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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
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-10519 Physician Quality Reporting System and the Electronic Prescribing Incentive Program Data Assessment, Accuracy and Improper Payments Identification Support

Dear Administrator Tavenner:

The American Medical Association (AMA) is deeply concerned with the Paperwork Reduction Act (PRA) data collection notice that seeks to conduct audits of physicians and other eligible professionals who received incentive payments under the Medicare Physician Quality Reporting System (PQRS) and E-Prescribing (e-Rx) programs.

The PQRS and e-Rx programs have been riddled with problems since their inception. These problems have only grown over time as program requirements have changed from year-to-year, causing a tremendous amount of confusion for physician participants. To address these concerns, the AMA has worked very closely with the Centers for Medicare & Medicaid Services (CMS) staff to educate physicians about both programs' requirements. While the AMA deeply appreciates the improvements that CMS has made over the years, the implementation of these programs has still been rocky. As a result, participation rates have been low and well-intended physicians, who attempted in every manner possible to comply with the program reporting mandates, were nonetheless unsuccessful. Many physicians were denied an incentive payment, often for reasons outside of their control. **While we understand that CMS needs to ensure the accuracy of its incentive programs, the numerous implementation problems, as described below, would make retrospective audits extremely complex and likely lead to erroneous, inequitable determinations. In addition, we urge CMS to consider that this proposal is inconsistent with its efforts to steer more physicians towards participation. Indeed, these audits are likely to have the opposite effect and discourage additional participation. We therefore strongly urge CMS not to move ahead with these audits.**

PQRS Program Challenges

Physicians have experienced a litany of problems with the PQRS program. Below we provide examples of these problems to inform CMS' consideration of any PQRS audits.

- **Inadequate preparation and response time**: CMS makes yearly changes to the PQRS program requirements and often also makes mid-program year alterations to specifications. In particular, CMS does not release updated measure specifications until close to the start of the program year, which does not provide physicians with much time to educate themselves and their staff on these changes. CMS education materials are often not released until after the program year has started and subsequent guidance is often released throughout the program year.

- **Submission problems**: Many physicians over the years have had issues with the submission of PQRS information on claims due to clearinghouses or billing systems not recognizing CPT II or G codes on claims, particularly if associated with a $0 charge.

- **Delayed feedback**: CMS does not provide the timely feedback needed for physicians to successfully submit PQRS data. By the time a practice is made aware of any problems with their reporting they are well into the next reporting period.

- **Shifting requirements**: With the group practice reporting option (GPRO), electronic health record (EHR), or registry reporting options, CMS has changed the requirements for either submission of data, reporting thresholds, and/or measure requirements on almost a yearly basis.

- **Conflicting requirements not under physicians' control**: The web interface reporting mechanism for registries, electronic health records (EHR), and GPRO is very different from the claims reporting option. For GPRO, groups do not select their measures or their patient population. Instead, GPRO participants submit data on a single set of measures for a random sample of patients that are assigned to them by CMS. In addition, for performance years 2010 and 2011, all GPRO participants were large groups that had at least 200 National Provider Identifiers (NPIs)/Tax Identification Numbers (TINs). In 2012, CMS expanded the GPRO web interface to groups with 25 or more NPIs/TINs, but created separate reporting requirements for groups with 25-99 NPIs/TINs and groups with 100 or more NPIs/TINs. In 2010 and 2011, GPRO participants reported 26 measures, which covered four disease modules plus four preventive care measures. In 2012, the number of measures and disease modules increased. For 2013, CMS changed the measure requirements and increased the number of required disease modules. The data submitted to CMS is through a web-based tool and is often required to be submitted through a third-party. Physicians are at the mercy of the vendor for submitting their information correctly.

- **Performance variation**: Consistent with CMS' analysis of the entire array of 2010 GPRO participants, there were wide variations in their performance. Our analysis of their experience is based on feedback from the Association of American Medical Colleges (AAMC), which actively works with GPRO medical practice academic sites to educate them on the program. The following are reasons for this performance variation:

    - Attribution: Several sites indicated that the patient attribution methodology CMS applied impacted their performance. In 2010 and 2011, beneficiaries were attributed to group practices based on the plurality of outpatient/office visits. When the patient came to the practice for specialty care, the patient population on which the practice expected to be measured differed from the patient population that was actually assigned.

- Missing data or documentation errors: When a service was performed by practitioners or providers outside the organization, the group practice frequently did not have the detailed results in the EHR or the documentation was hidden in a scanned note and not easily retrieved for quality reporting. In other situations, the service may have occurred within the organization, but the clinician did not document the service, or did not document it sufficiently for measurement purposes. This issue was mentioned by several practices for the diabetes foot exam measure. Physicians had documented "lower extremity" in the record, but that term did not meet the measure specification requirements.

- Issues related to measure specifications: Some preventive care measures did not provide an exclusion for patient refusal. In other measures, such as hypertension plan of care, the group was unclear about how to report the measure. In addition, for complex patients, the clinicians believed the blood pressure was under control based on the circumstances of that patient even though the blood pressure threshold in the measure indicated poor control.

- **Problems with 2011 GPRO reporting cycle**: While the patient attribution logic and the measures did not change in 2011, CMS hired a new contractor to convert the process from an access database tool to a web-based data collection tool. There were many delays and participants had to stop reporting on the first set of data due to programming errors in assigning patients to modules. The second data release was improved, but still had minor errors. In addition to the data issues, the web tool had multiple performance issues. Groups struggled with downloading and uploading data, response times were slow, and the system often timed-out. Specifications were inconsistent and in at least one case the date ranges for reporting a measure changed during the data submission cycle. The technical issues were compounded by poor communication from CMS, the contractor, and the QualityNet Help Desk. **Due to these issues, CMS promised the GPRO participants that they would be held harmless for the 2011 reporting cycle.** Groups were given additional time to complete the data submission, and they were not required to complete the submission in order to receive their incentive. While these adjustments were helpful, it did not compensate the groups for their missed opportunity costs and lost resources.

In addition to the numerous problems with PQRS noted above, the burden of an audit far outweighs the benefit of the PQRS incentive or avoiding PQRS penalties. In 2012, only 31 percent of eligible professionals (EPs) earned an incentive, and the average incentive was only $457 per individually participating EP and $5,736 per practice.[1] These minimal payments coupled with constantly changing requirements and scant direction from CMS limit the benefits of participating in the PQRS program. **Physicians should not be held accountable for possible accuracy issues related to improper payments due to CMS' poor program design.**

[1] Centers for Medicare & Medicaid Services. 2012 Reporting Experience—Physician Quality Reporting System and Electronic Prescribing (eRx) Incentive Program. March 14, 2014. Available at http://assets.fiercemarkets.com/public/newsletter/fiercehealthit/cmspqrserxreport.pdf

E-Prescribing Program Challenges

Like PQRS, physicians have experienced numerous problems with the e-Rx program. We offer the below examples to provide CMS audit staff with a sense of the complexity of the e-Rx program.

- **G codes removed from claims**: Many physicians who attempted to report the required G code were denied an incentive since the code has a $0 charge, which many physicians later learned was stripped off their claim because their billing system or clearinghouse was unable to process it.

- **G code changes**: In 2010, CMS changed the G code that physicians were required to report, causing confusion as many physicians were unaware of this change and little outreach was done to inform them.

- **NPI**: Physicians reported a group NPI rather than an individual NPI, which also resulted in many physicians being denied an incentive.

- **Hardships**: Under the program there are several hardship categories. Many physicians informed the AMA that they filed for a hardship but nonetheless received a penalty. Also, there were numerous problems with CMS' system for filing a hardship that precluded physicians from filing in a timely manner.

- **Reporting period challenges**: Reporting periods to avoid a penalty were only six months, which did not provide adequate time to report.

- **Last minute rule changes**: Throughout 2010, CMS repeatedly stated, through numerous communication vehicles, that EPs who elected to participate in the Meaningful Use (MU) program, which contains an e-Prescribing requirement, "cannot participate in the eRx Incentive Program in the same program year." Despite this repeated guidance, on November 29, 2010, CMS reversed course in its 2011 Physician Fee Schedule Final Rule. That rule said that physicians who chose to only participate in the MU program, and not the e-Rx program, would receive a penalty. Because the change was announced in November 2010 and became effective January 1, 2011, many physicians were not aware of CMS' reversal and experienced penalties as a result.

- **Information review**: While the 2012 Physician Fee Schedule (published in November 2011 and effective January 1, 2012) established an informal appeals process, the deadline for filing an appeal was only two months after the effective data, February 28, 2012. CMS, however, did not establish a method for filing an appeal until January 30, 2012. This short timeline, coupled with scant communication from CMS in regard to the appeals process, rendered the process ineffective and unknown to many physicians.

Like the PQRS program, the burden of an e-Rx audit for many physicians likely outweighs the benefit of the e-Rx incentive. In 2012, the average e-Rx incentive was only $1,474 per EP and $6,095 per practice.[2]

[2] Centers for Medicare & Medicaid Services. 2012 Reporting Experience—Physician Quality Reporting System and Electronic Prescribing (eRx) Incentive Program. March 14, 2014. Available at http://assets.fiercemarkets.com/public/newsletter/fiercehealthit/cmspqrserxreport.pdf

Conclusion

If CMS moves in the direction of the proposed collection request, it will have a chilling effect on new and continued participation in Medicare quality reporting programs. As described above, physicians are already facing numerous obstacles, outside of their control, that limit their chance of success in these programs. By adding an audit process, which spans over four years, CMS is creating yet another barrier to successful participation. Audits are not only time-consuming but require additional documentation and resources to again show that a physician has complied with the changing program requirements. While the AMA unequivocally condemns true fraud, we do believe that the overwhelming majority of physicians are honest and make a good-faith effort to comply with the laws and requirements of each program. We are concerned that, because of the PQRS and e-Rx program complexities described above, this audit program will be extremely challenging in its administration and will ensnare honest physicians, serving to deter future physician participation. Physicians may decide to drop out and take a financial penalty rather than expend significant time and resources attempting to comply and risk being faced with possible burdensome and time-consuming audits.

We think the better course for CMS is to support physician participation in incentive programs that invest in their technological capabilities, aid participation in new health care and delivery models, and facilitate care coordination. If you have any questions concerning our comments, please feel free to contact Margaret Garikes, Director of Federal Affairs, at margaret.garikes@ama-assn.org or (202) 789-7409.

Sincerely,

James L. Madara, MD