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August 30, 2012

The Honorable Max Baucus
Chairman
Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Orrin Hatch
Ranking Member
Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Baucus and Senator Hatch:

On behalf of the physician and medical student members of the American Medical Association (AMA), I am writing in response to your request for our suggestions regarding how to transition to a new Medicare physician payment system. We appreciate your continued efforts to address this issue and the work that the Committee has conducted this year through the series of roundtables on Medicare physician payment reform.

During the July 11, 2012 roundtable, which examined physician perspectives on this issue, you called for the repeal of the failed Sustainable Growth Rate (SGR) formula and for physicians to lead the way in instituting new systems that promote high-quality, high-value care. We agree that we must immediately begin to implement changes that will transform care delivery in Medicare, and that the first step in this effort must be to stabilize the program by repealing the SGR formula.

Physicians must play the leading role in implementing new systems in Medicare that will re-focus the delivery system on quality and value, rather than volume. As we emphasized during the roundtable, a flexible approach, rather than one-size fits all, is needed during the transition to a new system, including a menu of options to best address the needs of a particular practice, depending on the specialty, practice type, capabilities, and community needs and resources. In order to facilitate the transition, Medicare must aggressively test new payment and delivery methodologies and make those that are successful widely and immediately available to all physicians. Medicare must also integrate successful models being implemented in the private sector and partner with other payers to ensure that these reforms can be implemented across the full patient population of a given practice rather than solely on one segment of its patients.

Ultimately, we anticipate that a new delivery system must account for the wide differences in physician practices, both structural and geographic. As such, a new delivery system will

incorporate multiple solutions, and include a menu of the successful innovation options, accounting for varying physician practice types and allowing practices to participate in an option most scalable to their practice.

Congress and Centers for Medicare and Medicaid Services (CMS) can take immediate steps to help transition to a new Medicare physician payment and delivery system. Existing laws and regulations can be adapted to better facilitate fundamental delivery reform, instead of acting as barriers to reform. Below are several recommendations that Congress can act upon to facilitate testing of and physician participation in new payment models. We believe the following suggestions will help transition the Medicare payment and delivery system to one that promotes quality and efficiency:

- **Congress should direct CMS to initiate a process for cataloging models being tested or that have been tested, identifying gaps in available models relative to certain physician practice types, and for working with the private sector to identify and initiate testing of new models.**

    - As we discussed in our written testimony, the Center for Medicare and Medicaid Innovation (CMMI) is rolling out a number of alternative payment and delivery models. **The CMMI should expand the initiatives being tested, including the payment advances under the CMMI *Advanced Payment Initiative.***

    - CMS should be required to issue an annual report to Congress on that status of testing and implementation of all new payment models (including work of CMMI). This should catalog all pilots and demonstrations, their results, and the status of any models that are being implemented subsequent to testing.

        - The report should include a work plan for upcoming testing/piloting of new models.
        - The report should identify, based in part on CMS' dialogue with physician organizations, gaps in the types of physician practices that remain without opportunities to participate in new models. This assessment should be based on specialty, practice size, geography, practice business model, and other appropriate physician practice characteristics.

    - CMS should be required to develop an annual process for soliciting input from state and specialty societies on suggestions for new models and bundles to be piloted and tested, as well as on existing gaps in available models for certain physician practice types. CMS, working in conjunction with physician organizations, should establish criteria for selecting which proposed models should be tested, and begin the process of testing the models that meet such criteria.

- **Congress should require that CMS and CMMI make opportunities to engage in new models available on a rolling basis so physician practices can plan for the needed changes and join as they become ready.** To date, those wishing to participate in new Medicare payment and delivery reform pilots have been required to respond to requests for applications made available on a one-time basis with a short turnaround time. It is difficult to plan ahead for these announcements and organize the projects and resources necessary for a successful proposal. **Expanding enrollment opportunities will increase overall physician participation in new models, and will significantly aid the transition for small, solo and rural practices.**

- **CMS feedback to physicians must be significantly improved. To help achieve this goal, Congress should require CMS to modernize its Medicare data systems so the agency can bridge significant gaps in efforts to transition to alternative models.** Currently, because of its antiquated data systems, CMS has had great difficulty providing timely incentive payments and feedback reports, as well as actionable, real-time data to physicians that is correctly attributed, appropriately risk-adjusted, and relevant. These are key elements in effectively implementing quality improvement programs.

    - Providing timely data on individual patients to physicians is critical so they can verify the accuracy of performance reports and more accurately engage in data-driven decision-making.
    - CMS should be able to confidentially provide physicians with data that enables them to compare their own statistics with those of other practices in their communities or other areas.
    - **Modernized systems that would allow for measure reporting and feedback to occur at least quarterly would allow for opportunities for improvement before the reporting year ends.**

- **Congress should provide Medicare funding to CMS for quality measure development, testing, and maintenance, along with review and endorsement of measures**. In recent years, Congress has directed CMS to implement various quality reporting and value-based purchasing programs including, for example, the Physician Quality Reporting System (PQRS), Physician Resource Use Feedback Program, and Physician Value-Based Payment Modifier. These programs are intended to improve quality of care while helping to transition to a new Medicare delivery and payment structure. The development, testing, and maintenance of evidence-based quality measures, along with measure endorsement, review, and recommended selection, are critical aspects of these programs. This creates a continuous pipeline of endorsed measures, including advancement to subsequent generations of measures, such as outcomes or efficiency measures. We recommend that Congress provide stable funding to create a robust pipeline of quality measures to support federal and private sector efforts

focused on transforming health care delivery and payment systems.

- **Medicare Funding for Measure Development, Testing, and Maintenance.** To ensure a stable source of funding for quality measure development, testing, and maintenance that can support the various quality reporting and value-based purchasing initiatives as well as emerging payment and delivery models, Congress should authorize $10 million in Medicare funding annually in FY 2013 through 2017.

- **Streamlined Medicare Funding for Measure Review, Endorsement, and Input on Use.** Congress should initially provide a two-year extension of current Medicare funding [authorized in the Medicare Improvements for Patients and Providers Act (MIPPA)] for the National Quality Forum (NQF) to review and endorse quality performance measures as well as provide input into the development of national quality strategies. NQF received $10 million in Medicare funding annually for FY 2008 through FY 2012 for these activities. Congress should extend such funding through FY 2014 to ensure that NQF can continue the important work of reviewing and endorsing quality measures for use across public and private programs.

  The Affordable Care Act (ACA) authorized new functions for improving how quality measures are implemented for use. These included requiring a consensus based entity (i.e. NQF) to convene multi-stakeholder groups to review and provide pre-rulemaking input to policymakers on appropriate measures for use in federal quality initiatives. The ACA provided $20 million in Medicare funds annually for FY 2010 through FY 2014 for these activities, as well as key measure endorsement related activities.

  Starting in FY 2015, the funding streams established under the two separate laws for quality measure review and endorsement-related activities and for convening multi-stakeholder groups to review and provide input on measure use should be combined at the level of $30 million in Medicare funding annually from FY 2015 through FY 2017.

  This streamlined funding would make it easier for policymakers and stakeholders to oversee the resources and activities undertaken by the funding. It would also ensure stable funding for the critical work of reviewing and endorsing quality performance measures as well as providing input on national quality strategies and maintaining/updating quality measures that need to be revised based on new research and clinical information.

- **Congress should require CMS to establish models that coordinate Medicare and private payers' efforts.** Multi-payer initiatives hold much promise when Medicare and private payers align their programs so physicians can implement reforms in the way they deliver care to all their patients, with a consistent set of financial incentives and quality metrics. For example, CMMI and the private sector are currently collaborating in the Comprehensive Primary Care Initiative to improve care coordination among advanced primary care practices. **Congress should require CMS to establish other initiatives, modeled on existing ones such as the BCBS Alternative Quality Contract, that engage physician specialties beyond primary care and include a range of settings—in cities and rural areas, and for large and small group practices and solo practitioners.**

- **Congress should require CMS to establish models that focus on limited bundles for physicians' services or episodes of care (with warranties) and care coordination/case management activities, with limited up-front risk for physicians.** For example, physicians should be able to propose bundled payments for chronic conditions like diabetes, hypertension, or inflammatory bowel disease even when there is no hospitalization involved. This approach was recommended to the Committee by former CMS Administrators.

- **Congress should require CMS to implement certain PQRS improvements.** In 2010, 24 percent of Medicare eligible professionals participated in the program, and 69 percent of those professionals successfully received an incentive payment. Certain steps should be taken to improve these percentages:

    - **Congress should require CMS to reduce the number of measures required for inclusion in a PQRS measures group to a minimum of three measures, rather than four.** This would expand the number of measures groups and allow physicians to further focus quality performance activities on clinical conditions relevant to their practice.

    - **Congress should also provide CMS with the authority to establish a process that allows physicians and other eligible professionals to be deemed successful PQRS participants if they successfully participate in other meaningful quality improvement activities.** Some physician practices report on specific quality measures to facilitate improved patient outcomes at the local level, through a regional health improvement collaborative or state-initiated health care improvement programs. Many of these efforts have been successful, allowing these practices to appropriately measure and improve upon those health care services and treatments most relevant to their communities, *e.g.,* diabetes, oncology care and HIV. CMS should have the authority to identify a deeming

entity, such as Quality Improvement Organizations, that would determine if a physician practice successfully participated in a regional or local quality improvement program. If so, CMS could deem these practices as having met the requirements for the PQRS and meaningful use programs. A deeming process would allow meaningful quality improvement efforts at the regional and local level to move forward unencumbered by conflicting federal requirements.

- **Congress should direct CMS to initiate a public/private partnership for the purpose of validating risk adjustment and physician attribution models.** Two of the biggest barriers to assessing quality of care are risk adjustment and attribution of care to the appropriate physician. It is critical that there are not any disincentives for physicians to treat higher risk patients or more complicated cases. Under new models, it should be possible for risk-adjusted provider comparisons to be made at several levels (organizational, local, regional, and national) factoring in the issue of small sample sizes for many specialties. It is also essential that in making these comparisons, physicians are only held accountable for the care for which they were properly responsible.

- **Certain existing laws and regulations are not compatible with many new payment models.** These laws include the physician self-referral law (or "Stark law"), the federal anti-kickback statute, the civil monetary penalties (CMP) law prohibiting hospital payments to physicians to reduce or limit services (gain-sharing CMP), and the CMP prohibiting beneficiary inducements. **Based on the flexible approach taken by CMS/Office of Inspector General (OIG) for the Medicare Shared Savings Program (MSSP), Congress should waive these laws and regulations when they post barriers for physicians who seek to engage in and lead innovative delivery models that promote quality, increase coordination, and reduce costs. Congress should also require the current waivers for electronic health records (EHRs) be made permanent, instead of allowing them to expire in 2013.** Currently, when a hospital provides physician practices with EHR systems, this permissible donation does not run afoul of the Stark law and the Medicare anti-kickback statute under a temporary safe harbor that is in effect through 2013. Congress should make this waiver permanent since this would foster EHR adoption.

- **The AMA recommends that Congress authorize a U.S. Government Accountability Office (GAO) report on the status of efforts to make EHRs interoperable and establish standards to enable health care providers to exchange and have access to real-time clinical data on their patients.** The AMA supports the use of health IT in a manner that best supports medical practice efficiencies and enables physicians to provide better care to their patients. However, we have significant concerns with EHR usability and interoperability, as well as the lack of robust health information exchanges. One of the most compelling reasons for physicians to use EHRs and other health IT tools is their

ability to exchange data with other health care providers in order to improve the continuity and quality of patient care. Unfortunately, the vast majority of physicians today are not in a position to exchange data because the underlying infrastructure for exchanging data is spotty at best.

The GAO report should address the barriers to the electronic exchange of clinical data, including the need for costly customized electronic health record interfaces as well as privacy and security concerns. Finally, the report should include immediate recommendations for the Office of the National Coordinator for Health Information Technology to speed up the availability of interoperable EHRs.

We thank you again for your continued commitment to transforming the delivery system to improve the quality and value of care for Medicare beneficiaries. As physicians, we too are dedicated to ensuring that every patient receives the best possible care. These reforms will not happen overnight, but change must begin now. We look forward to continuing to work with you on this critical endeavor.

Sincerely,

Ardis Dee Hoven, MD.

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cc: Senate Committee on Finance