) to improve quality and reduce costs, these laws may unnecessarily impede activity that is appropriate and integral to delivery reform.

In April 2012, the Government Accountability Office (GAO) issued a report entitled *Medicare: Implementation of Financial Incentive Programs Under Federal Fraud and Abuse Laws* that concluded, "although health systems can implement certain types of financial incentive programs that may result in better patient health outcomes and lower health care costs, the challenges of implementing these programs within the current legal framework may, for some health systems, outweigh the potential benefits of doing so." The report also noted that, while regulators have outlined some discrete exceptions to the program integrity laws, "constraints of existing exceptions and safe harbors make it difficult to design and implement a comprehensive program for all participating physicians and patient populations." Furthermore, the GAO concluded that federal regulators' legal interpretation of the program integrity laws may "constrain the development of financial incentive programs that would align hospital and physician incentives to provide more cost-effective care, and hospitals may be reluctant to pursue an advisory opinion because of the time, expense, and uncertainty involved." (GAO-12-355)

In recognition of the barrier that the federal program integrity laws present, the OIG and CMS issued waivers of the laws to increase flexibility for participants in the MSSP for ACOs. Importantly, these waivers cover payment and delivery arrangements made prior to participation in the MSSP, allowing physicians to develop arrangements up front that are integral to ACO formation. To promote care coordination, the waivers also extend to arrangements "reasonably related to" the MSSP. And, by use of a "patient incentives" waiver of the CMP prohibiting beneficiary inducements, MSSP-participant ACOs will have the flexibility to encourage preventative care and compliance with treatment regimens. However, those waivers are limited to the MSSP, and cannot be relied on by physicians seeking to lead delivery reform efforts outside of that program. Those waivers also do not extend to arrangements pursuant to CMMI demonstrations, and guidance regarding waivers for the program integrity laws for these demonstrations is still needed.

The current sunset date for the existing EHR exception to the Stark law and safe harbor from the federal anti-kickback statute is also an impediment to reform that must be addressed. Utilization of electronic medical records may foster the development and adoption of innovative payment and delivery models. An important part of EHR adoption is "knowing what the rules are" in advance, because EHR adoption can be time consuming and expensive. Physicians who seek to adopt EHRs and utilize them in innovative delivery models should be assured that their systems will not run afoul of the federal program integrity laws when those protections expire after 2013. By making the exception and safe harbor protections permanent, instead of allowing them to expire in 2013, EHR adoption and utilization in innovative delivery models would be fostered.

Congress should act to waive the program integrity laws and regulations for physicians who seek to engage in and lead innovative delivery models that promote quality, increase coordination, and reduce costs. Congress should model such waivers on the flexible approach taken by CMS/OIG for the MSSP. Congress should also act to make the current waivers for EHRs permanent, instead of

allowing them to expire in 2013. The AMA welcomes the opportunity to work with the Committee to develop such waivers.

Antitrust Law Barriers

Physicians who seek to collaborate on patient care quality and cost must consider antitrust law and the enforcement guidelines of the DOJ/FTC. Under antitrust law, certain physician collaborations, especially those regarding payer negotiations, may be deemed per se unlawful if the antitrust agencies deem them to be anticompetitive and they do not meet financial or clinical integration regulatory guidelines. Historically, many physician collaborations, like Independent Practice Associations (IPAs), have found that meeting the agencies' bar for financial or clinical integration is a lengthy and expensive proposition that requires agency review and a significant financial investment. Hospital and insurer consolidation also present barriers to physician-led delivery reform. Physicians who seek to lead and engage in new models of care can be precluded from having a meaningful market presence by hospitals and insurers who have achieved an anticompetitive, dominant market share. These practical hurdles can chill innovation and physician engagement in innovative delivery models.

In recognition of the barrier of the antitrust laws to physician collaboration on issues of quality and cost, in April 2011, the DOJ and FTC issued a *Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program* to "ensure that health care providers have the antitrust clarity and guidance needed to form procompetitive ACOs that participate in both the Medicare and commercial markets." In that statement, the agencies provided generally that organizations meeting the eligibility requirements for the MSSP are reasonably likely to be bona fide arrangements intended to improve the quality, and reduce the costs, of providing medical care through their participants' joint services. Importantly, the statement affords a more flexible "rule of reason" analysis, as well as a "safety zone" for MSSP participants with a 30% or less market share.

While the Policy Statement makes great strides in affording physicians clarity and flexibility regarding the application of the antitrust laws to physician collaborations pursuant to the MSSP, physicians who are not participants in the MSSP may not enjoy the same degree of certainty. In March 2012, the GAO issued a report entitled *Federal Antitrust Policy: Stakeholders' Perspectives Differed on the Adequacy of Guidance for Collaboration among Health Care Providers.* In that report, the GAO notes the Agencies' belief that the eligibility criteria for the MSSP "serve as an additional source of guidance upon which providers can draw when structuring their clinically integrated collaborative arrangements." However, the GAO cautions that Agency officials made clear that "fulfilling the MSSP eligibility criteria did not automatically mean that the agencies would consider a collaborative arrangement as clinically integrated if it was not participating in the program, which requires regular monitoring and public reporting of each collaborative arrangements quality and cost data." (GAO-12-291R) For physicians seeking to lead and participate in new delivery arrangements outside the MSSP, this note of caution may inhibit innovation.

While the FTC-DOJ MSSP statement is helpful, it is a new policy and we have yet to see to what extent its enforcement by FTC and DOJ will enable or deter innovative physician-led models. Physicians who do not participate in the MSSP but are pursuing innovative contracting arrangements with payers are still subject to antitrust enforcement that is highly suspicious of physician arrangements. The AMA wants to work with Congress going forward to ensure that antitrust laws and enforcement are not barriers to physician-led models.

AMA Facilitation of EHR Use by Physicians

Physicians are deeply supportive of and committed to incorporating well-developed EHRs into their practices to improve quality of care delivery, enhance patient safety, as well as support practice efficiencies. The AMA has dedicated significant resources to developing tools and information resources to assist physicians with EHR adoption and use. These resources include summaries of current health IT incentive opportunities and instructive webinars. In addition, the AMA has developed health IT educational tools such as the Continuing Medical Education (CME) on-line learning modules. This particular program provides information to physicians and practice staff on methodologies for successful adoption of health IT solutions. The AMA has also developed on-line workflow tutorials. These tutorials provide information to physicians about the link between workflow redesign and effective use of health IT. Utilizing these tutorials, physician practices can proceed with greater confidence and develop the skill set to prepare for integrating technology to transform care delivery and ultimately improve health outcomes.

Improvements Needed on Federal Health IT and Quality Programs to Increase Physician Participation Rates

The AMA has been actively engaged in the regulatory process to ensure that the federal health IT and quality program requirements encourage widespread adoption and use of EHRs. EHR adoption offers for the first time an opportunity to get meaningful quality data in the hands of physicians at the point of care. The data derived from reporting on evidence-based quality measures allows physicians to improve care delivery in real time. Specifying quality measures for implementation in an EHR is a detailed process that requires the development of new specification sets. Efforts are underway by the PCPI to develop these specifications. The AMA has also worked closely with the EHR vendor community and others to increase functionality in EHR systems that facilitate physician use of measures for quality improvement and reporting.

On May 7, 2012, the AMA along with 100 state and national specialty medical societies submitted extensive comments on CMS' proposed rule for Stage 2 of the EHR meaningful use program that starts in 2014. **The AMA recommended that significant changes be made to the proposed Stage 2 criteria to increase physician participation rates in the program.** To date, CMS and the Office of the National Coordinator for Health Information Technology (ONC) have not comprehensively surveyed physicians

on Stage 1 of the EHR program to determine what works, what does not work, and what improvements need to be made for Stage 2 of the meaningful use program. The low physician participation rates for 2011, which was the first year of Stage 1, suggest that Stage 1 measures need to be refined in Stage 2 of the program. For example, if CMS' evaluation of Stage 1 reveals that physicians did not participate in 2011 because they could not meet certain core (required) health IT measures because of electronic exchange barriers or scope of practice concerns, then adequate exclusions should be developed for these measures or these measures should be transferred to the Stage 2 menu (optional) set. In addition, core measures should be limited to items for which it will clearly be possible for all eligible physicians to meet the measure with technology that will be broadly available at the time the measure takes effect.

We also recommend that CMS build flexibility into the meaningful use program to accommodate all specialists and their varying practice patterns and patient populations. By doing so, we believe more physicians would be able to take advantage of the EHR meaningful use incentives. For example, we strongly believe that physicians should get credit for making a good faith effort to meet the meaningful use requirements. Physicians should not have to meet all of the measures to prove they are a meaningful user of a certified EHR. Allowing physicians to opt-out of a certain number of measures is the type of flexibility needed in the meaningful use program that would encourage more physician participation and increase participation rates.

The AMA continues to raise concerns with CMS' proposal to back-date the meaningful use and other health IT penalty programs. CMS has decided to back-date the reporting requirements, which means that a physician will face a penalty based on activity in a year prior to the year of the penalty specified in the law. CMS has essentially pushed up deadlines for participation by up to two years due to its own administrative issues, and as a result, this back-dating policy will unfairly subject a significant number of physicians to financial penalties and slow down the EHR adoption and implementation rates. In addition, the AMA is urging CMS to better align the disparate program requirements under the multiple health IT and quality programs underway to reduce the burdens of participating in them. Physicians who successfully participate in one health IT program should be protected from penalties associated with the other programs. **Changes to the Medicare/Medicaid EHR meaningful use programs, including the proposed Stage 2 criteria and penalty programs, are necessary to ensure that the meaningful use program lives up to its intended purpose—to help physicians adopt, implement, and meaningfully use EHRs.**

<u>Facilitating Implementation of Multiple Quality Improvement Programs</u>

Due to CMS' back-dating policy discussed above, a collision course is soon to occur because of simultaneous implementation of multiple quality improvement programs that will create extraordinary financial and administrative burden, as well as mass confusion, for physicians. These programs include the value-based modifier, penalties under the electronic prescribing program, the PQRS, and the EHR incentive program. Attached is a

chart showing all of the penalties that physicians face simultaneously under these programs.

We have urged CMS to re-evaluate the penalty program timelines associated with these programs and examine the administrative and financial burdens and intersection of these various federal regulatory programs. We have also urged CMS to develop solutions for synchronizing these programs to minimize burdens to physician practices, and propose these solutions in the physician fee schedule proposed rule for calendar year 2013.

Legal Barriers

Physicians are eager to participate in new payment and delivery reform programs, but are very concerned about potential new causes of action or liability exposure as they develop and implement new ways to improve the quality and efficiencies of care. Lack of liability protections could have a chilling affect on physician participation in innovative reform models that require compliance with certain care delivery protocols and other evidence-based guidelines. **We urge Congress to pass H.R. 816, the "Provider Shield Act." H.R. 816 makes clear that health care providers would be shielded from liability exposure resulting from national care and practice standards or guidelines. In addition, the bill preserves state medical and product liability laws.**

Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Penalties

Privacy and security of patient health information is a principle that physicians take very seriously. At the same time, **privacy and security safeguards should be practical, flexible, and affordable for physicians and other health care providers with varying levels of technical sophistication to implement, and should not hinder the necessary flow of health information for treatment, payment, and health care operations purposes.** As physicians continue to move forward with the adoption of EHRs and the nation transitions to electronic exchange of health information, it is important that the privacy and security practices for protecting patient information remain effective but do not unduly compromise the ability of clinicians to operate their practices or care for their patients. We are alarmed by the number of HIPAA privacy and security investigations and fines levied against HIPAA covered entities that are as high as hundreds of thousands if not millions of dollars. **Overreaching, burdensome privacy and security requirements and enforcement mechanisms and the threat of extraordinary fines could severely hamper our nation's move towards improving patient care and reducing inefficiencies through the use of EHR technology.**

Administrative Simplification Solutions

Administrative waste is a barrier to delivery system reform. Cost estimates of inefficient health care claims processing, payment and reconciliation are between $21 and $210 billion. The AMA has been actively providing critical input on administrative

simplification solutions to HHS to move the health care industry toward point of service pricing. Our efforts have resulted in HHS' adopting uniform operating rules for eligibility and claims' status electronic transactions and standards for health care electronic funds transfers (EFT) and Remittance Advice (RA) transactions. The AMA also issued comments in May 2012, on CMS' proposed rules on delaying the compliance deadline for ICD-10 and on a standard for a unique health plan identifier – a critical piece of point-of-service pricing when the identification system for health plans provides patients and their health care providers with the information they need to navigate each encounter.

Another administrative simplification solution that needs to be part of the equation concerns standard claim edits and payment rules. Because of the complexity of the current pricing system for physician and other health care professional claims, price transparency depends upon the disclosure of the three separate components that go into the repricing of physician claims: the product and contract-specific fee schedule; the claim-edits; and the pricing rules. Unfortunately, except with respect to the Medicare program, none of these three elements are routinely disclosed in the current environment. Thus, neither physicians nor patients can predict what payments will be until the electronic remittance advice/explanation of benefits is received, and even then there is no easy way to validate the accuracy of the payment. Moreover, those commercial companies that have attempted to maintain ongoing, updated catalogues of each payer's claim edits and pricing rules report the need to commit several full-time staff to this effort, resources which are clearly not available to the vast majority of physician practices. Standardized claim edits would remove a large element of the ambiguity and complexity of this process, further enabling the adoption of point-of-service pricing. A standard claim edit set would not interfere with the ability of health plans or their agents to negotiate fee-schedules or otherwise limit contractual arrangements or terms that could be negotiated with health care providers. Nor would standardized claim edits dictate benefit plan design or medical policies.

The pricing of claims must also be made clear and transparent. To accomplish this, the ambiguity in the terminology which is used to discuss the various aspects of the claims revenue cycle must be eliminated, and systems that can be operationalized by all stakeholders and programmed into their practice management and claims adjudication systems must be developed. The Medicare NCCI appears to be the best basis for developing a standard code edit set. NCCI has a number of demonstrated benefits: it already contains nearly a million claim edits that are easily downloadable by health plans and physicians without charge; it is built on an established process which includes input from all stakeholders, and has a history of maintaining currency with CPT updates and other relevant changes. Its use has already been extended to state Medicaid programs; and it is already widely utilized by all commercial payers. **The AMA therefore, recommends: (1) that the HIPAA Transaction and Code Sets rule and other HIPAA administrative simplification provisions be revised as necessary to ensure the simplification and timely disclosure of all information necessary for determining patient and payer financial responsibilities at the point of care; and (2) that the**

Medicare NCCI should be the starting point for the development of a national claims edit standard.

3. Are there unnecessary administrative and regulatory burdens that your organization sees as taking valuable time away from seeing patients and/or increasing costs to the Medicare program? If so, please describe.

In general, the AMA believes that complex and time consuming administrative and regulatory requirements add significant costs to the health care system and take time away from patient care. In addition to the administrative burden imposed by the regulatory requirements discussed above, the AMA has provided comments to HHS regarding other administrative burdens in the Medicare program. For example, the AMA has commented on drug plan authorization procedures used by Medicare Part D plans and Medicare advantage plans, which include onerous prior-authorization requirements that are time consuming for physicians and delay patient access to appropriate medications; Medicare documentation requirements that require physicians to "over document" their patient interactions and verify physician orders and certifications multiple times for the same patient; and the need for a more streamlined billing system. In addition, the AMA is concerned about the lack of coordination among CMS incentive programs (*e.g.*, the PQRS, e-prescribing, and meaningful use of EHRs) and the varying reporting and other requirements associated with these programs.

In our response to the President's request for ways to reduce regulatory burdens, we also highlighted a long list of unfunded mandates that have been imposed on physician practices over the years, including a growing number of provisions that are intended to keep other providers honest by requiring physicians to certify and recertify the need for services, ranging from power wheel chairs to repeat orders of glucose strips or diapers for patients with chronic ongoing conditions, to physical therapy plans, to home health and hospice services**.** Taken one by one, many of these certifications do not seem unreasonable, but taken as a whole they have greatly increased the paperwork and cost of practice.

Attachment II

Medicare Physician Incentives and Penalties

Year	Deficit Reduction Sequester*	E-Prescribing	Health Information Technology	Physician Quality Reporting System, including Maintenance of Certification (MOC) Program	ICD-10 Implementation
2009		2%		2%	
2010		2%		2%	
2011		1%	$18K	1% if no MOC; 1.5% if MOC	
2012		1% (-1%)	$12-18K	0.5% if no MOC; 1.0% if MOC	
2013	(-2%)	0.5% (-1.5%)	$8-15K	0.5% if no MOC; 1.0% if MOC	
2014	(-2%)	(-2%)	$4-12K	0.5% if no MOC; 1.0% if MOC	$100 to $50,000 penalty per HIPAA violation, depending on if it is knowing, willful & corrected
2015	(-2%)		$2-8K (-1%)	(-1.5%)	
2016	(-2%)		$2-4K (-2%)	(-2%)	
2017	(-2%)		(-3%)	(-2%)	
2018	(-2%)		(-3%)	(-2%)	

Additional Penalties

***Deficit Reduction Sequester:** The Budget Control Act of 2011 required automatic spending cuts of about $1.2 billion from 2013-2021 unless Congress enacted legislation reducing the federal deficit by that amount. Medicare cuts cannot exceed 2% of total program expenditures, not just claims for health care services. Thus actual cuts in payments to physicians and other providers could slightly exceed 2%. Note: the 2% would come on top of whatever cuts are scheduled for that year under the Medicare sustainable growth rate formula which is currently approaching 30 percent.

Value Modifier: Beginning for some physicians in 2015 and all physicians in 2017, payment rates will be subject to a "value modifier." The modifier is budget neutral overall, so it will increase some physicians payments and decrease others. It is not known how steep these decreases will be.

IPAB: The Independent Payment Advisory Board or IPAB is authorized to make reductions in payments starting in 2015 in order to meet statutory targets for Medicare spending growth as a percent of GDP. It is not known whether or how much physician payment rates will be affected.