AMA
AMERICAN MEDICAL ASSOCIATION

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

Dear Administrator Tavenner:

On behalf of the physician and medical student members of the American Medical Association (AMA), I am writing to express our significant concern about the combined impact that various overlapping Medicare incentive programs are having on physicians and their practices. These programs, with often incomprehensible, conflicting requirements and flawed implementation processes, are all entering their penalty phases and pose a risk to the stability of the Medicare program that many policymakers do not seem to appreciate. The AMA calls on the Centers for Medicare & Medicaid Services (CMS) to synchronize and simplify the requirements for avoiding these penalties, and to reverse its proposals to raise total penalties from these programs to 10 percent or more in the foreseeable future.

Congress created these programs in several different pieces of legislation. To date, CMS and Congressional policymakers have typically assessed the various value-based programs by focusing on each of the programs in isolation. As demonstrated in the chart below, this ignores the cumulative effect of a set of penalties that, when combined with a two percent payment sequester reduction, would total 11 percent in 2017 and grow to 13 percent by the end of the decade.

Overlapping payment adjustments threaten physician practice viability

Year	Deficit reduction sequester	E-Prescribing	Health Information Technology/ Meaningful Use	Physician Quality Reporting System, including Maintenance of Certification (MOC) Program	Value-Based Modifier (Budget neutral increases and decreases in payments based on cost/ quality data measures from 2 years earlier)	Total Possible Payment Cuts including Sequester
2014	(-2%)*	(-2%)	$4-12K	0.5% if no MOC; 1.0% if MOC		(-4%)
2015	(-2%)		$2-8K (-1% to 2%)	(-1.5%)	(-1%) Applied to groups of 100 or more/2013 data**	(-5.5% to 6.5%)
2016	(-2%)		$2-4K (-2%)	(-2%)	(-2%) Groups of 10 or more/2014 data**	(-8%)
2017	(-2%)		(-3%)	(-2%)	(-4%) all physicians/2015 data**	(-11%)
2018	(-2%)		(-4%)	(-2%)	(?) all physicians/2016 data**	(-12%) or more
2019	(-2%)		(-5%)	(-2%)	(?) all physicians/2017 data**	(-13%) or more

*Red text indicates penalties, green text indicates bonuses.

**2017 marks the third year that the VBM will be applied; the magnitude of the adjustments that will be made in future years is determined through annual rulemaking. Since the adjustments have doubled each year since the VBM was first implemented, the potential for increasingly severe cuts in 2018 and beyond is significant. Some physicians will qualify for payment bonuses of an amount not yet known.

No other segment of the health care industry faces penalties as steep as these and no other segment faces such challenging implementation logistics. The tsunami of rules and policies surrounding the penalties are in a constant state of flux due to scheduled phase-ins and annual changes in regulatory requirements. In fact, the rules have become so complex that no one, often including the staff in charge of implementing them, can fully understand and interpret them. In many instances, physicians will be held accountable for expenses that are completely outside their control, and those treating Medicare's frailest patients are most at risk for incurring penalties. Ironically, the environment makes it difficult for physicians to invest in health information technology as well as make desired payment and delivery reforms.

There are significant challenges with CMS' systems and limited staff resources that heighten the AMA's concern surrounding the ability of the agency to implement these programs. Physicians have experienced great frustration with registering and attesting for various programs and significant system glitches, including situations that made it impossible for physicians to meet deadlines for requirements that carried significant financial consequences. In addition, many AMA members have repeatedly informed us that contractor Help Desks are so overloaded that physicians cannot get through, and if they are connected to someone the Help Desk is frequently unable to answer their questions. Also, while we appreciate CMS' intent to allow physicians to review the underlying data in the various value-based programs, the processes laid out to date will not achieve truly transparent and accurate data.

CMS is moving to implement these penalty programs at a time when physicians are scheduled to transition to ICD-10, which is a 68,000 diagnosis coding system—a five-fold increase from the current 13,000 diagnosis codes in use today. With this transition from ICD-9 to ICD-10, we foresee unintended consequences on quality measurement calculations jeopardizing physicians' ability to successfully meet the requirements of the Meaningful Use (MU), Physician Quality Reporting System (PQRS), and Value-based Modifier (VBM) programs.

Furthermore, physicians must report quality measures for both MU and PQRS, which have different sets of requirements, submission processes, and reporting periods. Not only is this unnecessarily burdensome, but it is causing tremendous confusion among physicians. Many physicians incorrectly believe that if they report the quality measures in the MU program, they have complied with PQRS.

Below, we offer a snapshot of just a few of the most troubling examples of the problems associated with the agency's key value-based purchasing initiatives.

Meaningful Use

- The AMA is very concerned that Administration officials recently announced that they are "moving beyond" MU. This action is highly imprudent at a time when physicians, hospitals, and other health care providers are struggling to comply with the current MU requirements.
- The MU program is overly complex and prescriptive, and half of Medicare physicians have yet to start participating. Success in the MU program is based on an "all-or-nothing" standard that requires them to meet 100 percent of the program's requirements.
- Within the 20 measures of the MU Stage 2 program there are approximately 125 criteria physicians must meet per patient; said a different way, more than 100 "clicks" of a mouse per patient.
- While Medicare recently finalized a rule that allows physicians to use older certified software (because newer versions simply were unavailable), Medicare initially failed to modify its own systems to recognize this regulatory change by the deadline for attestation, leaving physicians subject to a penalty despite their good faith efforts to comply with CMS' regulation. The AMA is very pleased that CMS responded to our concerns and addressed this error by extending the

hardship exception deadline through November 30, 2014. Yet, we remain concerned that these system errors continue to occur, creating confusion and uncertainty for physicians.

- MU compliance requires investment in poor-performing, non-interoperable systems, despite the fact that achieving interoperability across the nation's health care records system was the principal goal of the legislation that created the incentive program. Overly complex certification requirements have prevented many vendors from being able to deliver timely, updated products, jeopardizing full-year reporting in 2015.

The AMA recommends that CMS:

1) Remove the all-or-nothing provision; at the very least, make optional the measures that are the most challenging for the vast majority of physicians, including "View, Download, and Transmit," "Transitions of Care," and "Secure Messaging," requirements which in many cases are completely outside the physician's control;
2) Require physicians to meet one set of quality reporting requirements (MU, PQRS, quality section of VBM); and
3) Shorten the 2015 reporting period to 90 days.

These changes will address the most imminent threats posed by the current regulatory framework and allow both vendors and providers the opportunity to develop systems that actually support high-quality care rather than simply meeting the current year's regulatory checklist.

Physician Quality Reporting System

- Registration, submission, and obtaining feedback can be complicated. There is a widespread misperception that PQRS simply requires adding a code to a claim. Once a physician successfully creates an account (which can take up to 21 days), he or she must log into the CMS portal every 60 days just to maintain his or her account or be forced to start the registration process from scratch. Even when physicians obtain an account there are regular glitches with the website that prevent them from registering or reviewing their information.
- Available measures and requirements change annually, making it impossible for practicing physicians to keep up with the rules and creating holes in the program that will preclude some physicians from meeting increasingly arduous PQRS reporting requirements.
- CMS continues to scale down the claims-based reporting option and measures, which forces physicians to "pay-to-play." The other reporting options cost money (registry and EHR).
- Medicare does not provide physicians with information on their quality reporting until six months after the close of the PQRS reporting period. Consequently, there is no real opportunity for physicians to respond to the reports and make timely improvements because they are well into the next reporting cycle before they learn about any deficiencies.
- CMS is not providing the public with aggregate information on the number of physicians who successfully participated in the 2013 program and those who are subject to a penalty in 2015 until the spring of 2015. This does not allow the public or policymakers any opportunity to assess the program in a timely manner.
- CMS allows an "informal" appeal only if the agency believes that a vendor submitted a physician's PQRS information incorrectly. The information may be incorrect, but the physician still cannot appeal.

The AMA recommends that CMS: 1) release the aggregate 2013 PQRS data; 2) create a formal appeals process; 3) maintain a robust set of claims-based measures and claims reporting option; and 4) require physicians to meet only one set of quality reporting requirements (MU, PQRS, quality section of VBM).

Value-Based Payment Modifier

- Data from 2012 shows that more than 40 percent of groups of 25 physicians or more did not have enough data to calculate reliable cost and quality measures. Data for smaller groups is likely to be even sparser.
- Short of time and money to implement the VBM, CMS has incorporated inappropriate cost and outcome measures that penalize physicians treating the sickest patients. A CMS contractor found that physician groups with the highest risk patients were three times more likely than average to have poor quality scores and four times more likely to have poor cost scores.
- Rules, by necessity, are being constructed on the fly, change every year, and are now so complicated that it takes several weeks to get an answer from CMS on details of the program. Physicians are largely unaware that the VBM even exists, and a key report intended to help make them aware is difficult to access and for many practices will not include all the information they need to avoid VBM penalties in future years. Nonetheless, CMS continues to increase the potential for penalties under this program, doubling them in the second and third years.

The AMA recommends that: 1) penalties should not be increased; 2) participation in the budget neutral tiering process should be voluntary; and 3) CMS should ask Congress to provide a longer phase-in period and more flexibility to implement the VBM.

To be clear, the AMA has a great deal of sympathy for CMS and the position it finds itself in. It is hard to take the long view in an agency struggling to meet unrealistic deadlines with inadequate resources and a flawed IT platform. However, the current strategy of aggressively moving forward with policies that place an ever increasing burden on both CMS and physicians, combined with the flawed roll-out of the Medicare claims data release and Open Payments program and the problems with these programs, threatens to do serious damage to the agency's image and to physician confidence in the government's stated goal of achieving a health care system that delivers more value for the dollar. It is time to reassess where these programs are going and how to get there. The AMA offers our assistance in such an endeavor, which should begin with a realistic assessment of CMS' resource constraints, the methodological challenges, and the limitations of an all-or-nothing approach that is creating an unsustainable burden on physician practices and threatens the continued access to care of some of Medicare's frailest patients.

We appreciate the opportunity to provide these thoughts and look forward to a continued dialogue on this issue. If we can be of any further assistance, please contact Margaret Garikes, Vice President, Federal Affairs at 202-789-7409 or margaret.garikes@ama-assn.org.

Sincerely,

James L. Madara, MD