Proposals for House Energy & Commerce SGR Repeal July 18 Discussion Draft
American Medical Association / July 20, 2013

The American Medical Association (AMA) continues to commend the Committee for its dedication in developing legislation to permanently repeal the Sustainable Growth Rate (SGR). We offer the following comments and recommend that the Committee make the changes outlined below to the Committee's July 18 Discussion Draft:

SGR Repeal after 2013: The AMA strongly supports this provision.

Annual payment updates: Subsections (a) (2) and (b) (page 3, lines 7-14 & 22-25). Updates of 0.5 percent for 2014 through 2018, and beginning with 2019. We commend the Committee for recognizing the need to provide physicians with positive updates. We believe that physician updates should keep up with medical practice cost inflation and enable physicians to make necessary and desired investments in new payment models and quality improvement initiatives. We are concerned that the updates and other ongoing payment policies may not allow physicians to sustain their practices and purse new payment models that will improve the Medicare program. We understand the fiscal challenges, and we look forward to continuing to work with the Committee in this area.

UIP Measures replacing PQRS measures: Subsection (b) (2) (page 4, line 19 to page 6, line 16). "Enhancing Physician Quality Reporting System to Support Quality Update Incentive Program." We appreciate the Committee's attempt to build upon PQRS, but we do not believe replacing PQRS measures with UIP measures would be helpful.

- Does the Committee intend to discontinue PQRS reporting requirements and/or penalties? If so, that is not clear.
- Does the Committee intend for existing PQRS measures to serve as the foundation of UIP measures? If so, that would be extremely helpful, and also should be made explicit.

Other specific suggestions for Section 2:

- **Electronic Prescribing** -- Page 5, line 22-23: Delete "(including electronic prescribing quality measures)". This program is being phased out. The last reporting period ended June 30, 2013. Adjustments end after 2015. Any reference to electronic prescribing can be removed.
- **Clinical Improvement Activities --** Page 5 – 6: We support this language adding and defining clinical improvement activities.
- **Peer Cohort Concept** -- Pages 7-9: This adds to the complexity of PQRS. We recommend maintaining the current structure of PQRS, and allowing physicians to participate in the most meaningful option so they can focus on developing and implementing alternative payment models.

- **New Measure Sets Incorporating Clinical Quality Improvement Activities** -- Page 8: These new measure sets would be unnecessary if the PQRS is retained. We recommend strengthening the Secretary's ability to deem clinical improvement activities as qualifying for PQRS participation, as registries were so deemed pursuant to the Taxpayer Relief Act. PQRS quality measures should not be combined with a clinical improvement activity. Rather, physicians should be able to report traditional measures, or alternatively participate in a clinical improvement activity that may or may not use traditional measures, but help improve care outcomes, costs, and/or quality.
- **Peer Cohort Measures --** Starting Page 11: The plan to specify a single, final core measure set for each individual peer cohort is not practical. Physician specialty areas are not cut in stone. Many physicians have more than one specialty, and many physicians treat conditions and perform procedures outside their specialty area(s). Likewise, many common diseases such as diabetes and hypertension are treated by a wide variety of specialties. The existing PQRS structure offers flexibility in choosing measures, with measure groups, individual measures, and multiple modalities for reporting. We support the more realistic and practical approach embodied in PQRS.
- **Core Measure Sets --** Page 13, in developing a measure set for a "peer cohort," some physician specialty areas may find it difficult or impossible to cover all National Quality Strategy quality domains. For example, care coordination and patient satisfaction measures would not be relevant for physicians in specialties which do not involve direct patient contact.
- **Transparency & Timely Publication of Measures --** Page 15, lines 6-18: It is essential that proposed measures be made available for public comment as part of rulemaking published in the Federal Register. We recommend requiring publication in the Physician Fee Schedule proposed rule (published in July) versus the final rule (published in November). This allows measures to be fully vetted by the public and quality experts, as well as physicians and medical specialty organizations. Physicians must begin using the measures the following January. With first publication in November, they would have less than two months to do this. Requiring publication in the proposed rule would provide an additional four months to get their practices and systems ready to capture and transmit new measures. Additionally, the federal government has no legal authority to require medical journals to publish proposed measures.
- **Consultation with Organizations and Stakeholders –** Page 20, lines 12-13: Should read "State and national specialty medical societies." Specialty societies are instrumental in developing quality measures and registries, and they should be acknowledged.
- **Quality Adjustments –** Page 26-27: PQRS is currently a pay for reporting system. The UIP three-tiered adjustments create a true "Pay for Performance" program. We could support this approach, provided the current PQRS system is used, with added recognition of clinical improvement activities as a means of deeming participation. These activities

would require scores or data for CMS to use, so physicians participating in these activities could be accounted for in the adjustment tiering.

- **Electronic System for Quarterly Feedback –** Pages 28-30: We appreciate the development of an electronic system that will provide quarterly performance feedback to physicians. This would likely require significant resources. Will the $100 million provided in the bill from the Medicare Part A and B trust funds help support this?
- **Exemptions –** Pages 31-32: Regarding exemption (from penalties for failure to report under UIP) for eligible practitioners below "minimum per year caseload threshold" – will that minimum apply at the individual level, group level, or both?
- **Additional Exemptions –** Pages 31-32: The bill should also provide exemptions for: (a) physicians who are near retirement (i.e., physicians who are currently eligible for Social Security benefits or who will be eligible by 2014); (b) small practices (i.e., those under 10 FTEs) and rural practices; and (c) specialists who are unable to meet many of the measures due to their scope of practice. It is important to have exemptions for physicians who cannot reasonably be expected to participate in the new quality regime that the bill would establish. Requirements should accommodate various practice patterns and specialties, and protect more physicians facing hardships from penalties.

Advancing Alternative Payment Models (APMs)

- Page 34, lines 12-24, adding new Section 1848A(a): Does the Committee intend to limit APMs exclusively to Part B services and practitioners? APMs, by their very nature, encompass other Medicare programs, including Part A, Part D, post-acute services, durable medical equipment, etc. APMs are designed to align services and provide greater efficiency and quality of care across the various programs.
- **Payments to Other Medicare Providers:** It is not clear that the bill authorizes different payments to anyone other than physicians (e.g., hospitals). Page 34 refers only to "covered professional services furnished by an eligible professional." There is a reference on page 37 to the fact that models would be intended to modify payment to other providers, but they are not specifically required to do so. Did the Committee intend to omit Parts A and D and to only deal with APMs for professional services? We suggest a technical correction to more accurately describe the full scope of the Alternative Payment Models and the payments under all parts of Medicare.
- **Payment Arrangement:** Pages 40, line 24 to page 41, line 19: We propose that these provisions be deleted. They are unnecessary, add undue complexity, and make the payment scheme for APMs unworkable. For example, for APMs with bundled payments, it would not be feasible to separate out what would have been paid under the traditional fee-for-service approach and then adjust it as if the individual services were each being separately compensated. In addition, multiple practitioners and services may be involved in an APM.

- **Section (C) Criteria for Recommending Models for Approval without Evaluation under Demonstration, Pages 41-42:** The following amendment is needed to accelerate the development and diffusion of APMs that, by design, will cost no more than Medicare otherwise would spend under traditional fee-for-service on the health conditions or episodes of care. The amendment allows APMs to be approved without having to be evaluated as demonstration projects if they are designed to involve paying a risk-adjusted, preset amount of money that is less than what Medicare would expect to spend for the same condition or procedure. In other words, the budget is already known and does not need to be evaluated as a demonstration project. In addition, the physicians involved can provide sufficient safeguards that patient quality of care will be maintained or improved.

Amendment to Section (C) Starting at Page 41, line 20:

20 ''(C) CRITERIA FOR RECOMMENDING MOD-
21 ELS FOR APPROVAL WITHOUT EVALUATION
22 UNDER DEMONSTRATION.—The APM con-
23 tracting entity may make a recommendation
24 under subparagraph (A)(ii), with respect to an
25 Alternative Payment Model, if the entity

1 determines (X) that the model has already been
2 evaluated for a sufficient enough period and
3 through such evaluation the model was shown—
4 ''(i) to have satisfied the criteria de-
5 scribed in each of clauses (i), (ii), (iii), and
6 (vi) of subparagraph (B);
7 ''(ii) to demonstrate each of the abili-
8 ties described in clause (v) of such sub-
9 paragraph; and

10 ‘‘(iii)(I) to reduce spending under this
11 title without reducing the quality of care;
12 or
13 ‘‘(II) improve the quality of patient
14 care without increasing spending.

Or (Y) that the model is one in which

- the physicians involved, on a voluntary basis, agree to provide (directly or through arrangements) all of the health care services needed by a group of beneficiaries over a specified period of time for one or more specific health conditions (or one or more specific aspects of treating a health condition, such as all of the services associated with a specific procedure or group of procedures) in return for a specific payment amount under this part and part A from the Secretary, and that no additional or separate payment will be made by the Secretary for those services under this part and part A;
- such specific payment amount would be no greater than the total amount that otherwise would be paid under this part and part A to such physicians and other providers for such beneficiaries, conditions, or procedures over such period of time (as estimated by the Secretary); and
- the physicians provide sufficient safeguards that the proposed model will maintain or improve the quality of care for the beneficiaries.

Or (Z) that the model is one in which

- the physicians involved, on a voluntary basis, agree that the physicians will (directly or through arrangements) use an improved approach to care delivery for a group of beneficiaries under such parts over a specified period of time for one or more specific health conditions;
- one or more of the services used as part of the improved approach to care delivery would be paid for by the Secretary under this part or part A differently than would otherwise apply under this part or part A;
- the total of such different payments would be no greater than the total amount that otherwise would be paid under this part and part A to such physicians and other providers for such beneficiaries and conditions over such period of time (as estimated by the Secretary); and
- the physicians provide sufficient safeguards that the proposed model will maintain or improve the quality of care for the beneficiaries.

Section (f)(1) Implementation of Recommended Models as Eligible APMs, Pages 51-52:
The amendment that follows is needed so that APMs that have already gone through the approval process for the APM entity to recommend them can proceed to be implemented. As currently written, the APMs must meet certain standards in order to be recommended by the entity, but then they would have to go through an entire additional approval process by the HHS Secretary. The amendment would allow the Secretary to approve the recommended APMs for implementation unless a problem is identified with the costs or quality of proposed APM.

Amendment to Section (f)(1) Starting at Page 51, line 24:

24 ''(f) IMPLEMENTATION OF RECOMMENDED MODELS

25 AS ELIGIBLE APMS.—

1 ''(1) IN GENERAL.—Not later than the applica-

2 ble date under paragraph (2), the Secretary shall,

3 implement an Alternative Payment Model rec-

4 ommended under subsection (d)(1)(A)(ii) or

5 (e)(4)(E)(ii)(I) as an eligible APM unless—

6 ''(A) the Secretary determines that such

7 model is expected to—

8 ''(i) increase spending under this title

9 ; or

10 ''(ii) harm the quality of patient

11 care;

12 ''(B) the Chief Actuary of the Centers for

13 Medicare & Medicaid Services certifies that such expansion would increase

15 program spending

16 under this title; or

17 ''(C) the Secretary determines that such

model would deny or limit the coverage or provision of benefits under this title for applicable individuals.

Sec. 3: Expanding Availability of Medicare Data – Pages 55-57**:** For Section 3A, we would like to entirely replace this language with language below. Under the proposed Committee language, it is unclear what safeguards would apply to the use of the data. The language we propose would create further flexibility and maintain appropriate safeguards on public use of Medicare claims data.. The released language only allows for sale of "analyses" of data. However, all-payer claims databases (APCDs) would like to provide safeguarded "access to data" as well. We are concerned that APCD subscribers are broader than just providers and suppliers. The amendment would make data and information available to other groups, such as medical societies.

(a) Expanding Uses of Medicare Data

"(1) ALTERNATIVE SPECIFICATION OF USES AND METHODOLOGIES FOR CERTAIN QUALIFIED ENTITIES.—Notwithstanding the requirements of subsection (4)(B-D) of section 1874(e) of the Social Security Act (42 U.S.C. 1395kk(e)), certain qualified entities requesting data under this subsection that have at least 51 percent of commercial fully insured private claims data from their state may use data provided under this subsection for purposes other than public reports in accordance with the following specifications—

"(i) such qualified entities shall— (I) submit to the Secretary a description of the type of activities for which such all-payer claims database will use such data, which may include population health management, disease tracking, provider quality improvement, improving value and transparency in the health system, or using cost and quality measures to evaluate the performance of providers of services and suppliers using such data; and

"(II) commit to use, if available, nationally approved or endorsed measures to compare provider and supplier performance or to develop a transparent process for selection of alternative measures for such comparison; and,

"(III) to the extent such qualified entities make data available to registered or authorized users, subscribers, or for purposes of study and analysis (as described in subparagraph (ii)), establish data use policies limiting such entities to uses consistent with this subsection.

"(ii) such qualified entities may—(I) include data made available under this subsection with claims data from sources other than claims data under this title in the evaluation of performance of providers of services and suppliers;

"(II) make available to such qualified entity's registered or authorized users and subscribers, upon their request for the purpose of population health management, disease tracking, provider quality improvement, improving value – by reducing cost and increasing quality – in the health

system or evaluating the performance of providers of services and suppliers, data made available under this subsection which has been de-identified in accordance with section 164.514(a) of title 45, Code of Federal Regulations, including data in the format of a report for such provider or supplier developed from a search of such qualified-entity's database; and

"(III) provide identified data for studies and analysis that improve health care pursuant to policies and procedures consistent with the HIPAA Privacy rule; The entities under this subparagraph may establish data release policies and procedures that require data use applicants to obtain Institutional Review Board or Privacy Board approvals or establish a business associate agreement as a prerequisite for approval.

"(iii) The entities under this subparagraph may charge such providers and suppliers a fee for making such data available.

"(2) APPROVAL AND LIMITATION OF USES.— Data released to a qualified entity under this subsection shall not be subject to discovery or admission as evidence in judicial or administrative proceedings without consent of the applicable provider of services or supplier."

Section 3B: In order to make this section consistent with 3A, we will also need to make minor changes. Those changes are included below. These changes would ensure that the data, and information derived from the data, is not made public, but is safeguarded only for the explicit purpose outlined in the section.

(b) ACCESS TO MEDICARE DATA TO PROVIDERS OF SERVICES AND SUPPLIERS TO FACILITATE DEVELOP MENT OF ALTERNATIVE PAYMENT MODELS AND TO QUALIFIED CLINICAL DATA REGISTRIES TO FACILITATE QUALITY IMPROVEMENT.— Consistent with applicable laws and regulations with respect to privacy and other relevant matters, the Secretary shall provide Medicare claims data for internal, non-public use (in a form and manner determined to be appropriate) to—

(1) providers of services and suppliers solely to facilitate the development of new models of care (including development of alternate payment models, models for small group specialty practices, and care coordination models); and

(2) qualified clinical data registries under section 1848(m)(3)(E)) of the Social Security Act (42 12 U.S.C. 1395w–4(m)(3)(E)) solely for purposes of linking such data with clinical outcomes data and performing analysis and research to support quality improvement.

Physician Reporting System to Improve Accuracy of Relative Values -- Pages 65-68: We urge deletion of this section. The 1% per year reduction in MFS services from 2016-2018 negates the positive impact of having positive updates for five years.

- Assuming that Congress does not intend for Evaluation and Management services to be reduced, the 1% a year cuts would fall disproportionately on non-E/M services. However, an analysis of recently-or-soon-to-be-reviewed codes indicates that only $11 billion worth of non-E&M codes will not have already been reviewed by 2015.

- To hit the target required in this legislation, either these remaining codes would have to be cut, on average by 8% a year, E&M codes would have to be part of the cuts, or services that have already been hit with very significant cuts would have to be slashed again.
- Primary care specialties—especially general internal medicine—do a number of services other than visits so even if evaluation and management services are spared, all physicians will be affected by these cuts.