



Statement

of the

American Medical Association

to the

Practicing Physicians Advisory Council

RE: Physician Quality Reporting Initiative
Medicare Physician Enrollment Medicare
Non-Payment for Healthcare-Associated
Conditions

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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 the Physician Quality Reporting Initiative (PQRI), Medicare physician enrollment, and Medicare non-payment for healthcare-associated conditions (HACs).

PHYSICIAN QUALITY REPORTING PROGRAM

The AMA expressed strong concerns regarding implementation problems with the 2007 PQRI in our comments to CMS regarding the Medicare physician fee schedule proposed rule. We are extremely disappointed that CMS failed to address these concerns in the final rule.

According to CMS data, approximately 16 percent of physicians attempted to report on measures in the 2007 program, but only half of them received bonus payments. Further, feedback reports and bonus payments were not disseminated until 7 months after the reporting period ended, well after this information could be used by physicians to correct reporting procedures for either 2007 or 2008.

There is widespread confusion and no clear direction from CMS regarding why so many physicians were unsuccessful in reporting during the first year of the program. Without clearly understanding how physicians and eligible professionals can successfully report under the PQRI, it is nearly impossible to improve success rates. Yet, CMS is about to launch the third year of the PQRI program, and in the near future will make publicly available information about whether physicians' successfully participated in the PQRI. The AMA wants to help physicians succeed in participating in the PQRI, but as the program is

currently operating, that is nearly impossible. CMS must make changes now to assist physicians in successful PQRI participation. We sent the attached letter to the Centers for Medicare and Medicaid Services (CMS) in early November again urging CMS to work with the physician community to implement our PQRI recommendations, as set forth in the letter. **We urge PPAC to reiterate these recommendations to CMS.**

Further, the attached letter discusses the insurmountable hurdles to successful participation in the 2007 PQRI, as reported to the AMA in a September 2008 survey. **With such a troublesome start of the PQRI program, we urge CMS to conduct a formal, rigorous evaluation of the program to address and resolve its problems before expanding it further.**

The AMA also is disappointed that CMS continues to lack transparency in the PQRI measure selection and implementation processes. CMS failed to include certain measures recommended by the AMA-convened Physician Consortium for Performance Improvement (PCPI) in the 2009 PQRI and certain measures will only apply to registry-based reporting. Yet, the agency did not adequately explain its rationale for not including these measures or limiting application of some measures to registries only. **We reiterate our comments on the proposed physician fee schedule rule urging CMS to ensure greater transparency in all aspects of developing the PQRI program, especially regarding the measure and implementation processes.**

ENROLLMENT

The AMA urges PPAC to recommend that CMS withdraw the changes to the enrollment and appeals process contained in the physician fee schedule final rule until the chronic enrollment and related payment delays are resolved. The AMA is deeply disturbed by CMS' decision to move forward with significant changes to the Medicare enrollment process in 2009 at time when the system is strained beyond capacity and incapable of handling current workloads. Further magnifying these problems has been the transition to the National Provider Identifier (NPI). Unfortunately for physicians, because Medicare was unable to appropriately match enrollment data with the new NPI numbers, countless physicians across the country—even those who have been enrolled for decades—have been required to re-enroll in the program, further straining an already backlogged process. It is astonishing, given the systemic problems that have resulted from a series of changes that began in 2006 and have continued unabated through the NPI transition, that CMS is making even more changes to the program.

The AMA has repeatedly documented these problems for CMS, and has shared numerous individual physician issues with the agency. It is discouraging that the problems physicians have experienced could have been diminished if CMS had focused on a smaller subset of changes over the last several years. Instead, CMS has made so many changes to the process that neither Medicare contractor staff nor physicians are able to keep up.

The existing enrollment application processing delays are contributing to serious cash flow problems for physicians, problems that have been significantly amplified by the current

economic crisis. Physicians are reporting that they are unable to secure revolving loans to help them while they await processing of their enrollment applications. As the availability of credit and revolving loans for small businesses has shrunk dramatically, there has been a pronounced increase in the number of physician practices reporting that they are unable to meet their payroll, are late on payroll taxes, cannot make timely mortgage payments, are unable to pay their liability insurance, and have had to stop paying other key bills like phone service. In addition to a recent account of financial difficulties faced by physician practices in California, Nevada, and Hawaii by the *Los Angeles Times*, we have heard from a growing number of physicians, especially in New York and Connecticut, who are struggling financially. In some cases, physicians have said that attempting to get re-enrolled during the transition to the NPI was such a fruitless exercise that these physicians are no longer taking Medicare patients.

Since May, when the NPI became mandatory and physicians saw payment interruptions, we have urged physicians to ask their contractors for advance payments. Unfortunately, in many cases Medicare contractors are not aware of this option. Although CMS promised to make an advance payment option more widely publicized, to date this has not happened. Only a handful of Medicare contractor websites contain any information about advance payments, and when some physicians requested an advance payment from their contractor, they were told this option does not exist.

Complicating matters further is when contractors are familiar with advance payments, many physicians are denied this option because they have not been billing in the past several months, which we understand is a key criterion in establishing a physician's eligibility for advance payments. Yet, the precise reason physicians are having cash flow problems is because they are unable to bill while they wait to become re-enrolled. CMS recently instructed the contractor servicing physicians in California, Nevada, and Hawaii to streamline the process and relax the criteria for advanced payments. It is critical that the same flexibility apply nationwide.

Another problematic change that is scheduled to go into effect soon involves dramatically curtailing a physician's ability to retroactively bill while they are waiting for their enrollment process to be completed. While physicians are currently prohibited from billing Medicare prior to their enrollment, once enrolled, physicians, depending on their effective date of enrollment, may retroactively bill the Medicare program for services that were furnished up to 27 months prior to being enrolled to participate in the Medicare program. In the final rule, CMS has materially gutted a physicians' ability to retroactively bill. In its place, CMS has indicated that the eligibility date for billing will be the later of two dates: (1) the date of filing of a Medicare enrollment application that was subsequently approved by the contractor; or (2) the date an enrolled physician first started rendering services at a new practice location. The application filing date would be the date the contractor receives a signed enrollment application *that it is able to process to approval*. We have experienced, however, numerous instances where contractors send multiple applications back to a physician for picayune reasons. In other instances, contractors require physicians to re-file a new enrollment application when the physician has received inaccurate or incomplete guidance from their contractor or the contractor misplaces the physician's original

enrollment application and/or supporting documentation. Each time a physician is required to file a new application, the official application filing date is delayed, and this, in turn, delays the effective date of a physician's billing privileges. This will be extremely burdensome for a physician who begins treating Medicare patients when the physician files an initial enrollment application, but who subsequently may be barred for billing for those Medicare patients because the contractor unnecessarily requires the physician to continually re-file new applications (thereby establishing a delayed application filing date.)

In the past, this would create financial pressure, but the new rule will constitute a significant and substantial reduction in payment and also exacerbate tensions between physicians and contractors that have misplaced or otherwise provided inadequate guidance on the enrollment application process. These problems also will be exacerbated because contractors do not meet application processing standards and the MAC transition is still underway, with more transition challenges ahead. Further, there is some confusion surrounding when physicians may retroactively bill prior to the filing date of their enrollment application. The new enrollment requirements permit physicians to retrospectively bill 30 days prior to their filing effective date "if circumstances precluded enrollment in advance of providing services to Medicare beneficiaries." It is unclear what "circumstances" constitute those that "preclude enrollment" in advance of providing services to Medicare beneficiaries. We urge CMS to clarify this matter."

It is also unacceptable that CMS has established more stringent guidelines for physician enrollment when the Medicare contractors are not meeting the current standards in place today. Customer service lines are notoriously understaffed and staffed with inexperienced agents who are incapable of answering even the most basic questions correctly. This problem has been exacerbated by the transition to the MACs and the fact that contractors are unable to keep up with the relentless series of changes to the Medicare enrollment process. While we recognize that CMS has devoted additional resources to those contractors with the most problems, significant problems remain which must be resolved before more changes are made. CMS is starting to roll-out an internet-based enrollment system (PECOS web), which should ultimately mitigate lengthy application processing timeframes and backlogs. We are concerned, however, that as with any new large computer system roll-out, there will be glitches that will need to be overcome before optimal performance can be expected. Yet, relief for physicians in financial distress is needed now.

The foregoing underscores, especially in light of the current financial and credit malaise, that the existing delays in physician enrollment have already placed a growing number of physician practices on precarious financial footing. The application of the new enrollment and appeals process regulations will only increase the volume of work contractors must undertake to process new and updated enrollments when no additional recourses have been allocated for this work and despite the fact that there are currently insufficient resources to process the existing work load. We believe that application of the new requirements at this time will push an ever growing number of physician practices into financial distress. **Thus, we strongly urge PPAC to recommend that CMS:**

- **Withdraw changes to the Medicare enrollment process as proposed by CMS in the physician fee schedule final rule, until related physician payment delays are resolved nationwide, as this is a significant factor contributing to these serious cash flow problems;**
- **Increase flexibility for advance payments to physicians nationwide by relaxing the current criteria and take immediate steps to ensure that all contractors and physicians experiencing NPI/enrollment problems are aware of the advance payment option including posting this information on each contractor's website; and**
- **Continue to monitor physician satisfaction with the enrollment process and customer service lines and take appropriate actions to resolve problems with contractors identified as poor performers.**

MEDICARE NON-PAYMENT FOR HEALTHCARE-ASSOCIATED CONDITIONS

In the proposed Medicare physician fee schedule rule, CMS discussed that the Medicare non-payment policy for healthcare-associated conditions not present on admission (POA) in the hospital inpatient setting could be applied more broadly to other Medicare payment systems, including physicians' practices, the outpatient prospective payment system, ambulatory surgical centers, skilled nursing facilities, home health care, and end-stage renal disease facilities. CMS requested comments regarding application of this policy to other Medicare payment systems.

CMS acknowledged in the final physician fee schedule rule that it received many public comments raising concerns about the HAC policy, and its extension to physician practices. We are disappointed that CMS merely acknowledged these concerns, but failed to take them into consideration. Rather, CMS repeated its statement from the proposed rule that it "looks forward to working with stakeholders to expand VBP [value based purchasing] initiatives in all Medicare payment settings." CMS is holding a listening session to discuss the HAC policy with all stakeholders on December 9, 2008. The AMA will reiterate our grave concerns at that meeting.

As we discussed at the September PPAC meeting, the AMA strongly opposes non-payment for HACs in the inpatient or in any payment setting that are not reasonably preventable through the application of evidence-based guidelines, developed by appropriate medical specialty organizations based on non-biased, well-designed, prospective, randomized studies.

Our main concerns with the HAC policy and its potential extension to physician practices are:

- **CMS does not have the statutory authority to extend the inpatient HAC policy to other settings, including physician office practices.** Under the Deficit Reduction Act of 2005, Congress specifically provided CMS with the authority to begin applying the HAC policy to the hospital inpatient setting. If CMS were to extend this policy to other settings, it would likewise need similar statutory authority granted by Congress.

- **In developing the HAC policy, CMS confuses events that should never happen in a hospital, like wrong-site surgery, with often unavoidable conditions, like surgical site infections.** Medical conditions covered by the HAC policy should be reasonably preventable through the application of evidence-based guidelines. To be reasonably preventable, there should be solid evidence that by following guidelines, the occurrence of an event can be reduced to zero or near zero. Yet, there is strong, broad disagreement with CMS throughout the medical community that the conditions covered under the inpatient HAC non-payment policy are “reasonably preventable.” The AMA continues to work aggressively to improve quality and efficiency for patients, but simply not paying for complications or conditions that, while extremely regrettable, are not entirely preventable is not effective or good for patients or the Medicare program.
- **The HAC policy will increase Medicare spending on tests and screenings with questionable benefit to patients.** The HAC policy requires hospitals to ensure that certain medical conditions are not present on admission. To determine whether a condition exists when the patient enters the hospital will increase Medicare spending on tests and screenings with questionable benefit to patients. This could also delay needed care, with possible increased risk for patients due to the delay.
- **Expanding the inpatient HAC nonpayment policy to other settings would be extremely problematic, especially in physician offices, because the payment approach is completely different from the hospital setting.** For example, the appropriate level of an evaluation and management service is based on the conditions managed at a given encounter and the time and intensity of the work associated with those conditions. Because the presence and severity of additional conditions that are present during the visit will vary greatly among patients, identifying and valuing the work attributable to a preventable condition managed by the physician at a visit would be very difficult. In addition, the lack of adequate risk adjusters is an even greater problem in physician practices than in hospitals because some physicians specialize in treating the riskiest patients and do not have the ability to make up for losses on these patients through care of patients with below-average risks. Further, patient compliance outside of the physician office setting would be extremely difficult to assess and monitor, which also could seriously hamper any risk adjustment techniques. **Since many factors outside of a physicians’ control could cause a patient to acquire various conditions while under a physician’s care, CMS should instead encourage compliance with evidence-based guidelines rather than extending the HAC policy.**
- **CMS should conduct an analysis of the current inpatient HAC policy, in consultation with technical experts, physician organizations, hospitals and other impacted providers. This analysis must occur before extending this approach to other settings.** It is unacceptable that CMS is considering expansion of the inpatient HAC policy when the agency has not yet conducted any analysis of: (i) the impact of the current HAC inpatient policy with regard to such concerns as: impact on the quality of care delivered to patients, especially in proportion to the additional costs to the Medicare program required to comply with the HAC requirements; (ii) the need for

appropriate risk adjustment techniques; (iv) how to determine attribution issues with respect to when, where and why a condition has occurred; and (iii) the reasonable number of expected incidences in which these conditions will occur in individual hospitals, especially with regard to high-risk patients, when evidence-based guidelines are followed.

It defies any logical rationale to extend an approach to other settings when it is not clear that the approach achieves its quality improvement goals and, in fact, may cost significantly more money in proportion to overall program benefits and delay or deny access to needed care for patients.

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