AMA
AMERICAN
MEDICAL
ASSOCIATION

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

April 30, 2010

Marilyn Tavenner
Acting Administrator
Jonathan Blum
Deputy Administrator
Centers for Medicare and Medicaid Services
200 Independence Avenue, SW
Room 314G
Washington, DC 20201

Dear Ms. Tavenner and Mr. Blum:

I am writing on behalf of the American Medical Association (AMA) to ask that the Centers for Medicare and Medicaid Services (CMS) consider including important and necessary policy changes in the 2011 Medicare physician payment schedule rule. These changes are needed to address serious shortcomings in the Physician Quality Reporting Initiative (PQRI) and the Medicare Economic Index (MEI).

As the AMA has stated in numerous comment letters over the years, the MEI has become woefully outdated. We had hoped that when CMS modified the MEI productivity adjustment several years ago it would lead to a significant improvement. Unfortunately, that has not been the case. Instead, multifactor productivity growth in the non-farm economy has been so rapid that the MEI has continued on a very low trajectory. The combination of an unrealistic productivity adjustment and an outdated market basket led CMS to recently estimate the 2011 MEI at just 0.1 percent. With the MEI essentially shrinking to zero, today's physicians can detect no resemblance between the MEI and the rising costs they face every day in practice. The time has come to comprehensively reassess this index. **The AMA urges CMS to consider both a one-time adjustment to bring the MEI up to a more reasonable level and a comprehensive revision so that, prospectively, the MEI will provide a more accurate representation of 21st century medical practice costs.**

Although the AMA appreciates CMS' efforts to date to improve the PQRI program, it is troubling that the number of physicians successfully participating and receiving PQRI incentive payments remains very low. Physicians' initial experiences with the PQRI program have been discouraging. Many physicians are frustrated to learn long after the fact of CMS' determination that they did not successfully participate and are not eligible for incentive

payments. To improve participation in the electronic prescribing incentive program, effective with the 2010 reporting period, CMS has lowered the reporting threshold to 25 claims instead of 50 percent of claims. **The AMA urges CMS to take similar action to improve participation in the PQRI program by lowering the threshold for successful reporting from 80 percent to 50 percent**.

Revising the MEI

Hospital payments have increased by 34 percent since 2001 while physician payments are just one percent higher than in 2001. The 2010 Medicare payment schedule rule demonstrates that Medicare payments for practice expense now cover just 50 percent of physicians' direct costs, and there are 119 services where the entire Medicare practice expense payment does not cover the cost of one high-cost supply required for the service. In part, Medicare's failure to keep pace with increases in the cost of running a medical practice is due to the use of an outdated inflation measure.

The data used to calculate the MEI is based on what physician practices looked like in 1973. Since then, the MEI has accounted only for annual changes in the prices of the inputs but not changes in what the inputs are. For example, the MEI adjusts for changes in the price and mix of physician employees, but it does not adjust for the fact that most physicians have many more staff today than in 1973. Data published by the Medical Group Management Association (MGMA) in 2003 indicated that, between 1992 and 2002, the number of staff per full time equivalent physician increased by 18.8 percent. Data presented to the Medicare Payment Advisory Commission last year indicated that this trend has accelerated, with physician office employment rising by 27 percent between 1999 and 2008.

In addition to employment, other costs that have evolved since 1973 would include the cost of complying with new regulatory standards, such as those attributable to:

- the Occupational Safety and Health Act;
- the Health Insurance Portability and Accountability Act;
- the Americans with Disabilities Act;
- the Emergency Medical Treatment and Labor Act;
- complex self-referral and anti-kickback provisions;
- enrollment requirements and conversion to the National Provider Identifier;
- information technology;
- medical necessity certification for durable medical equipment and home health;
- interpreters for deaf and non-English speaking patients;
- ever-changing Part D formularies and preauthorization requirements; and
- quality improvement costs.

Soon, physician practices will need to bear additional new regulatory costs, including imaging accreditation, ICD-10 implementation, electronic prescribing and health information technology (HIT). To date, many physicians have found that participating in PQRI or adopting HIT programs are not cost effective endeavors.

The need to comply with a host of regulatory directives in recent decades as well as those on the horizon in the near future has led medical practices to contract with an army of professionals, including attorneys, accountants, billing services, and coding and compliance consultants. They have had to adopt new safe practices for needle disposal and other safety practices to protect worker health and prevent disease transmission between patients and health professionals. They have had to make numerous changes to accommodate patients with disabilities and those who do not speak English. Few would argue that a medical office in 2010 looks or operates like a practice did in 1973, before such commonplace and essential office equipment like computers and facsimile machines were even available.

The elements that are priced in the MEI need to be reviewed and revised so that the index bears some relationship to the reality of a 21st century medical practice. CMS recently incorporated findings from the new Physician Practice Information (PPI) survey into the practice expense relative values, and before that it relied on data from the AMA Socioeconomic Monitoring System (SMS). With the time gap between the two surveys, the PPI and SMS surveys may not be directly comparable, but a comparison of the two indicates that medical practice costs increased 79 percent from 2000-2006. Looking at the SMS alone, the SMS indicated a 35 percent increase from 1994-2000. The MEI, however, only increased 18 percent from 2000-2006. MGMA data also show higher growth than the MEI. So, while we do not know exactly what the right number is, **every other available measure of physician expense growth shows faster growth than the MEI**.

A comprehensive revision of the MEI is long overdue. We urge CMS to begin working on such a revision for implementation in 2011.

PQRI Modifications

CMS has made several significant improvements to the PQRI. These include adding an alternative e-mail modality for accessing individual feedback reports, applying modifications to program analytics to address problems with 2007 and 2008 PQRI claims processing issues, and increasing education and outreach activities online and through Medicare carriers. However, it remains troubling that successful PQRI participation rates have not improved. It is from this perspective that the AMA continues to advocate for modernizing Medicare's data systems and algorithms to allow for timely, individual feedback reports *during* the reporting period.

As 2007 and 2008 program data demonstrate, successful PQRI participation remains in the 50th percentile. The number of participants almost doubled in 2008 (to 153,000), but a mere 56 percent (85,000) were successful and received an incentive payment. The reasons that successful participation remained in the 50th percentile are still under review by the agency, but the AMA understands that one issue being explored is that physicians who commenced reporting measures late in the reporting period (November and December) were unable to meet the 80 percent reporting requirement for individual measures. Some have speculated that this problem is related to CMS announcing on its *2008* National Provider calls that eligible professionals should start reporting early to get familiar with the program in

preparation for *2009.* The AMA looks forward to receiving more detailed analysis from CMS on 2008 participation by reporting option and measure.

At the December 17, 2009, Practicing Physicians Advisory Council meeting, CMS discussed PQRI reporting rate threshold options and presented data on the potential impact of a modified reporting threshold. According to the presentation, 82 percent of PQRI TIN/NPI participants in 2008 reported on at least 50 percent of their patient cases for at least one measure. **CMS estimates that if a 50 percent reporting threshold was applied for 2008, approximately 66 percent of PQRI TIN/NPI participants would have been incentive eligible.**

Recognizing that in its fourth year successful PQRI participation is still languishing in the 50th percentile, it behooves the agency to use its authority to establish a more attainable threshold. Proposing a 50 percent threshold for successful participation for 2010 and 2011 would better reflect the current realities of the PQRI reporting environment for participating physicians. At a later date, if CMS' systems are modernized to provide more actionable, timely feedback to allow physicians to make participation improvements while reporting, consideration could be given to adjusting this threshold. As communicated by physician practices who participated in the 2008 PQRI, timely feedback (at least monthly reports) would have a huge impact on their ability to understand their participation and, where reporting problems exist, fix them *during* the reporting period as opposed to discovering ten months into the following reporting period that they were unsuccessful.

Since implementation of the 2007 PQRI, Congress has passed subsequent legislation granting CMS flexibility to add alternative reporting periods and alternative criteria for satisfactory reporting within the program. As a result, the PQRI program has grown from 74 quality measures in 2007 to a program with 175 measures, 13 measure groups, and several different reporting options in 2010. Specifically, the Medicare Improvements for Patients and Providers Act (MIPPA) (P.L. 110-275) authorized the Secretary, in consultation with stakeholders and experts, to revise the criteria for satisfactorily submitting data on quality measures. **The AMA urges the agency to use this authority to change the 80 percent threshold to 50 percent for the 2011 PQRI. CMS should also apply this change retrospectively to the 2010 reporting year in order to increase the rate of success for physicians currently participating.**

Thank you for your consideration of these recommendations. If you have any questions or if we can assist CMS in any way on these two issues, please do not hesitate to contact Margaret Garikes in our Washington office at 202-789-7409.

Sincerely,

Michael D. Maves, MD, MBA