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The Honorable Dave Camp
Chairman
Committee on Ways and Means
U.S. House of Representatives
Washington, DC 20515

The Honorable Fred Upton
Chairman
Committee on Energy and Commerce
U.S. House of Representatives
Washington, DC 20515

Dear Chairmen Camp and Upton:

On behalf of the American Medical Association (AMA), we appreciate the opportunity to comment on the recently released "Overview of SGR Repeal and Reform Proposal: Second Iteration." We appreciate the time and effort that your committees have devoted to developing a replacement for the failed Sustainable Growth Rate (SGR) formula. We agree that a new system must focus on quality, value and efficiency and are pleased that your proposal is similar in many ways to ideas put forth by the AMA and other physician organizations. We look forward to continuing to work with you and your staff on the development of this proposal and its enactment by the Congress this year.

Phase I: Stable, Predictable Updates

We agree that the SGR must be repealed. Continuation of this policy impedes the adoption of new payment and delivery modes that are necessary to improve care and slow the growth of costs. We strongly recommend that the Phase I payment updates be positive for a period of three to five years so that physicians may begin to transition to new payment models. The period of stability will afford physicians the opportunity to make necessary investments and practice modifications that improve quality and efficiency, and to assess alternative payment models both within Medicare and the private sector. Furthermore, it is essential that this period of stability provide ample time and adequate resources so that the Centers for Medicare & Medicaid Services (CMS) can prepare for and be equipped to effectively administer Phase II. Without these, the Phase II transition will be unsuccessful.

We appreciate that you recognize that physicians need sufficient time and payment stability to develop quality and efficiency measures as well as clinical improvement activities that are essential to Phase II implementation. However, the underlying concept of Phase I—stable and predictable payments—must also be reflected in payment models envisioned under Phase II of the proposal. Stable and predictable payment models are necessary to ensure

physicians can plan for investments in capital improvements and continuously make advancements in delivering higher quality and more efficient care.

Phase II: Portion of Payment Based on Quality through Update Incentive Program (UIP)

Base Rate:

Pay for Performance (P4P) programs must be structured carefully to promote program effectiveness and the quality and safety of patient care. All physicians should be able to participate in the program and should receive a positive base physician payment update to reflect increases in costs to deliver care, with an additional value-based payment for achieving quality goals. Base payment rates should not be subject to withholding. As small businesses, physician practices must have certainty regarding what payment rates will be applied to their services in order to sustain their practice. This is especially true given the significant investments that will be required by physicians to comply with myriad federal requirements, including ICD-10, meaningful use, and new reporting requirements under this proposal.

Programs that withhold a portion of physicians' payments and then require them to engage in various activities in order to recoup the payment would not meet that criteria and cannot be viewed as providing stable and predictable updates. This is especially true given the impact of the SGR. Medicare physician payment rates today are only four percent higher on average than they were in 2001, and only two percent higher after sequestration, while the cost of delivering care has grown more than 25 percent. To withhold some portion of those payments until year's end would deny physicians the resources they will need to undertake the very improvements the committees hope to encourage.

The resources necessary to implement redesigns of care are substantial. For example, a 340-plus physician group in North Carolina recently undertook a transition from a fee-for-service to a value-base model that is focused on population-based care management. This transition has involved a substantial effort in the redesign of clinical care, information infrastructure, and contract negotiations requiring a capital investment of $20 million. Withholding payments from physicians as a negative incentive to invest in care redesign would seem to be a self-defeating proposition.

In its value-based programs for other providers, such as hospitals, Medicare does not withhold a part of the base payment rate but instead is using differential updates based on meeting and/or reporting various quality and/or efficiency measures. To impose a program that takes money off the top of payments that have not kept up with inflation for more than 10 years will increase the migration of physicians into hospital settings, driving up overall Medicare spending in the process.

Finally, in 2006, Congress enacted a three percent withholding requirement for contractors doing business with the federal government, including physicians participating in the Medicare program. When that requirement was repealed in 2011 (by a vote of 422-0 in the House and 95-0 in the Senate) many members of Congress, on both sides of the aisle, noted that withholding would prevent business from hiring new employees and, in the case of Medicare, threaten access to care. The Administration also condemned "burdensome withholding requirements that keep capital out of the hands of job creators." The AMA stood with the Ways and Means Committee in support of repealing that withholding requirement and we strongly encourage you not to proceed in that way now.

Variable Rate:

Variable value-based payments should be funded with new money and should not be made on a budget neutral basis within the Medicare physician payment system. These payments should reflect potential savings to the Medicare program as a whole from decreased hospital admissions, readmissions, and emergency department visits resulting from up-front physician care. Further, variable value-based payment programs should not be funded through prospective reduction of the physician payment update, such as a "withhold pool." This would be in contrast to other types of variable value-based payment programs, such as those using a "differential" payment structure, under which a base payment is made for services provided with a small penalty applied to future updates for failure to report quality measures.

Further, incentive payments should be based on a minimum performance threshold and scored against both absolute values and relative improvements in those values. If a physician provides high quality care and meets performance standards, these efforts should be rewarded. Arbitrary assignment to a certain percentile based on a curve would unfairly penalize high-performing physicians as well as physicians who make significant improvements in the quality of care they deliver.

Physicians who receive variable payments under a value based reporting system must receive those payments in a timely manner. Payments should be made as close as possible to the time that the service is rendered, without a substantial time lag in determining the amount of payment due to a physician. A physician practice, like any other enterprise, must operate on a business plan based on predictable and reliable financial fundamentals. This is nearly impossible if a substantial amount of a practice's revenue stream is unknown and delayed for months or even years. Particularly in a credit-issue economy, small businesses, such as physician practices, cannot afford delayed payments as this creates significant cash flow problems. This, in turn, threatens the viability of physicians' practices, which impacts overall access to timely, high-quality health care.

Three ways to receive credit:

The proposal lists three options for determining a physician's performance-based rate. The AMA supports all three options listed, and urges that physicians have the flexibility to select the option that best fits their practice arrangement and patient population. Whether or not the three options present physicians with an actual choice or not will depend on how the program is structured. For example, a plan that in effect required physicians to participate in all three options in order to "claw back" a payment withhold could not be seen as truly providing physician flexibility.

Risk adjustment and attribution:

The AMA supports detailed and transparent risk adjustment and attribution methodologies for use in calculating quality measure performance. Currently, no single risk adjustment methodology is appropriate across a spectrum of conditions or episodes of care. As a result, risk adjustment model specifications should be condition specific. A risk adjustment methodology should also adequately address the complexities which arise from the multiple chronic conditions of the population of Medicare beneficiaries. Sensitivity analysis of the results of the condition-specific models should be conducted and available for review. In addition, benchmarking must take sub-specialties into consideration. Work by the Medicare Payment Advisory Commission (MEDPAC) has suggested modifications to improve the Hierarchical Condition Categories (HCC) that CMS currently uses to risk adjust payments to Medicare Advantage plans. In addition, CMS is currently funding a project by the AMA and others that among other things would make additional refinements that take comorbidities and chronic conditions into account.

The process of risk adjustment model selection should be based on physician and other expert input, and be transparent to all stakeholders. The AMA looks forward to reviewing and commenting on the details of data elements and data sources, and risk adjustment model specifications for use in a pay for performance system.

The AMA understands the need for a uniform attribution policy model to make comparisons within a national program. However, we believe it may not be possible to identify a single attribution model that can attribute care accurately across all types of specialties. It is premature to choose a particular model at this time. Congress must support the testing of many models and urge for the continuing analysis regarding the advantages and disadvantages of different methodologies.

Participation as an individual or group:

The AMA supports both individual and group practice reporting options under the UIP. This approach mirrors other efforts undertaken by existing Medicare performance programs,

specifically the Physician Quality Reporting Program. A challenge moving forward will be how to best balance the fact that quality measurement at the individual physician level is different than measurement at the group practice level or integrated system level. Individual physician measurement is essential for targeted quality improvement for specific patient populations. These measurement activities might target more low cost or less prevalent health care services but do provide value to both patients and physicians.

There are numerous reasons why measurement varies across health care settings. These include, but are not limited to: methodological problems with attribution and/or risk adjustment at various levels of attribution; measures have not completed testing and therefore have not been able to receive full NQF endorsement; funding is not available to help evolve a measure concept by adding specifications; or there is no solid evidence base available that justifies the development and use of a measure within a particular health care setting. **To better explore measure application across settings, the AMA recommends Congress provide resources to better develop and evaluate the application of certain quality or cost measures in various care settings and at different levels of evaluation, e.g., health plan, group, and individual levels. These evaluations should also explore the use of electronic health records and registries for capturing data for quality and cost measurement.**

Minimizing burden on physicians:

The AMA supports the four areas outlined in the proposal for reducing participation burden. To this end, it will be essential to ensure that any new quality and efficiency measures do not simply expand the plethora of current penalty programs. For example, a value-based program that maintained all the current penalties and then also withheld a portion of the base payment rate unless physicians met the current and/or new quality and efficiency requirements would essentially be "double jeopardy" no matter how well the new and old requirements were aligned. We therefore, urge Congress to eliminate the current penalty programs and build a new value-based system that retains the relevant objectives of the current programs but eliminates the separate penalties connected to them.

Streamlining is necessary for CMS as well as physicians. While improvements have been made along the way, implementation of the Value Based Modifier (VBM), PQRS, and Meaningful Use programs has proven to be a challenging task for an agency struggling with tight deadlines and budgets.

As an example, we note that data limitations led CMS to back-date the reporting requirements under the penalty programs so that a physician will face a penalty based on activity in the year prior to the year of the penalty specified in the law. **This suggests the need to eliminate these penalties or at the very least to modify the timelines and to provide the agency with more time and more resources in an SGR replacement plan.**

Ability to optimize incentive payments:

Key lessons from the PQRS are that quality reporting and pay for performance programs must allow physicians and CMS adequate lead time to implement changes and that CMS must aggressively educate and implement outreach activities for physicians and eligible professionals on how to successfully participate in a pay for performance program. Educational programs must include detailed, confidential, actionable interim and final feedback and compliance reports that inform physicians of reporting errors and how to correct them. These reports must also be issued on a timely basis. PQRS reports are issued far too late for physicians to address reporting problems and result in inaccurate reporting practices that continue far too long to be helpful even in the subsequent reporting year. Timely, detailed reports will assist in increasing the number of physicians who successfully participate in performance based payment programs and, hopefully, result in quality improvements that will benefit both patients and the Medicare program.

Physicians must be able to review the accuracy of the data that are the basis for determining successful participation or performance scores in any pay for performance program. If not, this calls into question how actionable and meaningful the program is for patients and physicians. Physicians must also have the opportunity for prior review and comment, along with the right to appeal and reconsideration.

The AMA also supports standardized reporting of performance data. For more information about this activity, visit http://www.ama-assn.org/ama/pub/physician-resources/practice-management-center/health-insurer-payer-relations/physician-efficiency-quality-data/practice-data/take-charge-of-your-data/physician-reporting-guidelines.page.

Establishment of quality measures to assess physician performance:

It is important to understand the necessary resources and time required for "establishing" a quality measure for use. Before the implementation of quality measure reporting, many processes must be undertaken, as highlighted in more detail below. The average time for these processes can take a year and a half to three years based on certain assumptions that include immediate transfer of measures from the development to endorsement process; and no significant results from measures testing that require major revisions and therefore a re-vote of approval by the measure developer to achieve consensus.

Priority setting: The development of a National Quality Strategy (NQS) was mandated by section 3011 of the Affordable Care Act (ACA). The Strategy creates national aims and priorities to guide local, state, and national efforts to improve the quality of health care in the United States. Specifically, the Strategy presents three aims and six priorities to help focus efforts by public and private partners to improve health care quality. The NQS is designed to

be an evolving guide to help the health care community move forward with its efforts to measure and improve quality.

Measure development: Measure development requires approximately six months. This entails agreement on the measurement topic, which is influenced by the NQS and other legislative demands that require measurement for certain government programs. Once a measurement topic is selected e.g. care transitions, the AMA-Convened Physicians Consortium for Performance Improvement (PCPI) will issue a call for nominations to the measure development workgroup. Once the workgroup is formed it must adhere to the PCPI's formal workgroup charge, which requires that the development of a comprehensive set of measures for use in quality improvement and accountability. These development processes must also recognize the Institute of Medicine's (IOM) six aims for quality improvement (safe, effective, patient centered, timely, efficient, and equitable). Once measures are developed, they are released for public comment. Staff reviews comments and revisions are made as needed. The final measures are then shared with the full PCPI membership for vote. Depending on approval, measures are then ready for testing.

Measure testing: Depending on the testing protocol, measure testing can take nine months or longer. After PCPI approval, a testing plan must be developed to determine if the measures are well defined and precisely specified so that implementation is consistent within and across organizations and allow for comparability. Once a protocol is defined and testing sites identified, testing begins. Testing usually includes two approaches—reliability and validity. Reliability testing demonstrates the measure results are repeatable, producing the same results a high proportion of the time when assessed in the same population and in the same time period. Validity testing demonstrates that the measure reflects the quality of care provided, adequately distinguishing good and poor quality. Depending on measure testing results, measure specifications may be edited or removed from the pipeline.

Measure endorsement: Endorsement of quality measures by the NQF is the gold standard. NQF endorsement is typically a six to nine month process. However, it can be longer if the NQF does not issue a call for measures for a certain topic whereby there are measures developed. The NQF is in the process of measure endorsement redesign, which would change how it calls for and reviews measures for endorsement. These changes are now being reviewed and discussed by relevant stakeholders.

Measure implementation: Implementation of clinically relevant measures that consistently allow for accurate assessment and comparability is possible only after thoughtful development, careful testing, and NQF endorsement. These processes are what afford physicians the real opportunity to use measures at the point of care for improving quality.

The AMA would caution against any policies that create unpredictable loopholes in the current processes for "establishing" quality measures for use. Specifically, the

committees' proposal indicates that the "Secretary is authorized to adopt additional measures that are needed to fill gaps to ensure there are measures for all providers." Permitting the Secretary to develop and use any quality measure in its performance programs, just to fill an immediate gap, threatens the integrity and transparency of the existing Medicare performance programs. **We urge that the aforementioned processes for establishing a quality measure remain central tenets in how the Secretary selects measures for use in performance programs.**

To date, physician-level measurement is focused on processes of care. For example, the current Medicare PQRS includes only a small number of "intermediate" outcome measures related to diabetes, chronic kidney disease, end-stage renal disease, and eye care. These types of measures focus on short-term outcomes, whereas strict "outcome" measures are longitudinal and population-based. **Recognizing the long-term implications of strict "outcome" measures, additional resources and time are necessary to gather the evidence base for development, methodologies for risk-adjustment, and eventual testing prior to accurate and consistent implementation across health care settings. We specifically urge Congress to provide Medicare support to CMS for quality measure development, testing, and maintenance.**

Recognizing and deeming clinical practice improvement activities:

Physicians are seeking opportunities to avoid payment penalties, while at the same time trying to evaluate new delivery reform models that rely on accurate and timely data for improving quality and lowering costs. Recognizing these realities, the AMA urges Congress to balance two primary goals:

1) The short term goal of allowing physicians the opportunity to successfully engage in quality measurement and improvement activities that both improve value and result in avoiding payment penalties and/or qualifying for an incentive.
2) The long term goal of moving away from pay for reporting policies towards pay for performance models predicated on the use of timely data capture and evaluation for improving quality and lowering costs.

The AMA recommends Congress support CMS under its current authority created by H.R. 8, the "American Taxpayer Relief Act," to create a mechanism so that physicians and other health care provider organizations are able to meet the federal data reporting requirements under a number of Medicare programs through their active participation in other "deemed" quality measurement and improvement activities. In its simplest form, the U.S. Department of Health and Human Services via CMS would "deem" medical specialty registry participation, medical board certification, Regional Heath Care Quality Collaborative participation, successful completion of an accreditation program (e.g., The Joint Commission [TJC], National Committee for Quality Assurance [NCQA]), measure

reporting through an EHR, and other quality related activities as meeting CMS' data requirements, and thus be eligible for any applicable financial incentive, while avoiding payment penalties. This approach facilitates a more streamlined and efficient process through single data submission that meets the CMS quality reporting requirements, while also supporting meaningful quality improvement activities already adopted by many physicians throughout the country. In addition, we believe that "deeming" a variety of quality measurement and improvement activities would enable CMS to work effectively with external stakeholders and make it feasible to expand the scope of truly relevant quality data collection, even for very small specialties or patient populations.

In order to make this concept operational, guidance and standards will need to be developed for physicians and other health care provider organizations to qualify under the "deemed" status. **The AMA recommends that baseline standards be determined with input from physicians and other stakeholders that encourage a variety of quality measurement and improvement activities while not setting the bar so high during initial years as to exclude any activities or organizations with an established record of achievement.** To begin work on establishing standards, the AMA recommends that CMS initially build upon its current processes for "qualifying" registries, while also considering the following important concepts: benchmarking of performance data; inclusion of comparative feedback reports to physicians involved in the "deemed" quality measurement and improvement activity; education outreach by the "deemed" activity to help participants understand their performance information; and transparent descriptions of risk adjustment and attribution techniques. More specific standards for evaluating eligible activities for "deeming" will be necessary after the initial years, especially as CMS moves towards full implementation of public reporting policies. Development of these future standards should include input from affected stakeholders, including physician organizations.

The AMA recently responded to a CMS Request for Information, recommending the agency create a mechanism so that physicians and other health care provider organizations are able to meet the federal data reporting requirements under a number of Medicare programs through their active participation in other "deemed" quality measurement and improvement activities. To read our comments, please visit http://www.ama-assn.org/resources/doc/washington/clinical-quality-measures-comment-letter-28march2012.pdf.

Process for updating and improving measures and clinical practice improvement activities:

The AMA does not recommend an annual update review for quality measures and/or clinical practice improvement activities. As mentioned above, the average time for "establishing" quality measures for use can take a year and a half to three years based on certain assumptions. Requiring an annual review process would result in additional administrative

burden. Rather, quality measures should be reviewed and updated when the underlying evidence base has changed, or the measure has "topped out."

In addition, the establishment of clinical practice improvement activities can also take more than a year. For example, The Joint Commission (TJC) accreditation is at least every 39 months. By not adopting arbitrary annual update reviews, potential practice improvement activities will be able to focus on the development, testing, and use of methods that strengthen their activities around quality measurement and improvement. **We recommend that Congress support, at a minimum, a three-year review and update process though not preclude the addition of new measures as they become available.**

Responses to the Committees' specific questions are below:

How should the Secretary address specialties that have not established sufficient quality measures?

The Secretary should provide a temporary exemption to allow such specialties the requisite time to fully develop, test and evaluate meaningful quality measures. In addition, establishing a pathway for recognizing physician participation in clinical practice improvement activities provides an alternative pathway for physician participation, other than the traditional reporting of quality measures. Clinical practice improvement activities include, but are not limited to, registry use, accreditation, board certification, and regional collaborative participation. As mentioned above, the AMA recently responded to a CMS Request for Information, recommending the agency create a mechanism so that physicians and other health care provider organizations are able to meet the federal data reporting requirements under a number of Medicare programs through their active participation in other "deemed" quality measurement and improvement activities.

Is it appropriate to reward improvement in quality over time in addition to quality compared to peers?

Performance measurement should be scored against both absolute values and relative improvements in those values. As performance-based calculation becomes more sophisticated through the allocation of additional resources and testing of such methodologies, there may be instances when a physician would want his/her performance-based rate determined by a combination of both improvement in quality over time and peer comparison.

Are there sufficient clinical practice improvement activities relevant to your specialty? If not, does your organization have the capability to identify such activities and how long would it take?

There are many examples of sufficient clinical practice improvement activities under which physicians report quality measure data. These include: Ongoing Professional Performance Evaluation (OPPE) utilized by pathologists; Maintenance of Certification used by a variety of medical specialty boards; accreditation tools and programs by TJC; NCQA certification programs; participation in clinical patient registries; Bridges to Excellence programs which measure the quality of care delivered in provider practices; and many others.

The necessary processes and safeguards required to make clinical practice improvement activities meaningful for physicians, patients, and the public requires time and resources. **Congress should provide the necessary lead time through a scaled approach in rulemaking that establishes criteria for moving toward accurate and meaningful clinical improvement activities.**

Should small practices have the ability to aggregate measurement data to ensure that there are adequate numbers of patient events to reliability measures performance? If so, how?

The AMA is concerned that in order to achieve comparison groups that are large enough to be statistically valid, individual physicians and small group practices will have to aggregate measurement data. It is important to point out that these types of aggregation activities, especially if done arbitrarily, may lead to groups that are so broad they do not result in "apple to apple" comparisons. For example, experience in the private sector has shown that subspecialty physicians frequently are identified as high-cost outliers in large part because commercial episode groupers used to date do not adequately adjust for differences in severity and case mix. As a result, physicians with very specialized expertise and complex patients may be identified as high-cost or low quality in comparison to other members of their specialty who treat less difficult conditions or patients. This is further complicated by Medicare's specialty designations, which are inconsistent in their recognition of subspecialized experience. (For example, CMS recognizes several subspecialties of cardiology, but none in most others. It also recognizes just one of the several orthopedic subspecialties.) One possibility for mitigating this problem is stratifying physicians by specialty and the conditions they treat. The AMA supports this approach, and we look forward to working with others to develop an improved physician specialty and sub-specialty list that could be applied consistently across many Medicare programs, including the value-based payment modifier, Physician Compare, and PECOS.

Phase III: Reward for Efficient Resource Use

A key decision in the development of a plan to reward efficient providers will be whether or not it includes both penalties and rewards. The AMA agrees that these incentives should only be available to physicians who meet some minimum quality threshold. We are also firmly convinced that given the rudimentary state of efficiency measurement at this time, this phase of the SGR Repeal and Reform proposal should include no negative incentives. That

is, we do not think that rewards for the most efficient physicians should be financed by reducing payments to other physicians who either did not meet the quality threshold or had high costs along with high quality.

We are pleased that the plan calls for consultation with physician organizations throughout this phase of the proposal. Experience in the private sector with the Quality and Resource Use Reports (QRURs) that will form the basis of the Value-Based Modifier suggests that there is an enormous amount of work to be completed before it is appropriate to go down this road. Discussions with an AMA-convened group of state and specialty societies that has worked with CMS to improve the QRURs makes us skeptical that it is practical to apply efficiency measures to all physicians and we note that private payers have focused these measures on certain specialties and/or high expenditure conditions where the appropriate medical care is clear. For example, it has become evident in our discussions that creating efficiency standards for radiologists, pathologists, and other physicians providing care that is largely ordered by others is not feasible at this time.

As noted in the preceding section, there are many methodological issues yet to be resolved. The finding in the initial round of QRUR distribution that patients often had been treated by 15 to 20 physicians provides some evidence of how difficult attributing costs among these physicians could be. CMS has not yet been able to make true apple to apple comparisons where sub-specialists are compared only to their peers. The most recent QRUR reports just distributed in nine states contain data from 2011. Also, while we support providing physicians the option of participating as either groups or individuals, experience with the QRURs suggests that even with this option, it still may not be possible to apply efficiency measures to all physicians at least in the near term. For example, under the current rules, many single-specialty groups will be excluded from competing for VBM cost and quality bonuses. In addition, it may never be possible to achieve statistical reliability in cost measurement for many individual physicians.

Noted in the proposal, efficiency measures will also need to take geographic differences into account. This will require far more than simply adjusting for differences in hospital and physician payment rates. Improved risk adjusters that can better account for regional variations in patient health are needed but a fair comparison across regions will also require consideration of other factors such as differences in social structure, risky behavior, and educational status.

Comparisons based on episodes rather than per capita costs will provide better information to patients who often would rather know which physician is most cost effective for a particular condition than who is the cheapest overall. Unfortunately, current commercial products have been found inadequate for the assessment of Medicare patients with multiple chronic conditions. Work that the AMA is participating in will help inform the development of tools for measuring episode costs but more time is needed to complete this effort.

In short, much work remains before efficiency measurement can be equitably applied and we have doubts as to whether it will ever be appropriate for all physicians. We strongly believe that CMS is not ready to implement the value-based payment modifier and that the VBM should be eliminated or at least rolled back in this proposal. We also recommend that any efficiency measures be tested in large group practices before they are imposed more broadly.

D. Provider Opt-Out for Alternative Payment Model (APM) Adoption

The AMA strongly supports the committees' goal of allowing an array of APMs to be offered, in addition to fee-for-service, with physicians able to select the Medicare payment system that best fits their practice situation. The AMA believes that the APMs offered under Medicare should be built around opportunities for clinical improvement that can simultaneously lower Medicare spending growth. Instead of focusing on how to place limits on high cost services, APMs should focus on how to help patients stay healthy, manage chronic conditions to stop disease progression and prevent emergencies and hospitalizations, and manage acute episodes to prevent complications and readmissions.

The current Medicare payment system can be a major barrier to these kinds of care improvements. It provides no payment for phone calls or emails with patients, to coordinate care among physicians, or for support services to help patients with self-management. For example, physicians who redesign their practices to take phone calls from patients on evenings and weekends and allow next day office visits would be unable to recoup the costs of those systems under the current fee schedule, even if they save money for Medicare by preventing some emergency department visits or other higher cost services.

We also believe that physician payment reform will be more successful and effective if APMs are established in a way that allows those physicians who choose to do so to move in this direction incrementally, instead of their entire Medicare practice abruptly changing to an APM. This type of transition could be accomplished by developing APMs that address specific episodes of care that physicians in different specialties provide, conditions that they manage, or particular savings opportunities that they choose to target, such as reducing the need for certain tests, hospital admissions or complications. We think that focusing first on the specific opportunities to improve care and lower costs that physicians feel they are most able to influence would have significant advantages over an approach that begins with global payments or total cost of care for a large patient population. A "bottom up" approach in which physicians develop experience, skill and confidence in demonstrating accountability for specific elements of health care quality and costs where they can have a significant impact is more likely to achieve meaningful and lasting improvements in care delivery and costs than a "top down" approach that does not match the practical realities of our nation's broad range of physician specialty practices, patient characteristics, and community needs.

While APMs should be focused on specific opportunities to improve care delivery, they should not be limited to Medicare physician fee schedule services. APMs that deal with particular episodes of care or managing particular conditions can give physicians the flexibility and resources to lower utilization of services that are outside of the physician fee schedule, like hospital outpatient and inpatient services. Physicians should be able to be rewarded when they achieve these savings. For example, the Society of Actuaries identified nearly $20 billion in costs associated with preventable complications in 2008, largely attributable to hospital services.

The Details of APMs Should Be Developed by Physician Organizations

Models that Medicare has made available to date include accountable care organizations (ACOs), bundled payments for acute care episodes, and patient-centered primary care medical homes. To allow physicians in all specialties to participate, and to have the greatest impact in improving care for Medicare patients, APMs should include additional models, such as bundled payments for acute episodes that do not include a hospital stay, and condition-based payments covering all the costs of care associated with managing or treating a particular health problem. (See attached table for a description and comparison of these models.) A process can be established that would require CMS to issue Requests for Proposals that would provide certain parameters, such as defining the key elements of a condition-based payment model, but then specialty societies and multispecialty organizations would propose specific APM proposals that meet the CMS criteria. This approach would allow physicians to determine the diseases or procedures and patient populations covered by the APMs, the length of time that is appropriate for the APM to cover, and how to ensure quality standards are met. Requests for proposals should also be flexible enough to allow the organizations proposing the APMs to indicate the level of savings that will be achieved relative to what Medicare currently spends for the episode or condition and the patient population covered by the model.

It will take time for physicians to gain experience with APMs, so no minimum amount of savings should be required in the first year of a physician's participation. In addition, participation in APM should be voluntary for physicians.

APMs Should Be Widely and Regularly Available

In addition to new APMs that will be developed under the House Committees' proposal, the many early innovator physicians participating in payment initiatives already underway in Medicare, such as ACOs, bundled payments, advanced primary care medical homes, and those involved in the Innovation Challenge aware programs, should be considered as participating in a qualified APM. We feel strongly, however, that the new APMs should not be limited to demonstration projects or tests. The more experience physicians gain with these new models, the more lessons will be learned and refinements can be made. It is not

realistic to expect that a test APM in one type of practice or community can be readily copied to another site based on a formal evaluation of the APM as a demonstration project. As former CMS Administrator Mark McClellan, MD, recently observed, we cannot try to do traditional evaluations of these new approaches because our evaluation methods have not caught up yet with the approaches we are using to test new payment models.

For this reason, any physician practice or organization that provides the types of services to the types of patients that are the focus of an APM should be permitted to apply to participate in such an APM. No limits should be imposed on the number of participating physicians, practices or geographic areas. Once an APM is offered, additional physicians should be permitted to apply for participation in that APM at regular intervals, such as annually.

Assigning Credit to Physicians for APM Participation

Under the House Committees' proposal, physicians participating in APMs will be exempt from the quality and efficiency requirements of its UIP. As the AMA noted in comments on the previous draft, it will be necessary to establish a way to measure and track physicians' APM participation, and to establish a threshold degree of participation that is sufficient to achieve an exemption. We recommend that a points or credits system be established that would allow various APMs and levels of participation in them to be quantified. For example, a physician getting paid under a bundled payment program for 40 percent of their Medicare patients that includes a warranty for any complications that develop related to the episode is taking on a higher level of accountability for quality and costs than a physician who has 20 percent of their patients in an upside-only shared savings program. A point system could be used to quantify the two physicians' participation in the two APMs and determine whether they quality for an exemption for the UIP. In addition, physicians who participate in APMs sooner should receive more credit for their participation than those who join APMs after they are more well-established.

We further recommend that a deeming process be created so that the specialty society or other organization whose members are participating in the APM could take responsibility for reporting to CMS on which physicians participated at different levels and assign the points to them. This would allow the overall implementation of the APMs to remain decentralized and provide significant opportunities for physician and specialty leadership in payment reforms.

Linking APM Participation to Payment Updates

To support the infrastructure improvements and care redesign that physicians need to succeed in APMs, they will need to receive adequate revenues. The APMs that we are proposing would all be designed to save money for Medicare relative to the spending growth that would occur under the current fee-for-service system. Although the main financial benefits that will accrue to APM-participating physicians would come from the APMs themselves in the form

of incentive payments, gainsharing, etc., as physicians transition into a new payment system they are likely to have some percentage of their revenues derive from APMs and the remainder from regular Medicare. Medicare payment updates for physicians involved in APMs that are significantly reducing overall Medicare spending—outside the physician fee schedule—should get higher payment updates. We recommend a three-tiered approach:

- In each year, if a physician's cumulative APM points or credits exceed a threshold level established by CMS for that year, that physician would receive a Bonus Update for the following year equal to the increase in the Medicare Economic Index plus two percent.
- A second, lower threshold level would be set and physicians whose cumulative points exceed the second level would receive a Full Update, equal to the MEI.
- Physicians who do not achieve either APM threshold would not be exempt from the UIP.

Supporting Physician Participation in APMs

The Committees have asked what will be necessary to support provider participation in new payment models. We recommend the following provisions to support this effort.

1. Availability of Medicare Data:

    - CMS should be charged with making analyses of Medicare claims data available at no cost to any physician organization that submits a preliminary application to participate in an APM. The analyses should be specifically designed to enable the physicians to identify the opportunities to improve care coordination and quality for their patients, to understand the most recent spending associated with the services that would be affected by the APM for the relevant patients that the physicians care for, and to calculate how payments and spending under the APM would compare to current levels.
    - CMS should also make Medicare claims files available at no cost to non-profit medical societies and multi-stakeholder regional health improvement collaboratives so that they can provide analyses that will: (a) assist physicians in applying to participate in existing APMs; and (b) enable physicians to propose additional APMs, particularly for specialties where no APM has yet been created. (It would be important, however, that these analyses not be used for public reporting about individual physicians or groups of physicians, unless the organization and the reporting meet the standards for Qualified Entities.)

- For approved APMs, CMS should provide updated data on utilization and spending related to the patients, conditions, and services covered on a quarterly basis.

2. Technical Assistance and Consumer Engagement:

   A program of grants should be created for non-profit medical societies and multi-stakeholder Regional Health Improvement Collaboratives to:

   - provide technical assistance to physicians in applying to participate in APMs;
   - provide technical assistance to physician organizations in successfully implementing an approved APM, including redesign of care and management of finances;
   - enable them to receive, store, and analyze claims data from Medicare and other payers to help design and participate in APMs; and
   - Educate Medicare beneficiaries about the advantages of improved care models that are supported by APMs.

3. Guaranteed Loans for Small Physician Practices:

   - A program should be established to guarantee loans to small, independent physician practices to help them cover the investments and cash flow they need to successfully implement APMs.

4. Antitrust and Gainsharing Waivers:

   - Federal policy on antitrust oversight should be the same for APMs as has been established for the Medicare Shared Savings Program.
   - Waivers of gainsharing, self-referral and similar federal policies should be the same for APMs as for the Medicare Shared Savings Program.

<u>Timeframe for Approval and Adoption of APMs</u>

Once regulations are created, CMS should immediately begin issuing Requests for Proposals. We believe 90 days is a reasonable period of time to review and approve applications submitted in response to these RFPs. We also believe CMS should be directed to provide a rationale for any applications that are not initially approved and give organizations the ability to resubmit.

Participation in More than One Payment Model

Especially for payment models that cover specific conditions or types of episodes, there is no reason not to allow physicians to gain experience participating in more than one.

E. Reports on Improved Provider Fee Schedule and Alternative Payment Models

The AMA supports ongoing analysis of Medicare payment and delivery model implementation and effectiveness.

F. Improvement upon Current Law

The AMA believes that there are multiple improvements in current law and regulation that will not only better enable physicians to engage in new models of care delivery but remove unnecessary burdens that accompany participation in the Medicare program. Specifically:

Administrative Simplification

Payers have a multitude of different ways they require physicians to perform typical tasks. Adopt uniform standards under the Health Insurance Portability and Accountability Act (HIPAA) for a number of administrative functions.

- Uniform way for physicians to enroll with payers.
- Uniform way for physicians to sign-up with payers to perform certain business functions electronically (send claims, get paid).
- Uniform way for physicians to access a payer's contracted fee schedule.
- Single set of claim code edits used across all payers.
- Uniform way to upload and access payers' fee schedules.
- Uniform way to let physicians know whether their claims and other transactions were received.
- Uniform auditing procedures.

Meaningful Use

- Significantly reduce the requirements to avoid a penalty.
- Independent evaluation of MU program.
- Eliminate measure requirements which are not relevant to a physician's practice.
- Extend electronic health record safe harbor.

ICD-10

- Phase-in implementation of ICD-10 (start with inpatient first).
- Financial and educational support for implementation.
- Activate CMS's advanced payment program for assistance to physicians during the transition.

Physician Quality Reporting System (PQRS), Value Based Modifier (VBM)

- Eliminate/postpone existing PQRS penalties.
- Eliminate VBM.
- Upgrade CMS systems to allow for more rapid feedback.
- CMS may not base penalties on a performance period that precedes the penalty year by more than three months.
- Revamping measures to focus on group (or team-based) outcomes.

Fraud and Abuse

- Recovery Audit Contractors (RACs) penalties for poor contractor performance.
- Reduce duplicative program integrity audits.
- Require better data sharing among audit contractors to ensure claims have not already been audited to reduce duplication.
- Eliminate overpayment notice requirement.
- Enhance Medicare Advisory Contractors (MACs) (i.e. more education and outreach to physicians).
- Instruct the CMS to compile a list and streamline physician certification requirements.

Promotion of New Models of Clinical Integration

- Stark waivers.
- Anti-kickback safe harbors.
- Remove civil monetary penalties for promising practices (gainsharing/ beneficiary inducements).

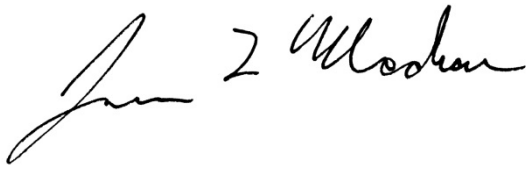
Other

- Limit record requests for Medicare Advantage audits.
- Reduce Drug Enforcement Agency fees for prescribers.
- Resolve problems with prescribing and dispensing Schedule II controlled substances in nursing homes and hospice.

While this is by no means a complete list, we believe that each of these items would substantially improve the practice environment for physicians participating in Medicare, leaving more time for care that directly benefits the patient.

Thank you again for the opportunity to share these thoughts on the second iteration of the committees' proposal. We value and appreciate your commitment to this process and your recognition of the importance of replacing the current Medicare physician payment system. We would be pleased to meet with you at your convenience to discuss any of the issues raised in these comments in greater detail. We look forward to continuing to work together in a constructive manner to advance our shared goals of repealing the SGR and replacing it with a system that focuses on quality, efficiency, and value in the Medicare program.

Sincerely,



James L. Madara, MD

Attachment

COMPARISON OF ALTERNATIVE PAYMENT MODELS

	FEE FOR SERVICE	BUNDLED PAYMENT FOR PROCEDURES	EPISODE PAYMENT FOR PROCEDURES OR HOSPITALIZATION	CONDITION-BASED PAYMENT	CAPITATION OR RISK-ADJUSTED GLOBAL PAYMENT
TRIGGERING EVENT	Triggered by delivery of a procedure or service	Triggered by delivery of a **procedure or group of services**	Triggered by delivery of a procedure or a hospitalization	Triggered by the **existence of a specific health condition**	**No triggers** other than patient selection or assignment of provider
PATIENT POPULATION	**Individual patients**	**Individual patients or groups of patients** receiving the procedure	**Groups of patients** receiving the procedure	**Groups of patients** with the condition	**Groups of patients** cared for by the provider
COSTS CONTROLLED	Cost of delivering the procedure or service by **one specific provider**	Cost of delivering the procedure or pre-defined **group of services** by **one or more providers**	Cost of delivering the triggering procedure or group of services by one or more providers **and the costs of all other services delivered in conjunction with the triggering procedure/services, including services needed to address complications of treatment over a defined period of time**	Cost of delivering **any/all procedures or services needed for the specific health condition and the costs of all other services related to the condition**, including services needed to address complications of treatment (or lack of treatment) for the condition over a defined period of time	Cost of delivering **any/all procedures and services needed for all health conditions**, including services needed to address complications of treatment (or lack of treatment) for the patients over a defined period of time
COSTS NOT CONTROLLED	No control on the **number of services provided**	No control on the **number of procedures delivered** or the number of **additional services provided beyond the bundle**	No control on the **number of procedures delivered or the number of hospitalizations**	No control on costs for **other conditions** or **the rate at which patients develop the condition**	No control on the **rate at which patients develop health conditions**

Source: Center for Healthcare Quality and Payment Reform