



Statement

of the

American Medical Association

to the

Practicing Physicians Advisory Council

RE: Pay for Performance: Measure Development
Medically Unbelievable Edits

Presented by: William A. Hazel Jr., MD

May 22, 2006

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202 789-7426

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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) pay-for-performance: measure development; and (ii) medically unbelievable edits (MUE or MUEs).

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 2007 and beyond. As we previously advised PPAC, Medicare payment rates for physicians and other health care professionals are projected to be cut by 4.7% beginning January 1, 2007. Further, the recently-issued 2006 Medicare Trustees Report confirms forecasted Medicare physician cuts totaling 37% over nine years (2007 through 2015). To compound matters even more, these cuts will occur as medical practice costs rise by 22% over this same time period, according to the government's own conservative estimate.

The AMA is working with the Administration, CMS and Congress to advance the use of health information technology (HIT) and quality improvement initiatives. Yet, stable, positive Medicare payment updates, that accurately reflect medical practice cost increases, are vital for encouraging and economically supporting physicians' ability to make the very significant financial investment required for HIT and participation in quality improvement programs. In fact, a 2006 AMA survey showed that if the projected nine years of cuts take

effect, 73% of responding physicians will defer purchase of new medical equipment and 65% will defer purchase of new information technology. Next year alone, half of the physicians surveyed will defer purchases of information technology.

An inadequately funded physician payment system will be most detrimental to Medicare patients. Although physicians want to treat seniors, Medicare cuts are forcing physicians to make difficult practice decisions. According to the AMA survey cited above, nearly half (45%) of the responding physicians said that if the scheduled cut in 2007 is enacted, they will be forced to either decrease or stop seeing new Medicare patients. By the time the full force of the cuts takes effect in 2015, 67% of physicians say they will be forced to decrease or stop taking new Medicare patients. In rural areas, more than 1/3 of physicians say they will be forced to cut off outreach services.

Medicare physician cuts also have a ripple effect across the whole health care system, reducing payment rates from other sources. For example, TRICARE, which provides health insurance for military families and retirees, ties its physician payment rates to Medicare, as do some state Medicaid programs.

Only physicians and other health professionals face such steep cuts. Other providers have been receiving updates that fully keep pace with their costs (and will continue to do so under current law). In 2006, for example, updates for other providers were as follows: 3.7% for hospitals, 3.1% for nursing homes, and 4.8% for Medicare Advantage (MA) plans (which are already paid at an average of 107% of fee-for-service costs). In addition, CMS recently announced a 7.1% update for MA plans for 2007, which is used to develop a benchmark against which MA plans submit bids (for providing Part A and B benefits to enrollees). Using this as a benchmark, CMS expects an average MA update of 4% in 2007, with some plans still receiving up to 7.1%.

Physicians and other health care professionals (whose payment rates are tied to the physician fee schedule) must have payment equity with these other providers. Physicians form a strong foundation for our nation's health care system, and thus a stable payment environment for their services is critical. Payment rates that are basically flat relative to 2001, along with skyrocketing practice costs and pending cuts totaling 37%, present an economic outlook that simply is not sustainable. Rather, the current Medicare physician payment system undermines policymakers' goal of an improved Medicare system that uses HIT and quality initiatives to deliver the highest quality of care to patients and jeopardizes access to care for the elderly and disabled, as well as for military families. Furthermore, every time action to repeal the SGR is postponed, the cost of the next temporary fix, as well as a long-term solution, becomes significantly higher.

Accordingly, we urge CMS to support: (i) repeal of the SGR physician payment system and replacing it with a system that adequately keeps pace with increases in medical practice costs; and (ii) establishing a 2.8% physician payment update in 2007, as recommended by the Medicare payment Advisory Commission (MedPAC). The AMA will continue to work with the Administration, CMS and Congress to achieve these goals. 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.

PAY-FOR-PERFORMANCE: MEASURE DEVELOPMENT

As we advised PPAC at its March meeting, 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.

As at the Council's March meeting, we again express the AMA's commitment to continuing our quality improvement efforts through the AMA-convened 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 93 measures covering 16 conditions. These existing measures cover clinical conditions that make up a substantial percentage of Medicare expenditures.

We reiterate our commitment to working with CMS to ensure that the measures and reporting mechanisms that form the basis of CMS' "Physician Voluntary Reporting Program" (PVRP) reflect the collaborative work already undertaken by the AMA, CMS and the rest of the physician community. To improve the PVRP and achieve our mutual quality improvement goals, the AMA has made the following recommendations and commitments to CMS:

- The AMA has allocated significant additional resources to accelerate the development of physician performance measures. We are in the process of doubling the staff dedicated to performance measure development, which is allowing 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. Work is already underway in 10 clinical work groups.
- The Consortium is reviewing PVRP hospital facility measures for conversion to physician-level measures, where appropriate. In situations where facility level measures do not translate to measuring an individual physician, the Consortium plans to 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/Consortium is continuing to accelerate the development of measures and is working through the AQA and other forums to ensure that a uniform set of measures are used by all parties.
- The AMA will co-host in June (with NCQA) 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 is working with CMS by providing practicing physician expertise on the evaluation of CMS demonstration projects on performance-based payments.

As we continue in our ongoing efforts to enhance quality improvement, it is important to ensure that quality and efficiency performance measures are developed through the 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). **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.

Accordingly, we urge PPAC to recommend that physician measures used by CMS should be developed by physician specialties through the Consortium, endorsed by the NQF, and implemented uniformly across public and private programs by working through the AQA. All measures – whether quality or efficiency measures – must be evidence-based, valid measures (with sufficient evidence to show that the measure will improve quality of care) and, as stated above, developed by the medical specialty societies in a transparent process. We also emphasize particular caution with respect to the development of efficiency measures. These measures must meet the same high standards that apply to quality measures, and it is imperative that efficiency measures avoid the danger that the lowest-cost treatment will supersede the most appropriate care for an individual patient. There must also be broad-based consensus regarding what constitutes appropriate levels of care before measuring for efficiency.

The development of quality measures for implementation of a pay-for-reporting or pay-for-performance program must also take into account any major barriers to optimizing quality of care. For example, as discussed above, 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 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, pay-for-performance initiatives must 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.

MEDICALLY UNBELIEVABLE EDITS

CMS is working on a new set of edits to HCPCS/CPT codes, called medically unbelievable edits. The purpose of the edits is to prevent overpayments resulting from such matters as reporting excess units of service due to entry errors or incorrect interpretation of HCPCS/CPT codes. These edits are maximum units of service (UOS) edits assigned to each HCPCS/CPT code, and will be applied to each HCPCS/CPT code reported by a provider for the same beneficiary on the same date of service.

We appreciated that CMS extended the MUE program implementation date from July 1, 2006, to no earlier than January 1, 2007, as well as the review period for public response to the proposed edits. Nevertheless, although we support CMS' efforts to reduce the Medicare error rate and believe that the appropriate use of unit edits to correct claims errors is a reasonable approach, we have serious concerns that CMS has underestimated the scope of review, the importance of accuracy and the need for detailed rationale and data behind these edits. **Thus, the AMA urges PPAC to recommend the following to CMS:**

1. CMS should make available the rationale and frequency data behind the MUEs.

In written correspondence, dated January 18, 2005, as well as in an AMA/medical specialty sign-on letter (signed by over 90 medical specialties), dated April 10, 2005, the physician community has requested that CMS make available the rationale and frequency data used in developing the prospective edits. In addition, the AMA has made this same request via numerous conversations with senior CMS staff. CMS has yet to disclose the data and rationale.

The continued lack of transparency in developing the proposed edits leads to a more time consuming review process because organized medicine must speculate on the basis for which each edit was established. Initial comments from the specialty societies on the MUEs suggest that the units assigned contradict current well established, evidence-based medical practice. Moreover, errors in the MUE file could have the unintended effect of hurting patients by setting clinically inappropriate limits. In addition, although we appreciate CMS' explanation that the intent of the MUEs is to identify obvious billing mistakes (rather than set Medicare payment policy), without any data to substantiate the edits, the intent remains unclear. Thus, CMS should make available the rationale and frequency data behind the MUEs.

2. CMS should move implementation of the MUE program to June 2007, and the deadline for public comments on the proposed MUEs should be moved to December 31, 2006.

CMS has proposed a dual public review and comment period (of the proposed MUEs), with the first set of public comments due on June 19, 2006, followed by another comment deadline in the fall of 2006. Due to CMS' failure to release the rationale and data for the proposed edits, these deadlines for public comment seriously underestimate the amount of time necessary to adequately review the proposed edits. The scope of review itself is a very lengthy and involved process. The file containing the MUEs involves over 10,000 CPT codes and HCPCS Level II codes. This is not merely a review of new and revised CPT codes for a new version of the National Correct Coding Initiative (NCCI). The AMA strongly believes that the current, condensed review process will negatively affect the MUE program. Thus, CMS should establish December 31, 2006, as the single deadline for all public comments, with an MUE program implementation date of June 2007.

3. Allow the use of modifiers for services that may be clinical outliers and develop an appeals process.

There is no system in place for using modifiers or for appealing an edit. These are two important aspects of the MUE effort that are essential for making this a workable edit system. Thus, CMS should allow the use of modifiers for services that may be clinical outliers and develop an appeals process.

We look forward to working closely with CMS to refine a program that works well for physicians, patients and CMS.

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.