



# Statement

of the

American Medical Association

to the

Practicing Physicians Advisory Council

RE: Physician Quality and Cost Measures  
Transparency Initiative  
National Provider Identification  
Recovery Audit Contractors

**Presented by: Stephen R. Permut, MD, JD**

March 5, 2007

Division of Legislative Counsel  
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The American Medical Association (AMA) appreciates the opportunity to submit this statement to the Practicing Physicians Advisory Council (PPAC or the Council) concerning: (i) physician quality and cost measures; (ii) transparency; (iii) national provider identification; and (iv) recovery audit contractors (RACs).

**PHYSICIAN QUALITY AND COST MEASURES**

The AMA appreciates that H.R. 6111, the “Tax Relief and Health Care Act of 2006,” prevented the scheduled 5% cut in Medicare physician payment rates for 2007, due to the flawed sustainable growth rate (SGR) formula. The Congressional Budget Office, however, recently forecast that Medicare physician payment rates would be reduced by 10% in 2008. Further, due to the SGR, physicians face drastic payment rate cuts totaling almost 40% over eight years (beginning in 2008), while physician practice costs will increase nearly 20% during that time period. These cuts come at a time when Medicare payments to physicians already lag far behind the cost of caring for seniors and just as the baby-boomers enter the Medicare program. (In 2010, the leading edge of the baby-boom generation will start enrolling in Medicare, with enrollment growing from 43 million in 2010 to 49 million by 2015.)

Thus, the AMA continues our commitment to working with CMS and Congress to repeal the SGR, avert future cuts, and ensure a stable Medicare program that provides beneficiaries with access to cost-effective, quality health care services.

**We urge PPAC to recommend that CMS commit to working with Congress to repeal the SGR this year and avert the projected steep cuts of almost 40% that threaten seniors' access to care over the next eight years. Further, Congress allocated to the Secretary of the Department of Health and Human Services \$1.35 billion for physicians' services in 2008, and we urge CMS to commit to using these funds to help repeal the SGR and avert the cut in 2008.**

In addition to the physician payment provisions in H.R. 6111, the legislation established a voluntary Medicare quality reporting program for physicians. Under this program, physicians that meet certain reporting requirements from July 1, 2007, through December 31, 2007, can receive a 1.5% bonus payment with respect to all claims submitted by the physician for which payment is made under the Medicare physician fee schedule. Those who are eligible to participate in the reporting program are: physicians, osteopaths, podiatrists, optometrists, dentists and oral surgeons; chiropractors; physician assistants; nurse practitioners; clinical nurse specialists; certified registered nurse anesthetists; certified nurse midwives; clinical social workers; clinical psychologists; registered dietitians; nutrition professionals; physical therapists; occupational therapists; and qualified speech-language therapists.

Other key features of the quality reporting program for the second half of 2007 are as follows:

- Measures to be included are those that are included in Physician Quality Reporting Initiative (PQRI), which is the Medicare physician reporting program being implemented by CMS and is formerly known as the Physician Voluntary Reporting Program (PVRP). PQRI measures for use in 2007 must be posted by CMS on its website by April 1, 2007, and may be modified by CMS, but not after July 1, 2007. Of the 74 PQRI measures now in effect, 60 were developed by the AMA Physician Consortium for Performance Improvement.
- The 1.5% bonus payment methodology is subject to a cap, and the AMA is working with CMS in determining how this cap will be applied.
- If 3 or more quality measures are applicable to their patient population, physicians must report on at least 3 measures for at least 80% of the cases for which each measure is reportable. If fewer than 3 measures are applicable to their patient population, physicians may still participate by reporting 1 or 2 measures, but each must be reported for at least 80% of the cases for which the measures are reportable in order to receive the bonus.

H.R. 6111 also establishes a Medicare voluntary reporting program for physicians in 2008, and key features of this program are as follows:

- While the legislation sets up a structure to report in 2008, it does not allocate funds to be used for reporting in 2008.
- Measures to be used in 2008 must be those that are adopted or endorsed by the National Quality Forum (NQF) or the AQA, and include measures that have been submitted by a physician specialty, and that the Secretary identifies as having used a consensus-based process for developing such measures. Under this provision, Congress intended that the measures be developed by physicians through the Physician Consortium for Performance Improvement.
- 2008 measures shall include quality measures, as well as “structural” measures (which are measures that relate to such matters as use of electronic health records and electronic prescribing technology in treating patients.)
- Measures must be proposed in the *Federal Register* for public comment by August 15, 2007, and finalized and published in the *Federal Register* by November 15, 2007.

**Some of the physician reporting provisions in H.R. 6111 contain ambiguous language and thus there are a number of questions to be resolved prior to implementation. The AMA appreciates CMS’ responsiveness in working with the AMA and the medical specialty societies in addressing these matters. We will continue to work with CMS to smoothly implement this new reporting program.**

### **TRANSPARENCY**

CMS has developed a questionnaire about transparency in health care quality and pricing information that the agency has distributed to employers and is available on the CMS website. Employers can use this questionnaire when contracting with health plans on behalf of employees. The intent of the questionnaire, in part, is to press physicians and other providers to make publicly available information concerning pricing and participation in quality initiatives. The AMA has long supported efforts to promote transparency (with regard to price and quality) and consumer driven health care. Yet, to be effective and fair, such initiatives must be developed correctly and must apply to all sectors of the health care market, not just to physicians.

Without transparency on the part of health plans and insurers, physician transparency will not be meaningful and both patients and physicians will suffer. For example, physicians themselves often have no idea what payment they will receive from a health plan or insurer, especially when the plan imposes authorized and unauthorized discounts and various code-editing practices. This makes it impossible for physicians to provide patients with price transparency at the point of service. Providing this information to physicians will not only help them to adjust and sustain their practices, it will allow them to pass essential pricing

information on to patients at the point of service—furthering the worthy goal of providing patients with the tools they need to be informed, competent consumers of health care.

**We urge CMS to promote the same level of transparency to health plans as CMS is promoting with regard to physicians and other providers. Specifically, we urge PPAC to recommend that when promoting transparency, CMS should:**

- **Press health plans to become more transparent about pricing information, physician fees, disclosure of insurance claims processing and payment practices, and identification of intermediaries that offer health plans unauthorized discounts and reductions in physicians' payments; and**
- **Dissuade health plans from implementing policies or quality initiatives that focus on cost without regard to quality.**

### **NATIONAL PROVIDER IDENTIFICATION**

The AMA has long promoted administrative simplification for our physician members who are grappling with the numerous billing requirements that stem from multiple government policies and laws, as well as payment guidelines imposed by the insurance industry. To that end, we recognize that replacing the multiple existing identifiers used by physicians for billing and other transactions, with the National Provider Identifier (NPI) can benefit physicians, their patients, and others in the healthcare sector and lead to administrative efficiencies. Long before these efficiencies can be realized, however, a process of conversion must take place and significant hurdles must be cleared.

The move to a single billing identifier, the NPI, represents a significant shift in workflow for physicians. NPI implementation will require: (i) physicians to purchase potentially costly new billing software and ensure that personnel are adequately trained in its use; (ii) the use of a new paper form to accommodate physicians who use clearinghouses and third-party billers; and (iii) testing and extensive communication with payers, vendors and other physicians and providers. **It is imperative, when implementing a change of this magnitude, that physicians and others are given adequate guidance by CMS to implement this mandate.** As we near the May 23, 2007, NPI compliance deadline, the more urgent these matters become. With this in mind, following are key issues that physicians have raised concerning NPI implementation:

#### ***Need for a CMS Data Dissemination Notice***

To date, CMS has not published a "Data Dissemination" notice, which is expected to articulate who will have access to the NPI numbers and associated data, as well as how the numbers will be accessed. In the absence of clear guidance on NPI data dissemination from CMS, individuals within the industry are being forced to create their own methods in this regard. This is leading to potentially dangerous results. The AMA has recently become aware that some health systems, states, and other entities have created databases of providers' NPIs that they have collected. They are then allowing access to or are sharing these databases with others. In one instance, the database was posted on a website that was

publicly accessible. **We urge CMS to publish the NPI “Data Dissemination” notice as soon as possible, and allow for comments following publication.**

*Maintaining Secure and Appropriate Access to NPIs*

Physicians have significant privacy concerns about who will have access to their NPIs and how their number and related data will be protected. The reason for their concern is that significant personal and sensitive data is required on the NPI application, including the physician’s home address, social security number, date of birth, tax identification numbers, state license numbers and business entities’ tax identification numbers. Physicians are increasingly targets of identity theft and this central repository of highly sensitive data is cause for concern. In an era of regular press accounts of data security breaches in the public and private sectors, physicians are understandably reluctant to provide this information in the absence of assurances that it will be appropriately safeguarded. **Accordingly, the AMA is opposed to releasing this private information as part of any CMS data dissemination strategy. We also oppose allowing unrestricted access to this data by the public at large.**

Physicians are also concerned that widespread access to NPIs could result in the sale of their number, as is currently the case with Drug Enforcement Agency (DEA) numbers. DEA numbers exist solely for the purpose of authorizing a physician to prescribe drugs, yet an active list of these identifiers is available for sale to the public by the Department of Commerce. The sale of DEA numbers has resulted in these identifiers being used for marketing and has spurred identity theft. **The AMA opposes the sale of NPI numbers and strongly advocates for a CMS policy that limits use of the NPI to identification of individuals.**

Although physicians have significant privacy and security concerns associated with others accessing their NPI number and associated data, at the same time, they are very concerned that those with a legitimate need, have access to their number. In order for physicians’ claims to be processed on or after May 23, 2007, physicians must have access to the NPI number for the corresponding referring/ordering physician. The AMA, therefore, acknowledges the need for rapid and efficient distribution of the NPI among health care providers and their trading partners (including other physicians, providers, payers, health plans, clearinghouses, and third-party business partners) to facilitate business operations. **We continue to believe that the optimal solution for ensuring that only those with a legitimate need have access to the NPIs is through creation and maintenance of a database by CMS that includes access restrictions and a “look-up” function (whereby a physician’s NPI number can be identified by those with a legitimate need to use that number, while protecting the security of the physician’s confidential information associated with their NPI.) This function would include the data elements that currently associated with the Universal Provider Identifying Number (UPIN).**

**In the absence of such a solution, the AMA supports the release of the NPI number (along with the data elements associated with the UPIN), through data use agreements (DUA). A DUA would provide more restrictive access than a public-use file and minimizes**

the opportunity for fraudulent uses. The AMA is eager to work with CMS to explore ways to minimize the administrative burden on those with legitimate needs to access the NPI while ensuring that appropriate security safeguards are in place. The AMA has experience managing and safeguarding databases of similar size and containing information of similar sensitivity. **Accordingly, the AMA would welcome an opportunity to discuss with CMS the feasibility of entering into a DUA (with the AMA) that would permit the AMA to appropriately secure this sensitive data on behalf of physicians.**

### *Continuity of Claims Processing and Need for a Contingency Plan*

**CMS must ensure the continuity of claims processing as NPI implementation becomes effective on May 23, 2007.** There is a growing concern among physicians that after the May 23, 2007 NPI implementation deadline, there will be significant claims processing and resulting cash flow interruptions. There is widespread acknowledgement that the health care industry as whole will not be ready for the May 23, 2007 NPI deadline, as evidenced by recent presentations and testimony before the Workgroup for Electronic Data Interchange (WEDI) and the National Committee on Vital and Health Statistics (NCVHS), which are groups that advise the Secretary on NPI and other Health Insurance Portability and Accountability Act (HIPAA) matters.

In addition, the lack of an NPI data dissemination notice published by CMS has thwarted the industry's overall ability to prepare for implementation of the NPI and has jeopardized compliance with the May 23, 2007 compliance deadline. Further, we understand from physicians that some payers and clearinghouses are not ready to accept NPIs. For example, a recent WEDI survey found that of those payers surveyed, only 66% were currently accepting electronic claims containing both "legacy" (which are those identifiers that ultimately will be replaced by the NPI) and NPI identifiers. Further, many vendors have not yet modified physicians' software to allow for use of the NPI, putting physicians in a particularly precarious position, and some vendors have no plans to update physicians' software to accommodate the NPI. As a result, some physicians will be forced to abandon their software systems altogether and purchase costly new ones that will accommodate the NPI, unreasonably burdening physician practices and further delaying NPI implementation. Others are experiencing delays in moving toward implementation as vendors update physicians' software.

Finally, concerns with the CMS 1500 paper claim form persist. The WEDI survey found that of the providers surveyed, only 49% said their billing system was capable of printing paper claims using the new 1500 form.

CMS should recognize the foregoing obstacles and ensure that they do not interrupt the processing of physicians' claims. **Accordingly, the AMA recommends that PPAC urge CMS to establish a minimum, one-year contingency plan for implementation of the NPI numbers. This is consistent with CMS' contingency plans for transition to HIPAA transaction and codes sets.**

Any contingency plan should also take into account that many physicians' software billing vendors have not yet made updates to these systems to accommodate the NPI. The AMA recognizes that submission of both the NPI and legacy billing number on claims is the preferred method for many payers, including Medicare, since this aids them in "crosswalking" a physician's NPI to their legacy number(s). Yet, many vendors, as evidenced by the WEDI data, are unable to support this. As discussed above, many vendors have not yet modified their systems to allow dual reporting, and therefore any contingency plan must allow for the continued use of legacy numbers. Otherwise, such a plan will not be viable for physicians.

### *Outreach*

**The AMA also recommends that PPAC urge CMS to engage in more targeted outreach, prior to implementation of the NPI, to ensure that all physicians receive their NPI.** CMS estimates that it will issue approximately 2.3 million NPIs and that more than 1.81 million have already been issued. Although CMS has published data on the number of providers who have received their NPI by state, the number of physicians without an NPI remains unknown. The AMA has shared data with CMS concerning the number of physicians in each state and the number in each specialty. We have not, however, been able to obtain data from CMS on the number of physicians broken down by specialty within each state who have obtained their NPI, which would significantly improve outreach efforts.

In addition to the need for the foregoing physician NPI data, an outlet for physicians and other providers who have questions concerning the NPI is needed. Presently, the NPPES is only authorized to answer a limited range of questions, such as status of an application and forgotten passwords. A technical assistance line is needed similar in nature to what CMS established prior to the HIPAA transactions and codes sets deadline for physicians and other providers with questions that cannot be answered by NPPES. Without this sort of assistance, implementation will be further stymied.

The foregoing recommendations are vital to assist in a smooth transition to the NPI. **Thus, we urge PPAC to recommend that CMS:**

- **Issue guidelines for the dissemination of the NPI numbers (and associated data), and restrict access to NPIs to physicians and other entities with a legitimate business need for healthcare administrative purposes, while restricting the sale of these numbers;**
- **Collaborate with the AMA to explore ways to minimize the administrative burden on those with legitimate needs to access the NPI, while ensuring that appropriate security safeguards are in place, such as through a data use agreement (DUA);**
- **Institute a contingency plan of a minimum of one year to allow physicians and other providers to continue reporting "legacy" numbers after May 23, 2007, so that the processing of claims is not interrupted — a contingency plan should not mandate the use of both legacy and NPI numbers since many vendors are not yet able to accommodate the use of the NPI; and**

- **Conduct more outreach activities, including (i) the provision of more detailed data concerning the number of physicians (by specialty within each state) that have obtained an NPI; and (ii) instituting a technical assistance hotline.**

The AMA looks forward to working with CMS, other providers, payers, vendors and third parties to facilitate the orderly adoption of the NPI and find a resolution to the many outstanding issues that must be resolved before the widespread use of NPIs is feasible.

### **RECOVERY AUDIT CONTRACTORS**

The AMA has continued concerns about the physician audits under the RAC demonstration project. These concerns are heightened by the fact that H.R. 6111 extended the RAC program (which is currently being pilot-tested in Florida, California and New York) to all states by January 1, 2010, and thus the program will impact physicians nationwide. **The AMA, therefore recommends that PPAC urge CMS to:**

- **Limit the number of times a physician can be audited under the RAC program.** Some physicians in the current pilot-tested states are experiencing undue administrative burden as a result of multiple audits by the RACs. For example, we understand that one physician in California received 60 audits total. Audits are very time consuming and the administrative burden can be debilitating for a physician and his/her staff. The RACs typically require physicians to collect and send myriad documents, including physician orders and progress notes, diagnostic test results, history, operative reports, and certificates of medical necessity, even when the requested documentation is housed in a multitude of different locations or facilities. In providing this documentation, physicians are being diverted from treating patients. Thus, if audits have been performed and outcomes are satisfactory, the RACs should not be able to audit the physician further.
- **Require the RACs to standardize communications with physicians concerning the audit, including (i) demand letters sent to a physician when requesting a Medicare overpayment, and (ii) letters requesting additional information about a physician's claim to determine if there has been an overpayment. We also urge that CMS invite comprehensive input from the physician community when standardizing these communications between the RACs and physicians.** The AMA has previously provided CMS with suggested language for use in the demand letters, and we urge CMS to ensure that the RACs are incorporating this language into the RAC standardized letter. We will also provide CMS with similar language for the "request for more information" letter.
- **Require the RACs to provide physicians with more information in written communications to physicians. Specifically, the RACs should provide an explanation in the audit notification letter of who they are and that they are performing RAC audits, along with a reference to a CMS-issued MLN Matters article (under which Medicare provides outreach information to physicians) explaining the RAC program. Further, RACs should be required to use the**

**CMS logo on all RAC written communications to physicians.** From the outset of the RAC program, we have heard about various instances in which the RACs sent communications to physicians without the CMS logo. In these cases, physicians are unclear about the origin or authenticity of the letter. Although we understand from CMS that this concern has been addressed, we again emphasize the importance of CMS exercising its oversight to ensure continued compliance with this policy, especially when the RAC program becomes extended nationwide. **Finally, RACs should provide information to physicians about requesting extensions under the audit to assist physicians in being able to provide the requested information while minimizing the associated burden.**

- **Make publicly available certain information specific to the scope of the RAC audits, including the total number of claims that have been and are being reviewed by the RACs, as well as the types of claims that the RAC may and may not review.**
- **Expand its outreach activities under the RAC program to provide physicians with educational information about billing errors being found by the RACs.** The RAC program was intended to be a constructive program that would assist physicians in correcting patterns of unintentional billing errors. To achieve this goal, the RAC program must be educational rather than punitive, and CMS outreach to communicate meaningful approaches to remedying common billing mistakes is vital for ensuring that the RAC program is consistent with its constructive intent.
- **Continue to work collaboratively with the AMA as the RAC program is expanded, and maintain an open dialogue that is conducive to addressing concerns before and as they arise.** The AMA appreciates the communication that exists with CMS today on the RAC pilot and is hopeful that this can continue and be strengthened.

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