Michael D. Maves, MD, MBA, Executive Vice President, CEO

December 30, 2008

Keith Holman
Project Leader
Office of Advocacy
U.S. Small Business Administration
409 Third Street, SW
Washington, DC 20416

Dear Mr. Holman:

On behalf of the physician and medical student members of the American Medical Association (AMA), I am submitting a nomination for the Small Business Administration's (SBA) ***r3 initiative***. This initiative is "intended to help small businesses address the cumulative Federal regulatory burden, which is now estimated to exceed $1.1 trillion." The AMA applauds the SBA for this program as it is, "designed to identify and address existing federal regulations that should be revised because they are ineffective, duplicative, or out of date." **The AMA is nominating the Medicare enrollment process, a process governed by multiple regulations. In brief, the current enrollment process is unwieldy, unduly complicated, resource intensive, inefficient, and a significant drain on small physician practices**.

Background

Physicians who want to be reimbursed for treating Medicare patients must submit an enrollment application to the Centers for Medicare & Medicaid Services (CMS), an agency within the U.S. Department of Health & Human Services. After the application has been accepted and processed a physician may begin billing the program for delivering services to Medicare patients. When the enrollment process is unduly lengthy and resource intensive, it directly affects access to health care for some of the nation's most vulnerable patients.

The current enrollment problems have contributed to the increase in the number of physicians who have decided to stop taking new Medicare patients or have elected to stop participating in Medicare altogether. Physicians' problems with the cumbersome and inefficient Medicare enrollment process are also troubling given reports of anticipated physician shortages coupled with the growth in the Medicare population due to the retirement of baby boomers.

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The AMA is deeply concerned by the rapid increase in the number of reports detailing the challenges patients face in locating a Medicare physician. The Medical Group Management Association (MGMA) has found that 24 percent of group practices already limit the number of new Medicare patients they accept. The Medicare Payment Advisory Commission (MedPAC), an independent congressional agency, also found 30 percent of patients seeking a new primary care physician have trouble finding one. According to the congressionally-created Council on Graduate Medical Education, it is predicted there will be a shortage of 85,000 physicians by 2020. And, according to Foundation Physicians, as summarized recently by CNN, "49 percent said they'd consider leaving medicine. Many said they are overwhelmed with their practices, not because they have too many patients, but because there's too much red tape generated from insurance companies and government agencies."

The Medicare enrollment process has long been considered by physicians to be a very complicated and burdensome process to complete because of significant paperwork requirements and poor guidance. This process can take six months or longer despite requirements which call for shorter processing timeframes. Until physicians are successfully enrolled in the Medicare program, they are unable to receive reimbursement from the agency for services delivered to Medicare patients.

Number of Physicians Impacted

Today, approximately 670,000 physicians bill the Medicare program. Over 50 percent of physician practices have five physicians or less. Ninety-five percent of physician practices are considered small businesses as defined by the SBA. These small businesses account for 80 percent of outpatient visits and their survival is inextricably tied to access and health care for Medicare's beneficiaries. A single practitioner who wants to become enrolled in the Medicare program must complete at least 35 pages worth of paperwork and sometimes more, as well as submit several pieces of documentation (i.e., licenses and school degrees). CMS's own Provider Satisfaction Survey found Medicare contractor enrollment process performance dismal; it was tied with Medicare appeals for lowest satisfaction (See page 21, http://www.cms.hhs.gov/MCPSS/downloads/MCPSS_Report.pdf).

The Problem

In addition to what has long been considered a paperwork nightmare and a system that is ripe for administrative simplification, the implementation of the National Provider Identifier (NPI) significantly impacted the Medicare enrollment system. The NPI is a uniform billing number that is required for use by all physicians who bill any payer (not just public payers) electronically pursuant to the Health Insurance Portability and Accountability Act (HIPAA). Use of the NPI went into effect on May 23, 2008. (The original compliance date was May 23, 2007, but was, for all intents and purposes, delayed one year due to the industry's need for additional time to comply.) The NPI replaced all other proprietary physician billing numbers issued by different payers. In order for physicians to be reimbursed by a payer, their claim must contain the NPI number. Industry compliance with the use of the NPI, while not specific to Medicare, is overseen by CMS.

The databases containing physician Medicare enrollment information and the NPIs are completely separate. Physicians who are new to the Medicare program or need to make a change to their billing information (e.g., change of address) are required to submit an enrollment application. Prior to enrolling in Medicare, physicians must have applied for and obtained an NPI number, which is a separate process. Unfortunately, for an untold number of physicians (certainly in the thousands—CMS has not supplied us with specific data), who were already enrolled in the Medicare program prior to when the NPI went into effect, in order to continue receiving Medicare reimbursements, they were required to re-enroll. The effect has been devastating. Countless physicians who have been billing Medicare for years, even decades in many cases, were required to re-enroll in the Medicare program in order to continue receiving reimbursement for services delivered to Medicare patients. The Medicare enrollment system was already severely backlogged prior to this requirement and this only exacerbated an already significant problem.

Aside from the incredibly burdensome task of having to complete the lengthy enrollment application, these physicians were unable to: 1) get claims paid by Medicare, a problem that persists today; 2) get through to customer services agents on the Medicare hotlines; 3) receive consistent and accurate information on their application or on NPI requirements; 4) qualify for advance Medicare payments to help them weather the period when they were unable to receive reimbursement while their applications were processed.

There have been additional problems and frustrations facing physicians who have been enrolled in the Medicare program since before 2003. In 2003, Medicare implemented the Provider Enrollment, Chain, and Ownership System (PECOS), a single system for use by the Medicare contractors for enrollment. Prior to this time, Medicare contractors had their own systems and methods for enrolling physicians and not all of the information currently collected under PECOS was collected for enrollment purposes prior to 2003 by the contractors. CMS has told the AMA that in order to match the NPI number(s) of Medicare physicians enrolled prior to 2003 with the enrollment information they currently have on file, certain pieces of data were needed because they were missing. Without an appropriate match CMS indicated it was unable to verify that an NPI number was associated with a physician in its files.

Rules Governing the Process and Unabated Changes

These administrative and regulatory requirements of the largest health care payer in the country have been nothing short of financially debilitating for physicians who treat Medicare beneficiaries. The foregoing is coupled with the fact that CMS has continued to make a number of sweeping changes that began in 2006 to the Medicare enrollment process. In short, the agency has moved too quickly to implement changes and did not furnish the Medicare contractors with adequate time or resources for adoption. The agency published more significant changes to the enrollment process on June 27, 2008, in the *Medicare Program; Appeals of CMS or CMS Contractor Determinations When a Provider or Supplier Fails to Meet the Requirements for Medicare Billing Privileges* final rule and again on

November 19, 2008, in the *Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2009; E-Prescribing Exemption for Computer-Generated Facsimile Transmissions; and Payment for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)* final rule. For example, among the new requirements are a severely truncated period during which physicians, once successfully enrolled, are able to submit claims for services furnished prior to their official Medicare enrollment date (this is often referred to as "retroactive billing").

Furthermore, these changes have occurred unabated even during the transition to the NPI, an effort even greater than what was required to move to Y2k or the first version of the HIPAA electronic transaction standards which was considered by the industry to have been monumental. The agency simply did not mitigate the Medicare enrollment problems or anticipate the problems that could occur during the NPI transition.

The ability of Medicare contractors to process enrollment applications consistent with specified timeframes is woefully inadequate in many cases. Although the current timeframes established by the agency for processing Medicare enrollment applications in a "timely" manner range between 60 to 90 calendar days in the paper-based process, many contractors take as many as 180 days. Following the May 23, 2008, NPI deadline, scores of physicians remain unpaid for services delivered to Medicare patients due to the processing delays. This has been financially and administratively burdensome for these physicians, many of whom enrolled in Medicare years, if not, decades ago and suddenly were forced to go as many as six months (sometimes longer) without being paid. This has dealt a crippling blow to physicians and their patients.

New Technology Affecting the Process

One thing the AMA and many others have been championing for several years is a system that allows physicians to submit their enrollment applications online. Although we are almost a decade into the 21st Century, Medicare has only in the last month rolled out an online system. It is entirely unclear why the online system has taken this long to be rolled out and why it was not up and running successfully prior to the transition to the NPI. While the online enrollment system is expected to reduce the timeframes for processing applications, the new program is still in its infancy. CMS has established requirements that call for the online applications to be processed within 30 to 45 calendar days. Our experience with large-scale Medicare system rollouts is inevitably there are bugs and these must be resolved before they can be used successfully. The new online system is expected to mitigate the application processing delays, but systemic issues exist such as the rapid fire rollout of new enrollment processing standards such as those included in the two aforementioned rules.

The problems experienced by physicians enrolling or re-enrolling in Medicare span years. And, it could be years longer before these problems are resolved. Many of the physicians experiencing enrollment processing problems have also experienced massive payment interruptions. As a result, they have to obtain short-term bank loans. With the serious downturn in the economy, physicians, like many other small businesses, are struggling to remain afloat and will remain extremely vulnerable for the foreseeable future as their access to lines of credit have disappeared. We have examples of several physicians who have been pushed to the brink of going out of business. Unless physicians are able to receive the reimbursement owed to them, they have faced the prospect of not being able to pay their mortgage, their medical liability insurance (which is needed in order to practice medicine), office rent and staff, and other bills. Also disturbing is the fact that the enrollment problems experienced by these physicians has led some to decide to stop seeing Medicare patients altogether or to stop seeing new Medicare patients.

Physicians continue to see more problems than solutions to the Medicare enrollment process. However, there exists a system in the private sector, the Council for Affordable and Quality Healthcare's Universal Credentialing Datasource® (UCD), used by 70 percent of physicians and other practitioners throughout the country to become credentialed with other health care payers. To date, Medicare has refused to consider establishing an interface with the UCD. By doing so though, the time and energy associated with Medicare enrollment could be significantly diminished as physicians would only be entering their information into a system once, creating vast efficiencies for them and for the Medicare program and taxpayers.

Recommendations

Although we have been assured through conversations with Medicare officials that several changes concerning enrollment that were scheduled to go into effect January 1, 2009, will be postponed, it is entirely unclear whether the serious problems we have outlined will be resolved by then. Furthermore, as also discussed, changes are still needed in order to address the systemic problems. **We recommend Medicare adopt the following broad recommendations to address the systemic enrollment problems:**

1. **Halt any further changes to enrollment standards until:**

    a. **It has been clearly established that the online enrollment system is working efficiently and the timeframes for processing most applications occurs within 30 days;**
    b. **It is clear that there are sufficient enrollment staff at the Medicare contractors to handle the new workload;**
    c. **There are enrollment staff at the Medicare enrollment contractors who are adequately trained.**

2. **Hold Medicare contractors more accountable for measurable enrollment application processing performance, including:**

a. **Improving the satisfaction scores on their Medicare Provider Satisfaction Survey;**
b. **Using this information to determine whether the contract should be renewed.**

3. **Establish better communication channels between physicians and Medicare contractors; communication must be fostered so to ensure applications are processed in a timely manner.**

4. **Develop better outreach materials for widespread distribution, particularly in advance of significant changes.**

5. **Relax the criterion for advance payments for physicians experiencing Medicare enrollment processing delays.**

6. **Make available online to the public the statistics concerning:**

   a. **Number of enrollment applications in the queue;**
   b. **Number of applications that have not been processed within the given time frame and reasons why (i.e. missing information required from the physician);**
   c. **Average wait time to talk to a Medicare customer service agent concerning enrollment;**
   d. **Average time it takes to get a call/email/or follow-up letter from Medicare contractors on enrollment inquiries.**

7. **Require all Medicare contractors to have an online system on their websites that allows physicians to check the status of their application.**

8. **Host regular enrollment conference calls with the physician community at least until these aforementioned problems are resolved.**

9. **Perform a risk analysis prior to any future systems changes that involve or interface with PECOS in order to ascertain the implications and mitigate negative outcomes (this should include HIPAA transitions such as the proposed move to the next version of HIPAA transaction standards and the ICD-10 codes sets intended to replace the current ICD-9 codes sets used by physicians on all health care claims).**

10. **Engage in a full and robust conversation with the appropriate industry stakeholders to discuss how Medicare could interface with the CAQH's Universal Credentialing Datasource® (UCD).**

We appreciate the opportunity to nominate the Medicare enrollment process for consideration by the SBA as part of the ***r3 initiative.*** Attached to this nomination letter you will find additional documents outlining the problems with this system and our efforts to improve it. The changes to the Medicare enrollment system can be implemented with existing agency authority and do not require additional statutory authority. Should you have any questions, please do not hesitate to contact my staff, Mari Savickis, at mari.savickis@ama-assn.org or 202-789-7414.

Sincerely,

Michael D. Maves, MD, MBA

Attachments

February 28, 2008

Mr. Kerry Weems
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Dear Administrator Weems:

The American Medical Association (AMA) and the Medical Group Management Association (MGMA) are concerned with the current progress of the physician community's transition to the National Provider Identifier (NPI). The AMA and MGMA are particularly concerned with Medicare's ability to smoothly move past March 1, 2008, the date Medicare will no longer accept claims with just legacy numbers. We urge the Centers for Medicare and Medicaid Services (CMS) to take immediate steps to ensure practices do not experience cash flow interruptions.

Despite the significant outreach our associations and others have conducted, we remain concerned that practices will experience claims processing problems and resultant cash flow interruptions. This, in turn, could impact patient care. As a result of Medicare's decision to activate the NPI crosswalk matching edit last fall, some carriers experienced claims rejection rates of greater than 10 percent. Ten percent of claims translates into a significant number of claims in both sheer volume and dollar value. Compounding the problem for physician practices is that it is not one claim alone that is rejected if the NPI and legacy number do not match on Medicare's crosswalk; it is all of the practice's Medicare claims that will be rejected, which will affect the practice's ability to conduct necessary business operations.

In order for a correct match to be made between legacy numbers and NPIs, Medicare has required many practices to complete entirely new provider enrollment packages, not an insignificant task. Moreover, many practices that experienced claims rejections were small, single incorporated physicians who through no fault of their own were never assigned two legacy numbers. As instructed by CMS, these practices have contacted their carriers; however, they often report significant delays in these attempts and receive inaccurate and conflicting information, making an already difficult situation even more challenging.

Additionally, according to Transmittal 313 dated February 1, 2008, a number of steps required to transition carrier work over to the new Medicare Administrative Contractor in Jurisdiction 4, Trailblazer Enterprise Services, will be occurring on March 1. Any difficulties practices in Jurisdiction 4 experience with the NPI will be further complicated by any issues that arise during the cutover from their current carriers to Trailblazer. This region is of particular concern, given the troubles experienced by practices with Trailblazer in the states of Maryland, Texas, Virginia and the District of Columbia in the area of provider enrollment. Also of concern is that Trailblazer as the Medicare Administrative Contractor will be adding three additional states, Colorado, New Mexico and Oklahoma before it is relieved of its duties as the Part B carrier for Maryland, Virginia and the District of Columbia.

The AMA and MGMA strongly urge CMS to:

1. **Closely monitor the claims rejection rates following the March 1, 2008 deadline;**
2. **Share information on rejection rates with us in a timely manner;**
3. **Allow claims to be processed with the legacy number only, if the claims rejections rate immediately following the March 1, 2008 deadline exceeds a minimal amount; and**
4. **Not reject claims in situations where practices have been caught up in enrollment backlogs. Demonstrate leniency in processing claims following March 1 where matching problems result in claims rejection particularly in situations where practices have been caught up in enrollment backlogs.**

We appreciate the opportunity to bring these concerns to your attention. Should you have any questions, please contact Mari Savickis at mari.savickis@ama-assn.org or Robert Tennant at RMT@mgma.com.

Sincerely,

American Medical Association
Medical Group Management Association

AMA
AMERICAN
MEDICAL
ASSOCIATION

Michael D. Maves, MD, MBA, Executive Vice President, CEO

March 31, 2006

Carolyn Lovett
CMS Desk Officer
Centers for Medicare and Medicaid Services
OMB Human Resources and Housing Branch
New Executive Office Building
Room 10235
Washington, DC 20503

Dear Ms. Lovett:

The American Medical Association (AMA) appreciates the opportunity to comment on revisions to the Centers for Medicare and Medicaid Services' (CMS) Medicare physician enrollment application Form No. CMS-855 (OMB #0938-0685), as issued on January 27, 2006.

MEDICARE PHYSICIAN ENROLLMENT PROCESS

The AMA recognizes the importance of ensuring that only qualified physicians participate in Medicare. We have concerns, however, regarding the overall process by which CMS gathers the information to make these determinations.

Revalidation Proposed Rule

CMS is in the process of finalizing a rule that may require physicians to reenroll in Medicare every three years (through what is called "revalidation"). The AMA continues to have significant concerns about this proposal, which, if finalized, likely would substantially decrease the time physicians are available for communication with and treatment of their patients. The revalidation requirement seems excessively redundant given the current requirement to report information changes to Medicare as they occur. Such an enormous new regulatory burden would undermine much of the progress made to date on regulatory reform, especially under the *Medicare Prescription Drug, Improvement, and Modernization Act of 2003* (MMA).

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Error Return Rate

CMS staff has previously noted that approximately 70 percent of submitted enrollment forms are returned to the applicant to correct errors. This volume of corrections is far too high. CMS and its contractors must ensure that instructions are clear and required data elements are minimized. CMS should explore the use of technologies that help prevent errors before submission. Forms with built-in intelligence, such as automatically noting incomplete fields, are prevalent today, and could save time and precious resources for the health system. We recognize that CMS' aim is to move toward this end, and we encourage CMS to expedite these plans.

On-Line Enrollment

Additionally, the AMA understands that CMS is still working to enable online Medicare enrollment. If designed properly, electronic submission of physician Medicare enrollment forms would reduce the burden on physicians and their practices while increasing the accuracy of the information obtained. **We strongly encourage CMS to make electronic enrollment available to physicians as swiftly as possible.**

We also note that CMS' website is confusing concerning which enrollment forms (CMS-855) are the correct ones for completion and submission to CMS. For example, enrollment forms dated as of 2001 and still currently in effect are housed on the CMS "forms" webpage at: www.cms.hhs.gov/CMSForms/CMSForms/list.asp. Yet, proposed draft forms are housed on separate CMS' Paperwork Reduction Act (PRA) webpage at: www.cms.hhs.gov/PaperworkReductionActof1995/PRAL/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=2&sortOrder=descending&itemID=CMS050282. We urge CMS to add "draft" to each form on the "PRA webpage" to clearly delineate them from the forms now in effect on the "forms webpage" to avert any confusion.

Timeline for Processing Enrollment Applications

As of March 1, 2006, pursuant to CMS Transmittal 134, Medicare carriers will have extended deadlines for processing enrollment applications. Specifically, carriers will have to process only 80% of CMS-855B and CMS-855I forms within 60 days of receipt. Prior to March 1, carriers were required to process 90% of these forms within 60 days. Further, Transmittal 134 requires carriers to process 99% of these applications within 180 days, instead of the 90-day timeframe in effect prior to March 1, 2006.

We urge CMS to continue with the processing deadlines in effect prior to March 1. These extended deadlines could cause further backlogs in the processing of enrollment applications, which would create a financial hardship for those physicians who would not be able to bill Medicare during an extended pendency of their enrollment application.

Transmittal 134 also requires that any changes in information submitted by the applicant prior to completion of the processing of the application, will be considered an update to the original application, rather than a separate change of information. As a result of this new policy, carriers will no longer be able to complete processing of the original application before processing the changes. Rather, carriers will have to consider the changes as part of the original application, thereby extending the processing deadline. We urge reconsideration of this new policy, as it will further delay the processing of enrollment application and impose an undue hardship on some physicians.

FORM CMS-855I

The AMA urges CMS to ensure that any efforts to revise the CMS-855 physician Medicare enrollment forms and process are focused on reducing the difficulty and burden associated with them. We greatly appreciate that CMS has made strides in this respect, including adoption of a number of recommendations the AMA submitted in September 2005 for revising the forms. We have additional recommendations, however, for greater simplification and reduction of administrative burden, as follows:

Page 1: The "General Instructions" section defines the National Provider Identifier (NPI) as "the standard unique health identifier for health care providers and is assigned by the National Plan and Provider Enumeration System (NPPES)." Presently, CMS' requirements about obtaining an NPI are not clearly articulated in the CMS-855I. We recommend adding a sentence, or a box immediately under the definition of NPI, with language similar to that found in CMS-855B, when defining NPI under "General Instructions," as follows: "The National Provider Identifier (NPI) is the standard unique health identifier for health care providers and is assigned by the National Plan and Provider Enumeration System (NPPES). As a Medicare health care supplier, you must obtain an NPI. Applying for an NPI is a separate process from Medicare enrollment. To obtain an NPI application, apply online at *https://NPPES.cms.hhs.gov*."

Further, we understand that CMS is considering requiring physicians to obtain an NPI prior to submitting their Medicare enrollment application. We recommend that physicians have the choice of whether to obtain the NPI first, or whether to simply indicate on their enrollment form that they wish to obtain an NPI (and this should be clearly articulated in the "General Instructions" section of the enrollment form.) To this end, we recommend that CMS streamline the application process for Medicare enrollment and for obtaining an NPI with regard to physicians who have not obtained an NPI prior to submitting an enrollment application (which would be especially helpful for new physicians). These physicians should be permitted to indicate on the enrollment application that they also want to be issued an NPI. This should be clearly stated in the enrollment application under "General Instructions." Delaying the enrollment process until an NPI is issued for these physicians would further delay the amount of time that a physician is unable to bill Medicare for their services, which could create cash flow problems for some practices. It is especially important to ensure prompt payment to physicians for Medicare services in light of the projected Medicare cuts totaling 35% through 2015.

Finally, the last paragraph on page 1 also seems to be missing some words, which are needed to fully understand what forms must be completed. It states that "If you furnish diagnostic tests, claims must be submitted as an IDTF and you must complete and the CMS-855B." (Emphasis added.) It appears that the word "and" should be removed from this sentence, or additional words should be inserted after the "and" to convey the full meaning of the sentence.

Page 3: The section on "Additional Information" clearly states: "[a]pplying for the NPI is a process separate from Medicare enrollment. You may obtain a separate NPI application or apply online." As discussed above, this language should be highlighted up front under the section on "General Instructions."

Page 6: The chart under "Basic Information" section, 1.B., which asks physicians and other providers/suppliers to identify their "reason for application," begins on page 6 and continues on page 7. It would be much clearer if this entire chart were set forth on one page only. As is, it could be confusing to an applicant who is submitting the application for the purpose of changing or revalidating their information (since neither of these choices is shown on page 6, but rather are found on page 7.) It would be easier to read the chart if it is contained on the same page, which is the case with the current version of the CMS-855I.

Page 7: The shaded box separating the top and bottom chart on page 7 appears to have instructional language in it. When the application is printed or copied, the shading in the box is so dark that the instructions are illegible. Thus, the shading should be lightened or removed.

Page 10: Under the "Identifying Information" section, physicians are asked to select their primary and/or secondary specialty form a finite list of specialties, including an undefined entry, that appear to have no relation to the new system of identifying physicians. The National Plan and Provider Enumeration System (NPPES) uses the Healthcare Provider Taxonomy Codes list for physicians and other providers to designate their specialty. The same list should be used in the enrollment application to ensure consistency with the NPPES system. The AMA recommends that the Healthcare Provider Taxonomy Codes for physicians be included in the application or available as a link from the application to the list.

Pages 15 and 16: The section on page 15 concerning "Adverse Legal Actions/Convictions" and the section on page 16, concerning "Practice Location Information," both appear to ask for the same information concerning "Adverse Legal History." It seems this information would be needed for only one of these sections, and is redundant when requested for both sections.

Page 16: While we appreciate that the revised application defines on the first page the terms "Medicare Identification Number" and "National Provider Identifier," page 16 uses the term: "Medicare number." It is not clear what number is required for this section. If it is the Medicare identification number, for consistency, this term should be used throughout the application.

The AMA appreciates the opportunity to provide the foregoing comments, as well as CMS' continued efforts to simplify and reduce the paperwork burden associated with the CMS-855 forms. We stand ready to assist in this important matter. If you have any further questions, please contact Mari Johnson at (202) 789-7414.

Sincerely,

Michael D. Maves, MD, MBA

AMA
AMERICAN
MEDICAL
ASSOCIATION

Michael D. Maves, MD, MBA, Executive Vice President, CEO

May 1, 2007

Ms. Leslie Norwalk
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 314-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Dear Ms. Norwalk:

On behalf of the physician and medical student members of the American Medical Association (AMA), I respectfully submit the following comments in response to the proposed rule *Medicare Program; Appeals of CMS or Contractor Determinations When a Provider or Supplier Fails to Meet the Requirements for Medicare Billing Privileges* that the Centers for Medicare & Medicaid Services (CMS) issued on March 2, 2007. As noted in the preamble, CMS's use of the term "supplier" for the purposes of this rule includes physicians.

Physicians who bill Medicare have long been concerned about the overall enrollment process. However, of particular ongoing concern has been the time associated with establishing Medicare billing privileges as well as the paperwork requirements associated with the application. While we are pleased with the additional rights afforded physicians pursuant to section 936 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) concerning enrollment denials and non-renewal, we have significant concerns with many of the provisions CMS has proposed in this rule. Our specific concerns are outlined below.

Section 405.874 Appeals of carrier determinations that a supplier fails to meet the requirements for Medicare billing privileges

The policy CMS has proposed in section **405.874(b)(3)** is confusing and we are requesting that CMS provide clarification. The proposed rule would prohibit payment for items or services unless a physician has a valid Medicare billing number. Furthermore, this section would provide carriers with the discretion to reject claims if a physician doesn't have a valid billing number. The foregoing carrier action would not be subject to an appeal. We have four concerns which are detailed below.

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First, we are concerned about retaining a physician's ability to bill retroactively. As written, this section is sufficiently unclear with respect to whether or not physicians will be allowed to continue billing retroactively. Presently, physicians treating Medicare patients with pending enrollment applications hold their Medicare claims until they are granted billing privileges. While CMS states in the preamble that a supplier may resubmit claims once their enrollment application is approved, the plain meaning of the proposed regulation creates ambiguity as to whether CMS will allow the current practice to continue. We strongly urge CMS to clarify that claims submitted by physicians during the enrollment approval process are held rather than rejected. **In addition, we strongly urge CMS to clarify that physicians may continue billing retroactively upon receiving billing privileges.**

Second, the terminology used in this subsection is inconsistent. In section **405.874(b)(3)(i)** the term "billing privileges" is used, while section **405.874(3)(b)(iii)** the term "active Medicare billing number" is used. Earlier in the proposed rule, on page 9483, CMS states that the term "Medicare billing privileges" will replace the term "Medicare billing number." The terminology should be conformed throughout.

Third, the AMA submitted comments to CMS on the earlier, proposed carrier determination rule published on October 25, 1999, *Medicare Program; Appeals of Carrier Determinations That a Supplier Fails to Meet the Requirements for Medicare Billing Privileges,* in which we noted that claim reimbursement rejections should only occur when a physician's enrollment has been revoked (denied), not when the carrier has yet to process a physician's enrollment application. The preamble section of the current, proposed rule provides that:

> [c]laims are rejected when the supplier does not have valid billing privileges at the time that claims were submitted. When a supplier's application is approved and it is assigned a billing number, these claims may be resubmitted and paid retroactively, except for DMEPOS suppliers, who do not have retroactive billing privileges.

Slow carrier reviews of physicians' enrollment applications have forced some physicians to wait over six months to become enrolled and establish Medicare billing privileges. The proposed rule coupled with the slow processing time of enrollment applications will create significant financial hardship to new physicians. To some this will prove to be an absolute barrier to participation in the program. **We therefore strongly oppose this proposed language and recommend claim reimbursement rejections should only occur when a physician's enrollment has been revoked.**

Fourth, under section **405.874(b)(3)(iii)** CMS proposes that, "[r]ejections of claims because a supplier does not have a valid billing number may not be appealed by the supplier." As stated in our earlier comments, we strongly oppose the application of this proposed rule to claims that are submitted by a physician and which are solely rejected because no billing number has, yet, to be assigned. Again, this language is confusing given CMS' decision to use the term "Medicare billing privileges" instead of "Medicare billing number." The proposal that these rejections would be non-appealable would further exacerbate the hardship created by the application of this provision to a physician who is attempting to enroll in the Medicare program for the first time. **We urge CMS to allow physicians who have submitted claims prior to receiving Medicare billing privileges to be afforded the opportunity to appeal a reimbursement decision once their enrollment has been approved.**

Under proposed section **405.874(c)(2)** we are pleased that CMS agrees that the carrier must notify the physician of the reasons relied upon by the carrier to deny or revoke the physician's enrollment. However, CMS states that a "provider or supplier's Medicare billing privileges *may be* handled by a carrier hearing officer not involved in the initial determination." (Emphasis added). The foregoing language is permissive and does not confer physicians with the right to review by an objective hearing officer. Language in the preamble appears to afford physicians an unambiguous right to appeal. **We urge CMS to clarify that this will in fact occur should the physician request it, rather than leaving it within the discretion of the carrier, which as currently written is how it could be interpreted.**

CMS proposes under section **405.874(c)(5)** to bar the introduction of new evidence by physicians at higher levels of appeals. It is possible that new evidence could become available only after the initial appeal request has been filed and heard. Therefore, a physician should be allowed to present new information at a later stage in the appeals process. Further, it is unclear how this section relates to section **498.56** on "Hearing New Issues," since under the latter section it provides that "[a]n ALJ finds good cause, for example, when the new evidence is material to an issue addressed in the reconsideration and that issue was not identified as a material issue before the reconsideration." **We urge CMS to permit physicians to introduce additional, new information that was not available at earlier stages of an appeal, during later stages in the appeals process.**

Under proposed section **405.874(d)(3)** CMS provides for reinstatement of a physician's billing privileges back to the date that the revocation became effective once a physician has successfully appealed revocation. However, under section **405(d)(4)** CMS proposes that where the denial of a physician's billing privileges is reversed, billing privileges should be established back to the date of the appeal decision. **We urge CMS to allow the billing privileges to be established no later than 60 days following the carrier's receipt of the physician's enrollment application.**

CMS proposes under section **405.875(h)(1)** that contractors have 180 days to process new enrollment applications. The AMA strongly opposes the length of time afforded contractors to process the applications. Six months is far too long for physicians to wait to enroll in Medicare. Many commercial payers enroll physicians in less than half that time. Furthermore, since Medicare prohibits physicians from submitting claims to Medicare until they have an active billing number, this presents a significant financial hardship for many physicians since they would be unable to bill for their work.

Additionally, although application processing timeframes are proposed in this regulation, they were already relaxed last year. Prior to publication of this proposed rule, CMS published Medicare Transmittal #134 on March 1, 2006, which extended the amount of time and percentage of applications which must be processed within specified timeframes. Prior to this time, CMS required carriers to process 90 percent of applications within 60 days and 99 percent within 90 days compared to the newly adopted standards which require them to process 80 percent within 60 days and 99 percent within 180 days. Given the transition to the Medicare Administrative Contractors (MACs), which are performance driven contracts, the standards by which they are measured should not be lower than what is currently required of the carriers. **The AMA urges CMS to return the application processing timeframes to those in effect prior to March 1, 2006.**

Section 424.510 – Requirements for enrolling in the Medicare program

The AMA understands CMS has chosen to interpret U.S. Treasury Department requirements as the basis for requiring physicians to receive reimbursement through Electronic Funds Transfer (EFT). According to these rules, the U.S. Treasury Department has adopted use of the Automated Clearing House (ACH) as the primary system for use by federal agencies conducting EFT.

As more physicians are required by Medicare to use EFT, we have heard increasing concerns about the parameters under which a Medicare contractor may recoup monies through EFT from a physician's bank account. While it is our understanding such situations are rather limited in scope the ACH rules are highly complex banking rules which are not clearly articulated under Medicare policy. For example, the agency's policy is not sufficiently clear regarding Medicare's treatment of situations involving "reversing entries" whereby a physician's bank account is debited in the case of an erroneous duplicate payment. **We have learned of situations where such recoupments have occurred with no notice, causing significant cash flow problems for physicians. We are encouraged that CMS has expressed a willingness to work with Medicine to address these concerns and we look forward to seeing this reversed entries policy narrowly defined in Medicare manuals.**

Section 424.525 Rejection of a provider or supplier's enrollment applications for Medicare enrollment

CMS has proposed to shorten from 60 days to 30 days the amount of time a physician has to furnish missing enrollment application information. The current 60 day requirements was part of the final regulation published last year in the *Medicare Program; Requirements for Providers and Suppliers To Establish and Maintain Medicare Enrollment; Final Rule*. CMS also acknowledged in the enrollment final rule that, "[c]ontractors may extend the 60-day period if the contractor determines that the provider or supplier is actively working with CMS to resolve any outstanding issues." Thirty days is an especially short timeframe given that it could often take more than this amount of time to obtain additional documentation requested by the carrier which is outside the control of the physician. The foregoing is particularly true for government and banking documents. We have similar concerns with CMS's proposal to reduce the length of time physicians would have to supply carriers with additional documentation from 60 days to 30 days.

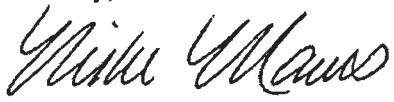
Finally, we are troubled by CMS's assertions that "approximately 70 percent of the submitted applications are incomplete or lack the supporting documents for enrollment," because it does not recognize a number of confounding factors that have contributed to this result that are outside the control of physicians such as backlogs created by a large number of CMS initiated changes to the enrollment process in 2006. Other delays are due to carriers losing documents and the inability of physicians to reach the carrier to obtain clarification on enrollment requirements. In an era when CMS has pledged to remove bureaucratic hassles associated with the enrollment process, these types of assertions are puzzling. **Furthermore, we urge CMS to retain the 60 day timeframe for allowing physicians to submit missing and additional enrollment information to the carriers as 30 days is inadequate.**

Section 424.535 Revocation of enrollment and billing privileges from the Medicare program

CMS proposes in **section 424.535(c)** that after a "provider, supplier, delegated official or authorizing official" has had their billing privileged revoked, they must wait three years before they can reapply for Medicare enrollment and billing privileges. The majority of reasons concern fraudulent and criminal wrongdoing, however, among the reasons a physician's billing privileges can currently be revoked is for "[i]nadequate reverification information" (section 424.535(a)(6)). We strongly oppose the application of this three year bar to a physician who has not submitted updated enrollment information within the current 60 day timeframe reestablishing Medicare billing privileges. Further, it is unclear whether CMS's proposed change under section 424.525 which calls for shortening the length of time to supply information, also applies to situations when a carrier is seeking "reverification information." If so, the AMA strenuously disagrees that 30 days is an adequate amount of time for a physician to compile the necessary documentation required for a reverifying enrollment information. Finally, while it appears CMS does not intend this provision apply to overturned revocations, it is unclear as written whether revocations which have been successfully overturned are included. **We urge CMS to: work with Medicine to establish an appropriate response time for physicians to supply a carrier with reverification information; exclude from the three year reapplication following revocation rule those physicians who were revoked as a result of "inadequate reverification information;" and specifically exclude revocations which have been successfully overturned, from this provision.**

The enrollment process remains a significant concern for physicians. The volume and degree of changes to the enrollment process over the past twelve months remain a significant challenge for practicing physicians due to the constantly changing rules and policies associated with it. The AMA appreciates the opportunity to share our comments and concerns with CMS. Should you have any questions please contact Mari Johnson at mari.johnson@ama-assn.org or (202) 789-7414.

Sincerely,



Michael D. Maves, MD, MBA

May 1, 2008

The Honorable Michael O. Leavitt
Secretary
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue S.W.
Washington, D.C. 20201

RE: May 23, 2008 National Provider Identifier Compliance Date

Dear Secretary Leavitt,

The undersigned organizations are writing to communicate our apprehension regarding the May 23, 2008, expiration of the National Provider Identifier (NPI) contingency plan. Specifically, we are concerned that significant claims processing and payment problems could result if health care providers are no longer permitted to include their legacy identifiers when conducting standard transactions after May 23rd. Based upon input we have received across the health care industry, while significant progress has been made to meet the NPI deadline, particularly over the last year, there remain entities that are still resolving implementation issues. **Therefore, we urge you to allow physician practices and others to continue to submit transactions that contain both legacy and NPI numbers for a minimum of six additional months after May 23. Furthermore, we urge you to closely monitor the readiness level of covered entities and take all appropriate steps necessary to ensure that the industry does not experience wide-scale disruption in claims processing and payment during this time.**

According to program officials, Medicare Part B claims are now processing at a rate of more than 99 percent following March 1, 2008, the date when the program began accepting claims with just the NPI or the NPI accompanied by a legacy number. However, Medicare has acknowledged that a relatively small subset— approximately 20 percent— of these claims are being submitted with just an NPI. Furthermore, the number of claims that have been submitted with just an NPI rose less than 5 percent in the past month. It is also unclear what percentage of claims physicians are holding while they work through any matching problems. With the May 23 deadline less than a month away, it is highly unlikely that the volume of claims being sent successfully with just an NPI will reach an acceptable level. Also, aside from claims transactions, the rate at which the NPI only is being included on other HIPAA transactions is likely even lower.

Following the March 1 deadline, physician practices that experienced reimbursement problems as a result of Medicare's inability to match their old legacy number(s) to their new NPI number(s) were in most cases instructed to re-enroll. While the undersigned organizations continue to harbor significant concerns with the requirement that physicians re-enroll in order to assist Medicare to establish a good "match," we are especially anxious with the pending May 23 deadline and the impact this could have on physicians still in the midst of the enrollment process. We also continue to hear from our members that carriers are providing conflicting or inaccurate information, with some members just now learning that they must re-enroll. While these issues may represent a small percentage of overall providers, in many cases these are small practices that simply cannot afford a cash flow interruption spanning a month or more. Once they have re-enrolled, they will also need time to send test claims to Medicare with just their NPI. We were pleased that Medicare has instructed the carriers to process any enrollment applications associated with NPI problems first, and believe that this practice should continue.

In addition to our concerns with Medicare, we are concerned about the readiness of clearinghouses and commercial payers. It is our understanding that the rate of claims that are being processed successfully with just the NPI by commercial payers is comparable to Medicare and thus is still very low. We have also heard the readiness level among state Medicaid programs varies. For instance, it is our understanding that New York State Medicaid has said they will not be ready to accept claims with just an NPI after the May deadline. In addition, some clearinghouses may be waiting until the May 23 deadline before beginning to submit claims with NPI only. This lack of testing could result in significant processing problems.

The rate of claims that are being submitted to payers with just an NPI may also be masking other readiness issues that may only come to light after May 23 — problems that could be averted if the rate of claims with just an NPI is substantially increased. For instance, some physician practices, especially the smallest ones, may have practice management systems that do not have the ability to submit claims with an NPI only to a payer(s) and claims with NPI plus the legacy number to another payer(s). This could present a real challenge for some practices if some payers are not ready by May 23. Practices that have not been using a clearinghouse would need to employ one or revert back to submitting paper claims if permitted.

With the above concerns in mind, we strongly urge:

1. **CMS delay enforcing use of just the NPI on claims and other HIPAA standard transactions and permit these transactions to be conducted with both legacy and NPI numbers for a minimum of six months following May 23 (November 23);**
2. **Medicare continue accepting claims and other transactions with an NPI number(s) accompanied by a legacy number(s) for at least six months following May 23;**
3. **CMS review and assess the rate of claims and other transactions being submitted successfully with just the NPI by Medicare, commercial payers and other public payers (and the rate of claims sent with the NPI only which are rejected) during the six month period following May 23;**
4. **CMS terminate any contingency plan if and only if it is apparent that the vast majority of claims are processing successfully with the NPI only; and**
5. **If the contingency timeframe terminates on May 23 as currently planned, that Medicare closely monitor the rejection rates and claims processing interruptions immediately following the deadline and be prepared to allow claims to be resubmitted with the NPI and legacy numbers together if there are significant interruptions.**

The undersigned organizations believe that the low volume of claims being processed with just an NPI number as well as the industry readiness feedback we have received point to the need for more time to continue to facilitate Medicare's ability to appropriately match a physician's old legacy identifier(s) to their new NPI number(s). We recognize that CMS does not want to extend the deadline, but we continue to be very concerned that the claims processing system will be interrupted and the impact that this could have on patient access to care.

We thank you for the opportunity to discuss our concerns and provide our recommendations.

Sincerely,

American Academy of Dermatology Association
American Academy of Family Physicians

American Academy of Neurology Professional Association
American Academy of Ophthalmology
American Academy of Otolaryngology—Head and Neck Surgery
American Academy of Pediatrics
American Association of Clinical Endocrinologists
American Association of Clinical Urologists
American Association of Neurological Surgeons
American College of Obstetricians and Gynecologists
American College of Osteopathic Internists
American College of Osteopathic Surgeons
American College of Physicians
American College of Radiology
American College of Rheumatology
American College of Surgeons
American Gastroenterological Association
American Medical Association
American Osteopathic Academy of Orthopedics
American Osteopathic Association
American Psychiatric Association
American Society for Gastrointestinal Endoscopy
American Society of Anesthesiologists
American Society of Hematology
American Society of Pediatric Nephrology
American Society of Plastic Surgeons
American Thoracic Society
American Urological Association
College of American Pathologists
Congress of Neurological Surgeons
Infectious Diseases Society of America
Medical Group Management Association
Renal Physicians Association
Society for Vascular Surgery
Society of Hospital Medicine
Society of Interventional Radiology
The Endocrine Society

May 20, 2008

The Honorable Michael O. Leavitt
Secretary
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue S.W.
Washington, D.C. 20201

RE: May 23, 2008 National Provider Identifier Compliance Date

Dear Secretary Leavitt:

The undersigned organizations are writing to strongly urge you to extend the contingency timeframe for the National Provider Identifier (NPI), which expires on May 23, 2008. We are seriously concerned that failing to extend the timeframe will result in enormous cash flow and claims processing interruptions if the NPI is the only identifier permitted on health care claims and other electronic transactions named under HIPAA.

Although we and our members have worked diligently and invested significant time and resources to comply with the NPI deadline, the health care industry is not well served by terminating the one year NPI contingency timeframe at this time. Doing so will only make what has been a complex undertaking, an exceedingly disruptive transition.

According to data from Emdeon, the nation's largest clearinghouse, the estimated financial impact of moving ahead with the May 23 deadline could be staggering. Based upon a sampling of a week's worth of professional claims, if the Department of Health & Human Services (HHS) terminates the contingency timeframe on May 23 and requires the NPI for all provider types possible in a claim, this could result in the rejection rate of almost 69.3 percent, on 10.5 million claims. Under this strict compliance interpretation, the 10.5 million claim sample could translate into $2.5 billion of rejected claims.

More time is therefore required to ensure the necessary foundation has been laid to switch to the NPI, continue the progress we have made already, and work together through the implementation problems as they are identified.

Therefore, we strongly urge HHS to:

- **Extend the contingency timeframe to allow healthcare providers, software vendors, clearinghouses, payers and others involved in this complex transition, additional time to continue working towards compliance;**

- **Continue working cooperatively with the stakeholders as a whole to ensure this transition moves ahead without wide scale cash and claims processing interruptions which could ultimately trigger access problems to the patients;**
- **Terminate the contingency plan only after consulting with the industry and when it is clear that the vast majority of claims are being processed successfully without interruption; and**
- **Extend the timeframe for required use of the NPI on other named HIPAA transactions given the transition issues associated with use of the NPI on claims persists.**

A more detailed analysis of Emdeon's findings can be found at http://www.emdeon.com/newsroom/npi_guidelines_industry_version.pdf. We appreciate the opportunity to bring this to your attention and welcome the opportunity to address our concerns in more depth.

American Hospital Association
American Medical Association
Medical Group Management Association

September 11, 2007

Kerry Weems
Acting Administrator
Centers for Medicare and Medicaid Services
200 Independence Avenue
Washington, DC 20201

Dear Mr. Weems:

The American Medical Association (AMA) and the Medical Group Management Association (MGMA) would like to express our concern over Medicare's recent decision to begin "turning on" the National Provider Identifier (NPI) edits on September 4, 2007. While it is important to ensure that Medicare is able to match the appropriate Medicare Provider Identification Number (PIN) to the correct NPI number**, we strongly urge you to reverse your policy and "turn off" and / or "leave off" the NPI edits until a more appropriate time.**

As the Centers for Medicare & Medicaid Services (CMS) is acutely aware, the magnitude of moving from using proprietary identifiers to the NPI is a change that has proven to be complex and costly for physician practices. We were especially disappointed to learn of Medicare's decision to turn the edits back on given that we were only made aware of this shortly before September 4.

There are two significant issues surrounding this recent decision that are cause for serious concerns because of the potential for massive claims processing problems. First, given the admitted complexity associated with matching the appropriate Medicare PIN to the correct NPI number, the potential for a mismatch is higher and the risk greater. This is an issue especially salient for medium to larger group practices where multiple Medicare PINs and NPIs are in use.

Second, NHIC, the California Medicare carrier, has identified at least 3,000 single, incorporated physicians in Northern California who will need to re-enroll in Medicare in order to obtain a group Medicare PIN so it can be associated with their Type II "organization" NPI number. Until 2003, the physicians were only assigned an individual Medicare PIN. Without the appropriate match between the organizational NPI required of any incorporated physician and the correct Medicare PIN, their claims will be rejected. Furthermore, many single, incorporated physicians remain confused about the need to obtain two NPIs.

This issue is of great concern. The NPI claims edits for NHIC are scheduled to be turned back on in mid-September and it takes a minimum of 60 days to get through the enrollment process. Simply put, this is an insufficient amount of time for physicians to begin compiling the documentation required for the lengthy enrollment process. The time to obtain a new PIN will exceed the time when the edits

become active. Furthermore, we are unclear whether the impact of the policy to assign an individual PIN only to incorporated physicians is limited to Northern California or whether this affects other physicians nationwide.

Unless physicians are given sufficient time to resolve the matching problems between the NPI and Medicare PINs, we fear thousands of physicians will experience claims delays and significant cash flow problems. Given the impact that turning the NPI edits on is expected to have on physician practices we are appealing to you to make the following changes immediately:

- **Redact the policy that calls for the carriers to begin turning the edits back on and institute a trial period for each of them that requires them to test the edits for one week in order to assess the impact on claims rejections volumes.**
- **Continue conducting widespread outreach to physician practices in Northern California to alert them to the need to apply for a group Medicare PIN.**
- **Work with us to identify whether other single, incorporated physicians nationwide will need to obtain a Medicare group PIN and conduct appropriate outreach.**
- **Give single, incorporated physicians a minimum of 90 days to obtain their PIN through the Medicare enrollment process, unless backlogs warrant a longer timeframe.**

We appreciate the opportunity to share with you our significant concerns and are eager to work with you to implement a policy that will allow physician practices to continue to work actively toward NPI compliance. Should you have any questions concerning this letter please contact Mari Johnson at (202) 789-7414 / mari.johnson@ama-assn.org or Robert Tennant at (202) 293-3450 x 1373 or rmt@mgma.com.

Sincerely,

American Medical Association
Medical Group Management Association

November 7, 2007

Mr. Kerry Weems
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Dear Administrator Weems:

Thank you for your response to our letter dated September 11, 2007 outlining concerns we have regarding the National Provider Identifier (NPI). The American Medical Association (AMA) and Medical Group Management Association (MGMA), however, are concerned that significant implementation problems persist five months into the Medicare's NPI contingency. We would like to take this opportunity to raise additional issues and offer the following four recommendations that we believe, if adopted, would assist practitioners transition more smoothly to this new identifier:

1. Implement a rapid and direct outreach plan with a special emphasis on small and rural practitioners;
2. Allow the carriers flexibility to ensure enrollment applications do not stall or result in unnecessary rejections;
3. Reconsider the revalidation process that began in October until the enrollment problems associated with Medicare NPI matching problems are thoroughly resolved; and
4. Carefully monitor and assess the industry's overall ability to use only NPI numbers by May 22, 2008, particularly the readiness of Medicare and those billing Medicare, before terminating the contingency plan.

The AMA and the MGMA are deeply concerned about Medicare's ability to appropriately "match" a physician's NPI number(s) to the appropriate legacy number(s); the requirements being placed on many practitioners to re-enroll; significant claims rejections practitioners are experiencing when there is a mismatch; and an overall lack of early and consistent information. With approximately seven months left until the May 22, 2008 NPI contingency plan deadline arrives, immediate outreach to physician practices is needed in order to avert further claims processing interruptions.

Until recently, when an appropriate match could not be made between a physician or group NPI to the appropriate legacy number(s) in the internal Medicare "crosswalk file," Medicare would pay the claim. Beginning September 3rd through the end of October, the Medicare carriers began putting NPI systems edits into place. We appreciate that Medicare, rather than electing to do a hard "cut over," chose to phase in the edits. Nonetheless, as you are aware, this has caused a significant number of claims to be rejected when a match cannot be made. Claims rejections spiked in some cases to more than 10% at carriers following the initial activation of the NPI edits. Although the matching problems in many cases were able to be resolved, a significant number of claim rejections are still occurring and we continue to receive numerous complaints. There can be significant financial implications for a single practitioner or small group practice who experience matching problems and the resultant claims rejections.

We are also concerned with the assertion made in your October 12th letter to us that practices were notified "three months ahead of the (crosswalk) bypass being lifted." While some practitioners received informational error codes on their remittance advice this summer, they were poorly explained, and insufficient outreach was completed. As a result, many recipients of this information did not fully understand their significance. We have been alerted to numerous situations in which practitioners received no error codes on their remittance advice but, nonetheless, are experiencing significant claims rejections resulting from matching problems. In addition, as explained in your October 12th letter, "contractors were directed to provide at least seven days advance notice of the bypass edits being lifted along with pertinent information to assist physicians and providers." One week notice, or even two, was simply not enough time to prepare practitioners, especially given the widespread misunderstanding of the significance of the informational edits. Furthermore, this did not give us an adequate amount of time to utilize our own internal communication channels before the edits went live.

Furthermore, single, incorporated practitioners continue to see significant matching problems and claims rejections. Efforts aimed at informing these practitioners early on that they needed an NPI, both for themselves and their corporation, was slow coming and inconsistently communicated. Frequently, these practitioners learned they needed two NPIs only after submitting an enrollment or change to enrollment application. Moreover, due to the way carriers enrolled single, incorporated practitioners in the past, an untold number of these practitioners were only assigned an individual PIN. It was not until after Medicare activated the NPI edits earlier this fall that single, incorporated practitioners with one PIN were instructed by Medicare to re-enroll to obtain a group PIN if they plan on billing Medicare with their Type II (corporate) NPI. We are unaware of any widespread outreach done on this prior to this time. We are also concerned that Medicare chose to wait to address these issues with practitioners until after the NPI compliance deadline – a decision which has complicated an already difficult transition.

The Medicare matching problems have been exacerbated by significant confusion surrounding what is expected of practitioners. In many cases, when practitioners have called their carriers for assistance with matching problems or for information on why their claims rejected, many are either unable to get through or the information regarding necessary enrollment steps they must take have not been readily forthcoming and often inconsistent. While some carriers have begun conducting outreach when matching

problems have been identified, much of this has happened only very recently. This type of targeted outreach was needed months ago, and Medicare should have instructed carriers to initiate direct contact with practitioners on these issues sooner. We also believe that significant matching problems have ensued as a result of earlier carrier PIN enumeration policies. Medicare's solution to this is for practitioners to re-enroll, a highly burdensome process that adds to already stressful situation when claims are not processing. Despite the advance notice concerning Medicare's recent decision to require NPI or NPI/legacy pairs on claims beginning March 1, 2008, we are concerned that this may not be a sufficient amount of time for practitioners who have been asked to re-enroll.

With respect to our concerns described above, we have four recommendations. **First, we strongly urge CMS to work quickly to implement a rapid and direct outreach plan with a special emphasis on small and rural practitioners.** This plan should include monthly phone calls for representatives of state, specialty and national organizations that represent practitioners. CMS should, in a timely manner, share clear and concise information impacting any future interim steps leading to the termination of their contingency plan. With Medicare's recent announcement that legacy only numbers will not be permitted on Part B claims after March 1, 2008 as well as the confusion surrounding the earlier information matching edits, we strongly urge Medicare to include more descriptive messages on remittance advice alerting practitioners when their NPI is missing and to the March 1 date. CMS should also host an increased number of roundtables to field questions, gauge readiness, and share information on Medicare's transition to the NPI. Continued direct carrier-to-practitioner contact is needed in order to resolve the matching problems. CMS should deploy additional, fully-trained, carrier enrollment and customer service staff to deliver prompt and consistent answers. As one example, NHIC, the carrier in Northern California, has assembled an internal team to troubleshoot physician NPI issues. Proactive steps like these are needed at every carrier.

Second, given the fact that an untold number of practitioners are being asked to re-enroll, we urge Medicare to allow the carriers flexibility to ensure enrollment applications do not stall or result in unnecessary rejections. We recognize and continue to communicate to our members the importance of a complete 855 enrollment application. Nonetheless, carriers need greater latitude in processing enrollment applications so as to avoid the 90 plus day backlogs seen at many carriers following the new enrollment process established in May 2006. Specifically, we urge Medicare to remove the rigid pre-screening process required under the current guidelines and revert back to the process in place prior to May 2006. This will allow for a more open exchange of information between carriers and practitioners and keep the enrollment process moving along. CMS should employ flexibility when minor errors or omissions are found on a physician's enrollment application.

Third, we strongly urge Medicare to reconsider the revalidation process that began in October until the enrollment problems associated with Medicare NPI matching problems are thoroughly resolved, as this will place further burden on an already strained enrollment process. Any revalidation efforts should be halted and resumed only after a web-based enrollment system is up and running. The current revalidation efforts began without appropriate education and little advance notice. It is unclear whether the previously identified communications problems between carrier provider

enrollment personnel and practitioners have been resolved. Without any assurances that this problem has been resolved, there is no way of ensuring that the appropriate personnel in each practice have received the revalidation letters. Given the significant penalties for failure to respond in a complete and timely fashion, it is critical to ensure that the current communication channels are functioning. Additionally, most medical groups, especially smaller ones, do not have dedicated enrollment staff whose sole function is to complete and process credentialing applications. Instead, most practices have one individual whose responsibilities include credentialing when necessary, which may be once every two or more years. This will result in the form taking additional time with increased potential for errors. Thus many practitioners will be completing new 855 applications to revalidate at the same time other practitioners are required to complete new 855 applications, leading to increased backlogs.

Lastly, we strongly urge CMS to carefully monitor the industry's overall ability to use only NPI numbers by May 22, 2008, particularly the readiness of Medicare and those billing Medicare. In making this determination, consideration must be given to how ending the contingency plan will impact those who may be entwined in the Medicare enrollment process and practitioners' ability to successfully submit claims to commercial payers. Practitioners have been working hard to become NPI compliant and we are pleased to learn that according to your figures, 84.78 Medicare Part B claims are being submitted with an NPI. However, the implications for terminating the contingency plan too soon could be especially crippling to some. Given the Medicare matching problems and the fact that many practitioners have had to revert back to using legacy numbers alone to get paid, we strongly encourage you to permit practitioners' use of legacy numbers only through the end of the contingency period.

In order to facilitate the appropriate internal matching needed in order for their claims to be processed, practitioners rely on information provided to them by their carriers. However, with a transition of this complexity, it is critical that practitioners receive clear information as soon as possible and that Medicare provide the carriers the appropriate resources and enrollment flexibility needed during this transition. We appreciate the opportunity to bring these concerns to your attention and your willingness to work with the physician community to ensure that the transition to the NPI goes as smoothly as possible. If you have any questions regarding our concerns, please contact Mari Savickis at mari.savickis@ama-assn.org or (202) 789-7414 or Robert Tennant at (202) 293-3450, ext. 1373 or rmt@mgma.com.

Sincerely,

American Medical Association
Medical Group Management Association

Michael D. Maves, MD, MBA, Executive Vice President, CEO

November 25, 2008

Mr. Kerry Weems
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Dear Acting Administrator Weems:

The American Medical Association (AMA) would like to thank you for your recent letter to the Editor of the *Los Angeles Times* demonstrating your commitment to assisting California, Nevada, and Hawaii physicians with the serious enrollment problems they are experiencing as a result of the transition to the National Provider Identifier (NPI) and the new Medicare Administrative Contractor (MAC), Palmetto. We appreciate that you acknowledged these problems and expressed your desire to see them resolved. As you continue to address this matter, we request that you address two areas of particular concern.

First, while physicians in these three Western states have been particularly hard hit by enrollment problems, there are many physicians nationwide who are in the same dire financial situation. We are aware of many physicians who are unable to meet their payroll or are late on payroll taxes, cannot make timely mortgage payments, are unable to pay their liability insurance, and have had to stop paying other key bills like phone service. For example, we have heard from a number of physicians in New York and Connecticut who are struggling financially. In some cases we have been told that the challenges physicians faced trying to get re-enrolled during the transition to the NPI was such a fruitless exercise that they are no longer taking Medicare patients. The current economic crisis faced by the nation is also being felt by physicians who tell us they are unable to secure revolving loans to help them while they await processing of their enrollment applications.

Second, certain criteria still could prevent many physicians from receiving advance payments. Since May, when the NPI became mandatory and physicians saw payment interruptions, we have urged physicians to ask their contractors for advance payments.

American Medical Association 515 North State Street Chicago Illinois 60610
phone: 312 464 5000 fax: 312 464 4184 www.ama-assn.org

Advance payments are not a solution for every physician as some may find the process of reconciling their books further complicated by such a payment. Despite the foregoing, as a result of significant cash flow interruptions and enrollment processing delays, many physicians are interested in advance payments. Unfortunately, all too often Medicare contractors are not aware of this option. In those cases where the contractors are familiar with advance payments, many physicians are denied them because they have not been billing in the past several months, something we understand is a key criterion in establishing a physician's eligibility. This is made even more frustrating since the precise reason physicians are having cash flow problems is because they are unable to bill while they wait to become re-enrolled. The AMA appreciates your instructions to Palmetto to streamline the process and relax the criteria for advanced payments for California, Nevada, and Hawaii physicians; however, it is critical that the same flexibility is afforded other physicians nationwide. To date, several contractor websites still contain no information about the advance payment option.

We request that you:

1. **Extend the same flexibility for advance payments for these physicians in the West, to all physicians nationwide who find themselves in a similar situation, by relaxing the aforementioned criteria;**

2. **Make all contractors and physicians experiencing NPI / enrollment problems aware of this option including posting this information on each contractor's website; and**

3. **Place a moratorium on the changes to the Medicare enrollment process as proposed by CMS in the physician fee schedule final rule with comment, until related physician payment delays are resolved nationwide as this is a significant factor contributing to these serious cash flow problems.**

We look forward to continuing to address these problems with your staff. Should you have any questions please contact Mari Savickis at mari.savickis@ama-assn.org.

Sincerely,

Michael D. Maves, MD, MBA

Statement

of the

American Medical Association

to the

Practicing Physicians Advisory Council

RE: Physician Quality Reporting Initiative
Medicare Physician Enrollment Medicare
Non-Payment for Healthcare-Associated
Conditions

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December 8, 2008

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Statement

of the

American Medical Association

to the

Practicing Physicians Advisory Council

Re: Physician Quality Reporting Initiative
Medicare Physician Enrollment
Medicare Non-Payment for Healthcare-Associated Conditions

December 8, 2008

The American Medical Association (AMA) appreciates the opportunity to submit this statement to the Practicing Physicians Advisory Council (PPAC or the Council) concerning the Physician Quality Reporting Initiative (PQRI), Medicare physician enrollment, and Medicare non-payment for healthcare-associated conditions (HACs).

PHYSICIAN QUALITY REPORTING PROGRAM

The AMA expressed strong concerns regarding implementation problems with the 2007 PQRI in our comments to CMS regarding the Medicare physician fee schedule proposed rule. We are extremely disappointed that CMS failed to address these concerns in the final rule.

According to CMS data, approximately 16 percent of physicians attempted to report on measures in the 2007 program, but only half of them received bonus payments. Further, feedback reports and bonus payments were not disseminated until 7 months after the reporting period ended, well after this information could be used by physicians to correct reporting procedures for either 2007 or 2008.

There is widespread confusion and no clear direction from CMS regarding why so many physicians were unsuccessful in reporting during the first year of the program. Without clearly understanding how physicians and eligible professionals can successfully report under the PQRI, it is nearly impossible to improve success rates. Yet, CMS is about to launch the third year of the PQRI program, and in the near future will make publicly available information about whether physicians' successfully participated in the PQRI. The AMA wants to help physicians succeed in participating in the PQRI, but as the program is

currently operating, that is nearly impossible. CMS must make changes now to assist physicians in successful PQRI participation. We sent the attached letter to the Centers for Medicare and Medicaid Services (CMS) in early November again urging CMS to work with the physician community to implement our PQRI recommendations, as set forth in the letter. **We urge PPAC to reiterate these recommendations to CMS.**

Further, the attached letter discusses the insurmountable hurdles to successful participation in the 2007 PQRI, as reported to the AMA in a September 2008 survey. **With such a troublesome start of the PQRI program, we urge CMS to conduct a formal, rigorous evaluation of the program to address and resolve its problems before expanding it further.**

The AMA also is disappointed that CMS continues to lack transparency in the PQRI measure selection and implementation processes. CMS failed to include certain measures recommended by the AMA-convened Physician Consortium for Performance Improvement (PCPI) in the 2009 PQRI and certain measures will only apply to registry-based reporting. Yet, the agency did not adequately explain its rationale for not including these measures or limiting application of some measures to registries only. **We reiterate our comments on the proposed physician fee schedule rule urging CMS to ensure greater transparency in all aspects of developing the PQRI program, especially regarding the measure and implementation processes.**

ENROLLMENT

The AMA urges PPAC to recommend that CMS withdraw the changes to the enrollment and appeals process contained in the physician fee schedule final rule until the chronic enrollment and related payment delays are resolved. The AMA is deeply disturbed by CMS' decision to move forward with significant changes to the Medicare enrollment process in 2009 at time when the system is strained beyond capacity and incapable of handling current workloads. Further magnifying these problems has been the transition to the National Provider Identifier (NPI). Unfortunately for physicians, because Medicare was unable to appropriately match enrollment data with the new NPI numbers, countless physicians across the country—even those who have been enrolled for decades—have been required to re-enroll in the program, further straining an already backlogged process. It is astonishing, given the systemic problems that have resulted from a series of changes that began in 2006 and have continued unabated through the NPI transition, that CMS is making even more changes to the program.

The AMA has repeatedly documented these problems for CMS, and has shared numerous individual physician issues with the agency. It is discouraging that the problems physicians have experienced could have been diminished if CMS had focused on a smaller subset of changes over the last several years. Instead, CMS has made so many changes to the process that neither Medicare contractor staff nor physicians are able to keep up.

The existing enrollment application processing delays are contributing to serious cash flow problems for physicians, problems that have been significantly amplified by the current

economic crisis. Physicians are reporting that they are unable to secure revolving loans to help them while they await processing of their enrollment applications. As the availability of credit and revolving loans for small businesses has shrunk dramatically, there has been a pronounced increase in the number of physician practices reporting that they are unable to meet their payroll, are late on payroll taxes, cannot make timely mortgage payments, are unable to pay their liability insurance, and have had to stop paying other key bills like phone service. In addition to a recent account of financial difficulties faced by physician practices in California, Nevada, and Hawaii by the *Los Angeles Times*, we have heard from a growing number of physicians, especially in New York and Connecticut, who are struggling financially. In some cases, physicians have said that attempting to get re-enrolled during the transition to the NPI was such a fruitless exercise that these physicians are no longer taking Medicare patients.

Since May, when the NPI became mandatory and physicians saw payment interruptions, we have urged physicians to ask their contractors for advance payments. Unfortunately, in many cases Medicare contractors are not aware of this option. Although CMS promised to make an advance payment option more widely publicized, to date this has not happened. Only a handful of Medicare contractor websites contain any information about advance payments, and when some physicians requested an advance payment from their contractor, they were told this option does not exist.

Complicating matters further is when contractors are familiar with advance payments, many physicians are denied this option because they have not been billing in the past several months, which we understand is a key criterion in establishing a physician's eligibility for advance payments. Yet, the precise reason physicians are having cash flow problems is because they are unable to bill while they wait to become re-enrolled. CMS recently instructed the contractor servicing physicians in California, Nevada, and Hawaii to streamline the process and relax the criteria for advanced payments. It is critical that the same flexibility apply nationwide.

Another problematic change that is scheduled to go into effect soon involves dramatically curtailing a physician's ability to retroactively bill while they are waiting for their enrollment process to be completed. While physicians are currently prohibited from billing Medicare prior to their enrollment, once enrolled, physicians, depending on their effective date of enrollment, may retroactively bill the Medicare program for services that were furnished up to 27 months prior to being enrolled to participate in the Medicare program. In the final rule, CMS has materially gutted a physicians' ability to retroactively bill. In its place, CMS has indicated that the eligibility date for billing will be the later of two dates: (1) the date of filing of a Medicare enrollment application that was subsequently approved by the contractor; or (2) the date an enrolled physician first started rendering services at a new practice location. The application filing date would be the date the contractor receives a signed enrollment application *that it is able to process to approval*. We have experienced, however, numerous instances where contractors send multiple applications back to a physician for picayune reasons. In other instances, contractors require physicians to re-file a new enrollment application when the physician has received inaccurate or incomplete guidance from their contractor or the contractor misplaces the physician's original

enrollment application and/or supporting documentation. Each time a physician is required to file a new application, the official application filing date is delayed, and this, in turn, delays the effective date of a physician's billing privileges. This will be extremely burdensome for a physician who begins treating Medicare patients when the physician files an initial enrollment application, but who subsequently may be barred for billing for those Medicare patients because the contractor unnecessarily requires the physician to continually re-file new applications (thereby establishing a delayed application filing date.)

In the past, this would create financial pressure, but the new rule will constitute a significant and substantial reduction in payment and also exacerbate tensions between physicians and contractors that have misplaced or otherwise provided inadequate guidance on the enrollment application process. These problems also will be exacerbated because contractors do not meet application processing standards and the MAC transition is still underway, with more transition challenges ahead. Further, there is some confusion surrounding when physicians may retroactively bill prior to the filing date of their enrollment application. The new enrollment requirements permit physicians to retrospectively bill 30 days prior to their filing effective date "if circumstances precluded enrollment in advance of providing services to Medicare beneficiaries." It is unclear what "circumstances" constitute those that "preclude enrollment" in advance of providing services to Medicare beneficiaries. We urge CMS to clarify this matter."

It is also unacceptable that CMS has established more stringent guidelines for physician enrollment when the Medicare contractors are not meeting the current standards in place today. Customer service lines are notoriously understaffed and staffed with inexperienced agents who are incapable of answering even the most basic questions correctly. This problem has been exacerbated by the transition to the MACs and the fact that contractors are unable to keep up with the relentless series of changes to the Medicare enrollment process. While we recognize that CMS has devoted additional resources to those contractors with the most problems, significant problems remain which must be resolved before more changes are made. CMS is starting to roll-out an internet-based enrollment system (PECOS web), which should ultimately mitigate lengthy application processing timeframes and backlogs. We are concerned, however, that as with any new large computer system roll-out, there will be glitches that will need to be overcome before optimal performance can be expected. Yet, relief for physicians in financial distress is needed now.

The foregoing underscores, especially in light of the current financial and credit malaise, that the existing delays in physician enrollment have already placed a growing number of physician practices on precarious financial footing. The application of the new enrollment and appeals process regulations will only increase the volume of work contractors must undertake to process new and updated enrollments when no additional recourses have been allocated for this work and despite the fact that there are currently insufficient resources to process the existing work load. We believe that application of the new requirements at this time will push an ever growing number of physician practices into financial distress. **Thus, we strongly urge PPAC to recommend that CMS:**

- **Withdraw changes to the Medicare enrollment process as proposed by CMS in the physician fee schedule final rule, until related physician payment delays are resolved nationwide, as this is a significant factor contributing to these serious cash flow problems;**
- **Increase flexibility for advance payments to physicians nationwide by relaxing the current criteria and take immediate steps to ensure that all contractors and physicians experiencing NPI/enrollment problems are aware of the advance payment option including posting this information on each contractor's website; and**
- **Continue to monitor physician satisfaction with the enrollment process and customer service lines and take appropriate actions to resolve problems with contractors identified as poor performers.**

MEDICARE NON-PAYMENT FOR HEALTHCARE-ASSOCIATED CONDITIONS

In the proposed Medicare physician fee schedule rule, CMS discussed that the Medicare non-payment policy for healthcare-associated conditions not present on admission (POA) in the hospital inpatient setting could be applied more broadly to other Medicare payment systems, including physicians' practices, the outpatient prospective payment system, ambulatory surgical centers, skilled nursing facilities, home health care, and end-stage renal disease facilities. CMS requested comments regarding application of this policy to other Medicare payment systems.

CMS acknowledged in the final physician fee schedule rule that it received many public comments raising concerns about the HAC policy, and its extension to physician practices. We are disappointed that CMS merely acknowledged these concerns, but failed to take them into consideration. Rather, CMS repeated its statement from the proposed rule that it "looks forward to working with stakeholders to expand VBP [value based purchasing] initiatives in all Medicare payment settings." CMS is holding a listening session to discuss the HAC policy with all stakeholders on December 9, 2008. The AMA will reiterate our grave concerns at that meeting.

As we discussed at the September PPAC meeting, the AMA strongly opposes non-payment for HACs in the inpatient or in any payment setting that are not reasonably preventable through the application of evidence-based guidelines, developed by appropriate medical specialty organizations based on non-biased, well-designed, prospective, randomized studies.

Our main concerns with the HAC policy and its potential extension to physician practices are:

- **CMS does not have the statutory authority to extend the inpatient HAC policy to other settings, including physician office practices.** Under the Deficit Reduction Act of 2005, Congress specifically provided CMS with the authority to begin applying the HAC policy to the hospital inpatient setting. If CMS were to extend this policy to other settings, it would likewise need similar statutory authority granted by Congress.

- **In developing the HAC policy, CMS confuses events that should never happen in a hospital, like wrong-site surgery, with often unavoidable conditions, like surgical site infections.** Medical conditions covered by the HAC policy should be reasonably preventable through the application of evidence-based guidelines. To be reasonably preventable, there should be solid evidence that by following guidelines, the occurrence of an event can be reduced to zero or near zero. Yet, there is strong, broad disagreement with CMS throughout the medical community that the conditions covered under the inpatient HAC non-payment policy are "reasonably preventable." The AMA continues to work aggressively to improve quality and efficiency for patients, but simply not paying for complications or conditions that, while extremely regrettable, are not entirely preventable is not effective or good for patients or the Medicare program.

- **The HAC policy will increase Medicare spending on tests and screenings with questionable benefit to patients.** The HAC policy requires hospitals to ensure that certain medical conditions are not present on admission. To determine whether a condition exists when the patient enters the hospital will increase Medicare spending on tests and screenings with questionable benefit to patients. This could also delay needed care, with possible increased risk for patients due to the delay.

- **Expanding the inpatient HAC nonpayment policy to other settings would be extremely problematic, especially in physician offices, because the payment approach is completely different from the hospital setting.** For example, the appropriate level of an evaluation and management service is based on the conditions managed at a given encounter and the time and intensity of the work associated with those conditions. Because the presence and severity of additional conditions that are present during the visit will vary greatly among patients, identifying and valuing the work attributable to a preventable condition managed by the physician at a visit would be very difficult. In addition, the lack of adequate risk adjusters is an even greater problem in physician practices than in hospitals because some physicians specialize in treating the riskiest patients and do not have the ability to make up for losses on these patients through care of patients with below-average risks. Further, patient compliance outside of the physician office setting would be extremely difficult to assess and monitor, which also could seriously hamper any risk adjustment techniques. **Since many factors outside of a physicians' control could cause a patient to acquire various conditions while under a physician's care, CMS should instead encourage compliance with evidence-based guidelines rather than extending the HAC policy.**

- **CMS should conduct an analysis of the current inpatient HAC policy, in consultation with technical experts, physician organizations, hospitals and other impacted providers. This analysis must occur before extending this approach to other settings.** It is unacceptable that CMS is considering expansion of the inpatient HAC policy when the agency has not yet conducted any analysis of: (i) the impact of the current HAC inpatient policy with regard to such concerns as: impact on the quality of care delivered to patients, especially in proportion to the additional costs to the Medicare program required to comply with the HAC requirements; (ii) the need for

appropriate risk adjustment techniques; (iv) how to determine attribution issues with respect to when, where and why a condition has occurred; and (iii) the reasonable number of expected incidences in which these conditions will occur in individual hospitals, especially with regard to high-risk patients, when evidence-based guidelines are followed.

It defies any logical rationale to extend an approach to other settings when it is not clear that the approach achieves its quality improvement goals and, in fact, may cost significantly more money in proportion to overall program benefits and delay or deny access to needed care for patients.

The AMA appreciates the opportunity to comment on the foregoing, and we look forward to continuing to work with PPAC and CMS to resolve these important matters.