



Statement

of the

American Medical Association

to the

Practicing Physicians Advisory Council

RE: Physician Quality Initiatives
Implementation Of Part D Drug Program

Presented by: John H. Armstrong, MD

March 6, 2006

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 pay-for-performance and implementation of the Part D drug program.

Before turning to the issues on the agenda today, the AMA would like to advise PPAC of the status of the Medicare physician payment rate for 2006 and beyond. In early February, the President signed *The Deficit Reduction Act of 2005*, as passed by Congress, which enacts a freeze in payment rates under the Medicare physician payment formula (the sustainable growth rate, or SGR), reversing a scheduled 4.4 percent cut that went into effect on January 1, 2006. We are grateful for this intervention by Congress and the Administration and appreciate efforts by the Centers for Medicare and Medicaid Services (CMS) to ensure that the freeze is applied retroactively to services provided between January 1, 2005, and date of enactment (February 8, 2005). Specifically, CMS will automatically adjust claims that were submitted by physicians during this period, and physicians will not need to re-submit such claims. Further, at the AMA's request, CMS has instructed its carriers to forward adjusted claims to Medigap and secondary insurers. Thus, most Medigap plans and some secondary insurers will also make automatic adjustments, as well.

Despite these intervention efforts, however, we remind PPAC that a crisis still looms. **It is projected that on January 1, 2007, payment rates will be cut across-the-board by about 5 percent, and the 2006 Medicare Trustees' report is expected to project cuts in physician payment rates, due to the SGR, totaling 34 percent through 2015.** The AMA will continue to work with Congress and the Administration to avert these cuts, which threaten to seriously impact patient access to quality care. In doing so, we emphasize that although the Administration and many policymakers envision transforming the physician payment system to emphasize health information technology and quality improvement, that

vision will never be realized as long as the SGR and the pay cuts that result from this formula continue.

PHYSICIAN QUALITY INITIATIVES

The AMA is committed to continuing our work with CMS concerning initiatives to provide the highest quality of care for our patients. This includes working with CMS to establish a voluntary reporting system using evidence-based physician-level measures developed collaboratively across physician specialties, that can be reported by physicians with minimal administrative cost and burden. The AMA was founded to advance quality of care and that goal remains paramount to the AMA and its physician members. Over the last 158 years, AMA efforts have strengthened medical licensure requirements, reformed medical training programs, and provided oversight for continuing medical education activities.

The AMA leadership plays an active role in various national multi-stakeholder organizations dedicated to quality improvement, including the National Quality Forum (NQF), Hospital Quality Alliance (HQA), and the Ambulatory Care Quality Alliance (AQA). Further, five years ago, the AMA convened the Physician Consortium for Performance Improvement (Consortium), which has developed physician-level performance measures that are the foundation for emerging physician quality reporting activities in the public- and private-sectors.

The Consortium brings together physician and quality experts from 70+ national medical specialty societies as well as representatives from CMS, the Agency for Health Care Quality and Research (AHRQ), and the Consumer-Purchaser Disclosure Project. To date, the Consortium has developed 90 measures covering 15 conditions. These existing measures cover clinical conditions that make up a substantial percentage of Medicare expenditures.

The AMA believes it is critical for CMS to work through these existing multi-stakeholder groups, such as the Consortium, NQF and AQA to pursue its quality roadmap. CMS already participates in these groups as well. Without input and buy-in from physicians, patients, private sector purchasers and health plans, establishing successful quality improvement initiatives will be extremely difficult. Physician measures used by CMS should be developed by physician specialties through the Consortium, endorsed by NQF, and implemented uniformly across public and private programs by working through the AQA.

The AMA is in the process of working with CMS to ensure the measures and reporting mechanisms that form the basis of CMS' recently announced "Physician Voluntary Reporting Program" (PVRP) reflect the collaborative work already undertaken by the AMA, CMS and the rest of the physician community. In fact, the AMA has made a number of recommendations and commitments to CMS to improve the PVRP and achieve our mutual quality improvement goals, as follows:

- The AMA is allocating significant additional resources to accelerate the development of physician performance measures. We are doubling the staff

dedicated to performance measure development by adding 5 new staff, which will allow us to significantly accelerate the work of the Consortium. By the end of 2006, the Consortium plans to have developed a total of approximately 140 physician performance measures covering 34 clinical areas.

- The Consortium is reviewing PVRP hospital facility measures in early 2006 for conversion to physician-level measures where appropriate. In situations where facility level measures do not translate to measuring an individual physician, the Consortium will propose appropriate alternatives.
- The AMA is fast-tracking approval of CPT II codes, which many stakeholders believe are a better alternative than the proposed G codes for reporting quality data to CMS on physician claims.
- The AMA is continuing to accelerate the development of measures and will work through the AQA and other forums to ensure that a uniform set of measures are used by all parties.
- The AMA is working with CMS to co-host a follow-up meeting with CMS and electronic health record vendors to discuss integration of quality reporting activities in software products.
- The AMA is continuing to expand educational activities for our member physicians on incorporating quality measurement and improvement in their practices.
- The AMA will work with CMS by providing practicing physician expertise on the evaluation of CMS demonstration projects on performance-based payments.

The AMA has made the foregoing commitments to continue our ongoing efforts to enhance quality improvement, while federal programs seek to do the same. As we continue in these efforts, it is important also to act to eliminate any major barriers to optimizing quality of care. For example, as we have previously advised PPAC, continuation of the SGR eliminates opportunities for investment and innovation that will benefit patient care and generate system-wide savings. An adequate Medicare physician payment structure is fundamental for implementation of Medicare quality of care initiatives. Pay-for-performance and the SGR are not compatible. Pay-for-performance may save dollars for the program as a whole. Many performance measures, however, ask physicians to deliver more care, as has been found by the Leapfrog Group in their recent study (The Rewarding Results Project) which showed significant increases in physician visits for many services. If the SGR is linked to value-based purchasing, more physician services will result in more physician payment cuts. Further, pay-for-performance depends on greater physician adoption of information technology, as was also indicated by the Leapfrog study referenced above. Unless physicians receive positive payment updates, however, these investments will not be possible.

Thus, we urge PPAC to recommend to CMS that pay-for-performance initiatives be premised on elimination of the current SGR formula. The AMA looks forward to continuing our work on quality improvement and pay-for-performance with Administrator McClellan and physician leaders. Working together, the Administration, Congress, and the physician community can strengthen the Medicare program and correct problems that undermine Medicare patient access to their physician of choice, along with high quality medical services.

IMPLEMENTATION OF THE PART D DRUG PROGRAM

The Medicare program has been providing its new outpatient prescription drug benefit since January 1 of this year. The initial implementation of this new benefit, which is a significant expansion of the Medicare program, created serious hardships for many patients, especially patients who were switched overnight from their previous Medicaid drug plans to their new Medicare drug plans. Although we understand from CMS and the pharmacist organizations that many of the initial systems failures have been corrected and that a much smaller percentage of patients are experiencing problems in the benefit's second month than was the case in the first month, there are still problems that must be addressed.

The AMA is grateful for CMS' recent efforts to address the various problems that have arisen, and we are committed to continuing to work with CMS to address implementation issues, as well as minimize the additional administrative burden physicians will experience as a result of this new benefit. Keeping the administrative burden to a minimum is always a priority, but is now even more so now in light of the steep Medicare pay cuts that are being projected through 2015.

To help implement the new benefit, the AMA launched a working group last June comprised of physician, pharmacist and patient organizations. It is crucial to ensure effective implementation of this new benefit since 40 percent of seniors take five or more prescription drugs. The working group has been collaborating with CMS, and we are very appreciative of the diligence shown by CMS and agency officials, who have listened and effectively responded to our requests. For example, Dr. Jeffery Kelman was instrumental in getting CMS approval and website posting of a standardized voluntary form that the working group developed to facilitate and streamline communication between physicians and pharmacists. Pharmacists can use the form to inform physicians of issues with drug plan coverage policies and to let physicians know if alternative medications may be available at lower cost to the patient. It is posted on the AMA and CMS web sites, as well as other sites, for easy access by physicians and pharmacists. This will help patients get the drugs prescribed by their physicians and save money with the new benefit.

We also requested that CMS require Medicare prescription drug plans to extend from 30 to 90 days the amount of time that enrollees will be permitted to obtain prescription drugs under the coverage and payment policies of their former drug plan, *e.g.*, a state Medicaid drug plan. We are grateful that CMS approved this request. Originally, CMS was going to require Medicare drug plans to provide new enrollees with one-month of re-fills under the

coverage policies of the enrollee's former drug plan. This was intended to allow patients time to determine whether coverage of certain drugs regularly prescribed by their physician would have the same level of coverage, if at all, under their new Medicare drug plan. If not, patients would need time to consult with their physician to ascertain whether a change to a similar, but different brand of drug, would be medically advisable, especially with regard to possible adverse drug interactions. CMS has agreed to extend this 30-day transition window to 90 days, which means that the Medicare plans must provide patients with three-months of drug re-fills under the coverage and payment policies of their old drug plan. This extended transition window will go a long way toward helping patients.

We are also appreciative that CMS has developed solutions to address confusion about prescription drugs that could be covered by Part D or Part B. As for any further confusion about additional implementation issues under the Medicare new drug benefit, the working group's efforts will continue. **We are now working with CMS to create a model, standardized voluntary form for physicians to use when supplying plans with information needed to make a formulary exception request.** This form will assist physicians in helping patients quickly get prescriptions filled that the plan does not normally cover. Physicians consider multiple factors in selecting drug therapies for their patients in order to optimize benefits while minimizing problems like drug interactions, side effects and allergies. In order to avoid complications from changes in medication, physicians may need to seek exceptions for these patients. The new model form will also help some patients pay lower co-payments for a drug they need when a substitute drug will not work, as well as help minimize the administrative burden on physicians.

We look forward to working with CMS, as the new Medicare drug benefit is implemented, to help Medicare patients and physicians easily utilize this new important benefit and access prescription drugs that are critical to patients' health and quality of life.

RAC AUDITS

The AMA would also like to advise PPAC of our concerns about ongoing implementation of the recovery audit demonstration program (the RAC audits), as mandated by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). Under this MMA provision, CMS and its contractors are conducting audits (now underway in Florida, New York and California) to identify over- and under-payments, as well as recoup over-payments.

The AMA fully supports accurate billing practices and is very mindful of the need to educate physicians about Medicare policies and related billing issues. Since the RAC program was rolled out last April, we have had numerous conversations with CMS staff in which we conveyed our strong desire to maintain open lines of communication with physicians and the need for advance outreach to physicians. While CMS has agreed that outreach is a critical component, we have concerns about the roll out of the RAC program with regard to physician communications:

- We understand that the content and format of the demand letters is both confusing and unnecessarily blunt, which serves only to incite physicians and undermine the purpose of the audits, *i.e.*, to educate physicians concerning billing problems and to prevent future problems as well. **We have expressed our strong desire to work with CMS to improve the demand letter, and we are hopeful that CMS will allow us to provide input in the near future.**
- Physicians remain confused about their rights and key deadlines under the recoupment and appeals processes, and we encourage CMS to clarify these.
- CMS has yet to share with physicians, through clear communication channels, the types of overpayment problems the RACs have uncovered in Florida. If the intent of the program is to curb inappropriate Medicare payments to physicians and other providers, sharing this information will go a long way in helping to educate physicians and prevent future billing problems.
- As we advised PPAC at the December 2005 meeting, there is no process for providing contractors conducting the RAC audits with incentives to identify underpayments during a RAC audit. Currently, the RACs receive a portion of the overpaid monies collected, as reimbursement for their services. We understand that CMS is close to establishing an incentive program that rewards the RACs for identifying underpayments, and we look forward to hearing about it.

Physicians across the country are very interested in following the RAC demonstration, and the AMA is committed to continuing to keep the dialogue open as this demonstration moves into its second year. We stand ready to aid CMS in reaching out to our state medical societies to help educate them on the issues that stem from the overpayments identified by the RACs. **To aid in this effort, we urge PPAC to recommend that CMS make public: (i) copies of the types of the demand letters mailed to Florida and California physicians, (ii) a clarification of the key deadlines that apply to the recoupment and appeals processes; and (iii) information concerning how CMS intends to create incentives for identifying underpayments.**

We appreciate the opportunity to provide our views on the foregoing and look forward to continuing to work with PPAC and CMS in addressing these important matters.