May 15, 2009

The Honorable Max Baucus  
Senate Finance Committee  
219 Dirksen Senate Office Building  
Washington, DC 20510-2602  

Re: Response to Transforming the Health Care Delivery System: Proposals to Improve Patient Carte and Reduce Health Care Costs  

Dear Mr. Chairman:

On behalf of the Medical Group Management Association (MGMA), I want to extend my sincere gratitude for your leadership in addressing the importance of meaningful health reform through your Transforming the Health Care Delivery System: Proposals to Improve Patient Carte and Reduce Health Care Costs policy options paper. MGMA members are eager and encouraged by reforms that Congress and the Obama administration will execute that modernize the current health system in a sustainable way that both ensures affordable health insurance coverage for all Americans and moves providers towards properly structured value based purchasing programs.

MGMA is pleased to submit the following comments on selected sections of your issues paper that directly impact the effectiveness of medical group practices and the patients they treat. We appreciate your outreach to the provider community and your willingness to participate in constructive dialogue to improve the current health system.

MGMA is the premier membership association for professional administrators and leaders of medical group practices. Since 1926, MGMA has delivered networking, professional education and resources, and political advocacy for medical practice management. Today, MGMA’s 22,500 members lead 13,700 organizations nationwide in which some 275,000 physicians provide more than 40 percent of the health care services delivered in the United States. MGMA’s mission is to continually improve the performance of medical group practice professionals and the organizations they represent. MGMA promotes the group practice model as the optimal framework for health care delivery, assisting group practices in providing efficient, safe, patient-focused and affordable care.
**Sustainable Growth Rate (SGR)**

MGMA is extremely concerned that the Committee’s proposal does not repeal the Sustainable Growth Rate. The SGR should be repealed immediately and replaced with an update system that reflects increases in costs of providing modern and high quality care to patients. Since the options proposed return providers to a negative update environment in just a few years, it will be extremely difficult for a reformed delivery system to be successful, based on an ever expanding Medicare and non-Medicare population.

However, MGMA is grateful that the Committee highlights this important payment issue by allocating significant funding to establish a realistic budget baseline for future Medicare payment updates. By providing a more honest budgetary baseline, future payment policies whose concepts are fully tested will be better positioned to replace the SGR.

If Congress is not yet able to repeal the SGR, at the very least a transitional path should be established for eventual repeal of this flawed payment methodology. Despite potential bonus payments through the PQRI and electronic prescribing incentive programs, as well as the projected financial incentives for the use of health information technology, many providers would still find their overall Medicare reimbursement reduced. Projected reductions to physician reimbursement would have disastrous results for the Medicare program and to Medicare beneficiaries. Congress should first concentrate on the flawed Medicare physician payment policy before addressing the expansion of health insurance coverage.

Though MGMA fully supports expanding health insurance coverage to the uninsured and underinsured, Congress should not build these reforms on unsound polices, doing otherwise would only serve to further exacerbate existing problems.

**Physician Quality Reporting Initiative (PQRI)**

MGMA continues to support quality improvement activities that focus on improving patient care and clinical outcomes and remains committed to assisting Congress and CMS achieve the laudable goal of providing physicians with the appropriate reimbursement levels for high quality services. As the Senate Finance Committee’s *Call to Action* paper references, there are significant concerns with the agency’s development of the PQRI. MGMA is therefore encouraged by the Committee’s proposals to improve the program.

Long advocated for by MGMA, the association strongly supports your proposal to establish a PQRI appeals process. According to CMS, approximately 16 percent of eligible providers participated in the 2007 PQRI, and yet, only half of these participants received the 2007 bonus incentive. This clearly indicates significant confusion and hesitation regarding the
PQRI. Providers will have greater trust in the PQRI through the ability to appeal a potential CMS determination of inaccurate reporting.

Additionally, MGMA also strongly supports your proposal for more timely PQRI feedback reports. MGMA believes that to truly improve patient care, programs such as the PQRI must provide timely, actionable, clinical information to physicians. The lag time between their initial reporting of quality measure codes and receiving the PQRI feedback report frustrates participants. Detailed confidential interim feedback reports should be provided by the agency as it continues to evolve the PQRI. These reports should clearly identify to PQRI participants possible reporting issues and should also provide clear instructions on how to make needed changes to their reporting method.

Furthermore, MGMA is pleased the Committee recognizes that multiple existing quality improvement efforts not developed by the government lend themselves well and deserve recognition via PQRI incentive payments. By including Maintenance of Certification and similar programs as one of the PQRI reporting options, the Committee gives providers the ability to demonstrate their continued advancement in medical education and quality improvement while also being a successful PQRI participant for two years.

However, MGMA compels the Committee to reconsider PQRI penalties in any form. Given the considerable problems the agency has had developing and implementing this initiative, it would be premature for the PQRI to be punitive in any form. CMS continues to admit to flawed data analytics, announces new reporting methods, and publishes mid-year PQRI “clarifications”. By doing so, the agency increases provider uncertainty, frustration, and apprehension with the entire program. Therefore the PQRI should continue to be based on positive incentives for voluntary participants. Considering an environment with continued forecasted Medicare Part B reimbursement cuts, MGMA especially thinks PQRI penalties are not appropriate at this point in the program’s development.

**Primary Care and General Surgery Bonus**

MGMA applauds the concept of bonus payments for primary care and rural general surgery scarcity areas. Ensuring these services are available for Medicare beneficiaries is a substantial investment that is essential for the long-term improvement of the overall health care system.

However, MGMA opposes imposing budget-neutral modifications to the Medicare physician fee schedule in order to fund these bonus payments. MGMA therefore implores the Committee to identify alternative funding approaches that address this specific issue.

In addition, the Association is concerned over the proper definition of rural general surgeon scarcity. This new concept needs to be developed with
input from key stakeholders to ensure all appropriate rural surgeons are able to receive these needed funds.

*Accountable Care Organizations*

MGMA supports the proposal for providers to voluntarily form Accountable Care Organizations (ACOs) in order to collaborate across existing payment silos, meet quality thresholds together, and share in the cost savings achieved for the entire Medicare program. MGMA continues to advocate for innovative payment system reforms that support physicians who provide high-quality care in a cost-effective manner. However, the development of these payment policies needs to be carefully considered in a fully open and transparent manner. In addition, we urge the committee to clarify that ACOs may consist of various multispecialty group practices and that the participation of a hospital is not a requirement. However, if a hospital is part of the ACO, there must be equal and shared decision-making between the hospital and the medical group practices.

MGMA is pleased the Committee recognized the need for targeted relief from legal or regulatory impediments to provider cooperation in the options paper. Therefore MGMA advocates for meaningful antitrust reform as part of the health care reform legislation. This is essential to allow providers to partner together to form ACO contracts.

Additionally, the Association is concerned that the continuity of care for 5000 Medicare beneficiaries is beyond the control of providers. Patients travel seasonally and often visit relatives outside of their primary home area. Costs incurred by patients when they are treated outside of their ACO would unfairly penalize the ACO. Because CMS has little actual experience with ACOs, the continuity of care concern serves as an example of a significant operational issue surrounding ACOs, further underscoring the need for the concept to be developed and fully tested before widespread implementation.

Experiences of providers that participated in the Physician Group Practice (PGP) demonstration, the only experience the government has with this concept, need to be carefully considered. Although all PGP participants showed significant quality improvements in the care provided to their Medicare patients, many PGP participants were unable to meet the shared savings threshold and had significant difficulties adapting to the demonstration. PGP participants reported requiring significant resources in infrastructure to participate successfully. The groups cited frustrations with uncompensated investments in health information technology, care coordination for patients, role of the medical home care, and roles of non-physician providers. Even a study by the Government Accountability Office (GAO) cited lack of timely and actionable feedback to the PGP participants.

PGP participants have the advantage of being large, integrated, multispecialty institutions with access to more resources than the average sized group practice. Yet just two of the 10 PGP participants earned a
portion of the incentive payment in the first year only and only four of the participants earned part of the incentive payment in the second year of the demonstration project. Therefore MGMA believes the proposed 2 percent savings threshold before ACO participating providers are eligible for shared savings is too high and will be a considerable barrier impeding ACOs from forming or successfully participating.

Self-referrals

The in-office exception ancillary services exception to the Stark law is fundamental to group practices. Providing specialized and ancillary services though a group serves patient convenience, enhances coordination of care, facilitates access and patient compliance, and often produces much faster diagnostic or therapeutic benefits, thus improving quality.

The disclosure requirement set forth by the Committee is generally in line with requirements that are imposed on other providers, namely physician-owned hospitals and ambulatory surgery centers. As the Committee moves forward with this proposal, we ask that the same requirement be placed on hospitals ordering imaging services for its outpatients. In addition, the burden on practices would be significantly decreased if the required list of alternative providers was based on the practice’s location, rather than where the individual resides. With this slight change, a group practice could distribute a prepared list of alternative providers to its patients rather than use staff time to compile a unique list for each individual patient at the time of service. In the alternative, a government-produced list of providers by state would ensure that alternative provider information is updated and accurate, and patients would be able to select a provider of his/her choosing. In addition, any proposal should recognize that in certain emergent situations, it may not be appropriate for a patient to travel outside of his/her physician’s office to receive treatment. In those situations, a physician’s professional judgment should be respected.

Imaging Services

In recent years, imaging services have been targeted by policymakers concerned with increased imaging utilization. We have seen imaging payment cut as part of the Deficit Reduction Act of 2005 (DRA), as well as through the reduction of payment for the technical component of multiple procedures in certain circumstance. With passage of Medicare Improvements for Patients and Providers Act (MIPPA) in July 2008, Congress has enacted changes to address overutilization and quality of imaging by directing CMS to develop a demonstration project to determine the appropriateness of advanced diagnostic imaging services furnished to Medicare beneficiaries and required accreditation of advanced diagnostic imaging suppliers by 2012. Most of the available analyses of imaging utilization and cost are based on pre-DRA data and therefore do not reflect changes to payment policy already in effect and the changes that will be forthcoming when the MIPPA
provisions are fully implemented. In light of this fact, we believe it is premature to add additional administrative requirements to overburdened practices that are still reeling from the changes that have occurred and the changes to come when the results of previous enactments have not been measured.

Notwithstanding, we offer the following comments in response to specific proposals.

Appropriateness criteria and related measures

As a threshold matter, MGMA is supportive of efforts to incorporate clinical guidelines that are transparent and developed in a collaborative manner by the relevant stakeholders as an alternative to the “black box” methodology of radiology benefit managers (RBMs). We do not, however, believe that the proposed 2010 deadline for the Secretary to designate appropriateness criteria and use measures for reporting is a realistic timeframe. In an ideal scenario, health care reform legislation would be enacted prior to the end of calendar year 2009. Making the appropriate criteria and use standards effective in 2010 would not give the stakeholders enough time to work with the Secretary to vet these standards, making sure they are agreed upon by a multispecialty consensus and that they include appropriate risk adjustment and case mix protections. More time is needed to develop the criteria and then devise reporting mechanisms for practices.

Additionally, we recommend that the Committee not use data from 2011, the first year feedback is provided to ordering and interpreting physicians, as the baseline year to vary payment to outlier physicians in 2013. The proposal to incorporate appropriateness criteria and use measures in a short period of time will undoubtedly be fraught with difficulties as practices develop new systems and become familiar with the new requirements. New technology will be required at the point of ordering a test, and staff will need to be trained on this and other intricacies of the process. As we have seen with the reporting of measures in the PQRI program, even well-intentioned, informed practices have struggled to successfully participate in that program. Instead, physicians should be given time to review their feedback and become familiar with the system before their conversion factor is reduced by 5 percent.

We also recommend that any proposal include allowing outlier physicians to correct their ordering irregularities and restore full payment without having to suffer a full year of reduced Medicare payments. Such a dramatic reduction has the potential to destabilize a practice’s financial security.

The government needs to allow sufficient time and provide sufficient education before making major cuts to Medicare payments. By the same token, once a realistic baseline is established, practices that successfully implement and comply with the new standards should realize some benefit of the expected cost savings to the Medicare program.
In the debate concerning growth in imaging, it is widely recognized that a key component of growth is patient demand for the most sophisticated, advanced testing available. Physicians are often placed in the position of facing potential malpractice claims if he/she does not cater to the patient’s demands of more testing. Physicians who follow the nationally recognized appropriateness criteria should be afforded some degree of tort protection for doing so.

Health Information Technology

MGMA is pleased that the Committee recognizes the important role mid-level providers (i.e., nurse practitioners and physician assistants) play in the delivery of care in a modern medical group practice. These providers can take full advantage of electronic health records technology in the practice as they treat patients, and as such they should have access to the American Recovery and Reinvestment Act (ARRA) incentives which are available to the physicians in the practice. A single set of requirements to receive ARRA related health information technology incentives should apply to all provider types.

Physician Payment Sunshine

MGMA is generally supportive of the proposal to have drug, device, biological and medical supply manufacturers report payments to and ownership by physicians to the Secretary. Because the information reported will be made public, we request that the Committee’s proposal eliminate the inclusion of the National Provider Identifier (NPI) to prevent inappropriate abuse of this number. We appreciate inclusion of an opportunity to submit corrections to information submitted and ask that physicians and manufacturers be afforded this opportunity before the information is posted on the Internet to ensure that inaccuracies are not reported to the public.

In addition, we believe that the proposal to track payment and ownership information of physicians’ family members is unworkable and should be removed from the proposal. Finally, we are supportive of the Committee’s intention to have these requirements preempt state law. This will eliminate the confusion and duplicative reporting that would be required if parties had to comply with state as well as federal reporting requirements.

Physician-Owned Hospitals

As the science and technology of health care services are constantly changing, the site of care is also in constant flux. Just as services once reserved for large general hospitals can now safely and efficiently be provided in specialty hospitals, so too does care migrate from general or specialty hospitals to surgery centers, specialized non-hospital ancillary
providers, and physician group practices. Restricting physician ownership in any of these evolving delivery sites could become a very slippery slope.

Physician-owned hospitals serve many needs. In some communities, such hospitals are model facilities that raise the standards for other hospitals in the area. In other communities, physician-owned hospitals are the only alternative, particularly in rural areas. Over the years such hospitals have been the subject of many attacks, while studies have continually shown high quality of care and little to no negative impact on competing general hospitals in the community. MGMA has repeatedly urged the government to proceed carefully on matters where the Stark law is evoked to protect the economic interest of any provider class. We are particularly concerned that the current proposal would eliminate altogether the option for physicians to invest in new hospitals, even in areas where no hospital exists. The restrictions placed on existing hospitals through the “grandfather” provisions are insufficient to ensure patient access to care.

Workforce

MGMA is pleased the Committee recognizes the need to redistribute unused graduate medical education slots in order to promote the growth of students entering primary care. However, though this redistribution is necessary, MGMA remains concerned that the proposal does not add to the number of Medicare-supported training positions for medical residents overall. The number of training slots needs to be increased to ensure that all patients have access to an adequate supply of physicians, especially in health professional shortage areas.

In addition to training based teaching hospitals, the Committee should strongly consider allowing residents to train in non-hospital settings such as physician offices, community health centers, and other ambulatory care sites.

Medicare Advantage

MGMA continues to urge Congress to examine the structure, costs and operational policies of the Medicare Advantage program. Therefore the Association is pleased that the Committee’s proposal addresses Medicare Advantage payments. By modifying the current process used to establish the Medicare Advantage benchmark rate, the Committee’s proposal allows the Health and Human Services Secretary to encourage Medicare Advantage efficiency and improvements to quality care. MGMA continues to advocate for level payments between Medicare Advantage and Medicare Fee for Service.

Provider Screening
Current problems with the Medicare physician enrollment system need to be understood and corrected before any new processes are imposed. The current process is overly burdensome, and decisions made by Medicare contractors frequently tend towards arbitrary and inexplicable. The complex nature of the current enrollment process has created confusion for providers and contractors alike, spurring additional work as providers and contractors strive to correct applications that would have been completed correctly the first time if it were not nearly impossible for providers and contractors to understand the associated rules and forms.

Thus imposing moratoriums on new providers would only further prevent qualified providers from treating patients in need of care. MGMA is concerned that Medicare contractors, many of which are experiencing backlogs with Medicare applications, simply do not have the resources required to perform prepayment reviews for all new providers and suppliers. Furthermore, imposing enrollment fees would only create an additional barrier to participation in the program. This is especially worrisome given the forecasted Medicare physician payment cuts as well as the shortage of available physicians.

MGMA appreciates your dedication in addressing the current health system and remains ready to continue to work with you and your staff as issues affecting medical group operations are considered. If you have any requests or questions, please contact Robert Bennett in the Government Affairs Department at (202) 293-3450.

Sincerely,

William F. Jessee, MD, FACMPE
President and CEO