AMA
AMERICAN MEDICAL ASSOCIATION

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The Honorable Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Sebelius:

I am writing to follow-up on a conversation that you had at the recent World Health Organization meeting with American Medical Association President Jeremy Lazarus, MD. On behalf of the physician and medical student members of the American Medical Association (AMA), **I am writing to urge you to: 1) streamline the Stage 2 Meaningful Use (MU) requirements; 2) increase the alignment of physician quality performance reporting mandates; and 3) work with stakeholders to find ways to mitigate the impact of the ICD-10 transition on practicing physicians.** Congress has passed multiple Medicare and Medicaid reporting requirements under separate laws affecting physician practices that carry significant financial penalties for non-compliance. These include e-prescribing, MU, the Physician Quality Reporting System (PQRS), and the Value Based Modifier (VBM) programs, which are connected to present and future financial penalties, if physicians fail to successfully fulfill reporting criteria. These overlapping penalties coupled with the costly transition to ICD-10, will deliver a devastating financial blow to stressed physician practices.

Taken together, these reporting mandates represent a tidal wave of overlapping requirements; better coordination could reduce administrative burdens on physicians while still accomplishing the intended goals. To further illustrate our concern, we have enclosed a table and timeline to illustrate the combined impact of the multiple financial penalties associated with various federal programs that physicians will be facing all at once if they do not successfully participate in these programs.

Greater Flexibility Needed to Meet Stage 2

The AMA is pleased that you decided to extend Stage 1 MU an additional year through 2013 and not engage in rulemaking for Stage 3 this year. Nonetheless, we have serious concerns with the MU program.

We firmly believe that unless more flexibility is infused into Stage 2 requirements of MU that many physicians – including physicians who have already received incentives under Stage 1 – will be unable to meet them and, as a result, we will fail to meet our shared goal of widespread adoption and use of electronic health records (EHRs).

Meeting Stage 2 MU requires far more than a mere 20 requirements as posited by the Department of Health and Human Services (HHS). Many of the MU requirements contain requirements within requirements. For example, the clinical summary requirement calls for physicians to provide clinical summaries to patients within one business day for more than 50 percent of office visits. It also requires the summary to include 26 additional pieces of information, including but not limited to, current problem list, current medication list, current medication allergy list, procedures performed during the visit, immunizations or medications administered during the visit, vital signs taken during the visit (or other recent vital signs), laboratory test results, and list of diagnostic tests pending. When broken down, the "20" Stage 2 MU requirements are akin to more than 125 requirements. Certain requirements also require that physicians engage in time-consuming manual processes, such as keying in lab results if they cannot afford an expensive interface. Exceptions are detailed, multi-faceted and inflexible – in almost all cases every parameter must be met to qualify for an exception. While a few exceptions are permitted, the program offers little flexibility. If even a portion of one measure is missed the physician will fail to qualify. If a physician misses a requirement, if even by a fraction, it does not mean they are not using their system in a meaningful manner – but it does mean they miss out on the incentives. This not only reduces their ability to help defray the costs of EHRs, but it also puts them at risk of incurring a penalty. Furthermore, physicians who have been audited and found to have missed a measure(s) or portion of a measure(s) have seen their entire incentive payment recouped.

The AMA also remains very concerned that the current MU requirements are too primary-care centric. Primary care physicians have traditionally been among the earliest adopters of EHRs, while the rate of adoption among specialists has been lower. A recent *Health Affairs* article found that over the past decade (2002-2011) physicians 55 and younger, those in practices of ten or more, and practices that were not owned by physicians all saw higher rates of EHR adoption. It is unworkable to continue a policy that is overly primary-care centric, does not provide an exemption for physicians who are close to retirement, and does not provide more flexibility for small practitioners. Unless more flexibility is added to the program, many physicians will simply "check the box" for measures that have little if any applicability to them or their patients, stop seeing Medicare patients, decide it is more cost effective to take the penalty than to comply with the requirements, or simply retire early. All of these results run contrary to the underlying concept of "meaningful use."

We also continue to hear several common complaints from physicians concerning their EHRs. The AMA does not dispute that the use of well-developed and thoughtfully implemented EHRs undoubtedly can help drive higher quality and greater efficiency in care delivery. What is creating a significant cause for concern, however, is that certified systems physicians are required to use to meet MU are often clunky, hard to use, and poorly designed for their needs. This is also challenging physicians' ability to comply with the requirements.

According to the American EHR survey, an annual survey designed to identify clinician needs associated with enhanced access to electronic health information, between 2010 and 2012 the percentage of doctors who would not recommend their EHR to a colleague increased from 24 percent to 39 percent. Approximately one-third of all surveyed also said they were "very dissatisfied" with their EHR and that it is becoming more difficult to return to pre-EHR productivity levels. Vendors are not required to meet usability standards for Stage 1 and while Stage 2 contains some, it is far from what is truly needed to ensure systems are being developed to meet physicians' needs.

The AMA therefore urges you to:

1. **Change the requirement for having to meet 100 percent of Stage 2 requirements to 75 percent;**
2. **Instead of recouping an entire incentive following an audit, recoup an amount that is proportionate to the MU requirements that the physician was deemed not to have met (i.e., recoup 10 percent when one requirement is missed);**
3. **Exclude physicians who are near retirement from penalties (i.e., physicians who are currently eligible for Social Security benefits or who will be eligible for Social Security benefits by 2014); and**
4. **Provide a hardship exemption for small practices (i.e., those under 10 FTEs) so they have more time to adopt EHRs before being affected by penalties.**

Greater Quality Reporting Alignment Needed

We appreciate the efforts made to date by the Centers for Medicare & Medicaid Services (CMS) to further align the reporting requirements associated with clinical quality measures reporting in MU and PQRS programs. However, we believe that the discretionary authority provided by Congress enables you to develop more ways to better synchronize these programs, thereby reducing the administrative and financial burdens these overlapping requirements have on physicians. **Further aligning reporting requirements across and within the multiple federal performance programs will help improve patient access to care, and minimize the aggregate financial and administrative blows to physician practices as they grapple with rising practice costs and physician payments that are only two percent higher than they were in 2001.**

One specific area in need of further attention is the alignment of the Physician Group Practice Reporting Option (GPRO) within MU. Starting in 2014, group practices have the option to report quality measures at the group-level using their EHR. The single data submission could meet the clinical quality measures (CQM) reporting requirement of MU and satisfy the reporting requirements for the PQRS GPRO. The VBM program requires most large group practices to participate in the PQRS GPRO or face a penalty. As a result, many physician groups are currently evaluating how two different group reporting options, the GPRO web Interface and the GPRO EHR, will align with the MU program. While CMS has outlined a general framework for how these reporting programs will align, many details still need to be clarified. In the interim, many physician practices face serious questions about what reporting option they should work to adopt, and which will enable them to successfully avoid the penalty and prevent unnecessary disruptions to patient care**. The AMA urges CMS to work with relevant physician stakeholders, especially those participating in the GPRO, to identify implementation options that support the alignment of a single data submission for satisfying the CQM reporting requirements for PQRS, MU, and the VBM.**

Mitigating Impact of ICD-10 on Practicing Physicians

The AMA appreciates your decision to delay the implementation date of ICD-10, by one year to October 1, 2014. However, despite the delay, it still comes at a time when physicians are currently spending significant time and resources, and experiencing declining productivity, in implementing EHRs into their practices, and undergoing practice work flow redesigns to ramp up their reporting

efforts related to the PQRS and VBM programs. Requiring physicians to make the costly investment needed to comply with ICD-10 competes for other valuable resources needed to meet health IT and quality requirements, and their bandwidth to accomplish all of these activities is limited. This also is occurring against the backdrop of Medicare payment rates that are falling farther below practice cost inflation each year because of the Medicare sustainable growth rate formula (SGR).

To be clear, implementing ICD-10 is not just a technology project. It will impact most business processes within a physician's practice, including verifying eligibility, obtaining pre-authorization for services, documenting the patient's visit, research activities, public health reporting, quality reporting, and, most of all, submitting claims. Implementing ICD-10 requires physicians and their office staff to contend with 68,000 diagnosis codes – a five-fold increase from the approximately 13,000 diagnosis codes that these utilize currently. This is a massive administrative and financial undertaking for physicians, requiring education, software, coder training, and testing with payers. As required under Health Insurance Portability and Accountability (HIPAA), physicians are responsible for complying with this ICD-10 mandate, and therefore must bear the entire cost of such a transition, without any financial aid from the government, despite the fact that there will be no return on investment for them.

Depending on the size of a medical practice, the total cost of implementing ICD-10 ranges from $83,290 to more than $2.7 million. The CMS has expressed interest in finding ways to mitigate the impact ICD-10 will have on physicians. Since cost estimates of inefficient health care claims processing, payment and reconciliation are between $21 and $210 billion dollars, it seems prudent and fair to look for ways to mitigate the cost ICD-10 is expected to have on physicians in other areas involved in the claims processing and adjudication system. **We are pleased to offer the following ideas on ways to help offset this costly change:**

1. **Retool Medicare's "advance payment policy."** According to Medicare's own analysis claims processing disruptions pose one of the biggest risks associated with moving to ICD-10. Medicare's current policies on advance payment are convoluted and inflexible. A more flexible policy is needed to accommodate situations such as ICD-10 and other HIPAA transitions where the risk of claims processing and cash flow interruptions is great. Also, to be clear, the term "advance payment" suggests a cash advance, which it is not. It is simply requesting Medicare reimbursement for services *already* delivered to a patient but were unable to be paid through the normal payment process. We have met with CMS staff and will provide additional ideas on how this could best be achieved.
2. **Commit Medicare to reducing the number of requests for additional information/attachments.** Medicare has stated in numerous forums both written and orally that the move to ICD-10 is expected to result in fewer requests for attachments and additional information to substantiate claims before physicians can be reimbursed. We urge CMS to formally adopt a policy that states when the most specific ICD-10 code is submitted by a physician no additional information will be required to adjudicate the claim.
3. **Mandate uniform set of payment rules and edits.** Payers adjust claims based upon their own payment rules, which adds confusion for physicians when determining payer and patient responsibility due to variations in multiple procedure reduction, bilateral, assistant at surgery, global services rules, etc. At the same time, payers also adjust claims according to custom edit packages or payer-specific coding rules. Uniform rules are needed to streamline this process and reduce the back and forth that happens today between physicians and payers.

4. **Medicare pilot test X12 standards to achieve more efficient use of prior authorization.** Prior authorization is a practice many payers, including Medicare, are increasingly using. Yet, currently there is no standard way for physicians and payers to complete prior authorization from beginning to end. This results in a time consuming and administratively burdensome process for physicians who on average contend with approximately 20 different payers. HHS has already adopted several X12 standards including the 278 (referral and prior authorization) and 270/1 (eligibility and response) that can be used to help facilitate prior authorization in combination with the X12 275 standard (attachments - not yet named under HIPAA). The AMA has shared some of these ideas with CMS but would welcome the opportunity to have an in depth conversation on how Medicare could pilot test this approach.
5. **Utilize the Regional Extension Centers (RECs) to help educate and train physicians on ICD-10.** The RECs, as established and overseen by the Office of the National Coordinator (ONC), have been tasked with helping certain physicians select, implement, and begin using EHRs to meet the MU requirements. The RECs already represent "boots on the ground" and could be a valuable resource to help physicians prepare for ICD-10. Other countries such as Canada have provided assistance to providers when they moved to ICD-10 and their transition was substantially less complex than the one in the U.S.
6. **Adopt coding guidelines for all HIPAA-adopted code sets.** The only code sets to have their guidelines (which dictate how each code should be used) adopted under HIPAA are ICD-9 and ICD-10. Requiring CMS to adopt the coding guidelines of other named code sets would ensure that the use of each code means the same thing to everyone in the industry, would bring much needed uniformity to the claims processing process, and would generate cost savings.
7. **Mandate claims acknowledgments.** Implementing a standard claim acknowledgment for the whole industry will assist physicians in identifying claims that are being rejected as early as possible. This will minimize resubmission delays for the related claims and help to shorten the claim revenue cycle.

HHS has an opportunity to ease the burdens on physician practices by making these suggested changes. In the wake of this onslaught of overlapping regulatory mandates and reporting requirements, we welcome the opportunity to discuss all of these ideas in more depth. Thank you in advance for your attention to these urgent matters. Please feel free to contact Margaret Garikes, Director of Federal Affairs, at margaret.garikes@ama-assn.org or 202-789-7409 for more information.

Sincerely,

James L. Madara, MD

Attachment
cc: Jeremy A. Lazarus, MD

Incentives and Penalties

Year	Deficit Reduction Sequester	E-Prescribing	Health Information Technology	Physician Quality Reporting System, including Maintenance of Certification (MOC) Program	Value-Based Modifier (Budget neutral increases and decreases in payments based on cost/ quality data measures with 2-year time lag)
2009		**2%**		**2%**	
2010		**2%**		**2%**	
2011		**1%**	**$18K**	**1% if no MOC; 1.5% if MOC**	
2012		**1% (-1%)**	**$12-18K**	**0.5% if no MOC; 1.0% if MOC**	
2013	**(-2%)**	**0.5% (-1.5%)**	**$8-15K**	**0.5% if no MOC; 1.0% if MOC**	
2014	**(-2%)**	**(-2%)**	**$4-12K**	**0.5% if no MOC; 1.0% if MOC**	
2015	**(-2%)**		**$2-8K (-1%)**	**(-1.5%)**	Applied to large groups
2016	**(-2%)**		**$2-4K (-2%)**	**(-2%)**	Applied to large groups
2017	**(-2%)**		**(-3%)**	**(-2%)**	Applied to all physicians
2018	**(-2%)**		**(-3%)**	**(-2%)**	Applied to all physicians

Note: ICD-10 implementation begins in October 2014, with significant impact on practice workflow and cashflow expected