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May 31, 2013

The Honorable Max Baucus
Chairman
Senate Committee on Finance
219 Dirksen Senate Office Building
United States Senate
Washington, DC 20510

The Honorable Orrin Hatch
Ranking Member
Senate Committee on Finance
219 Dirksen Senate Office Building
United States Senate
Washington, DC 20510

Dear Chairman Baucus and Ranking Member Hatch:

On behalf of the American Medical Association (AMA), I am pleased to respond to your letter of May 10, 2013, requesting specific input on several issues related to implementation of new Medicare physician payment and delivery reforms. We agree with your statement that the Sustainable Growth Rate (SGR) formula must be repealed. The constant threat of steep payment cuts under Medicare not only threatens physicians' ability to participate in the program and care for new Medicare patients, but prevents them from making important investments that are needed to implement new payment and delivery models. We are pleased to have been involved in the Finance Committee's work on identifying appropriate replacements for the SGR, and offer our continuing commitment to working with you to implement a replacement policy that focuses on the quality and value of services provided to Medicare patients. We appreciate your continued dedication to this goal.

Your letter requested comments on three specific questions. Each of them is addressed below.

Question: MedPAC and others have suggested changes they believe would improve the accuracy of fee schedule payment amounts and the validity of resource inputs used to establish payments for services under the fee schedule. What specific reforms should be made to the physician fee schedule to ensure that physician services are valued appropriately?

As required by the Omnibus Budget Reconciliation Act of 1989, the Medicare Physician Fee Schedule (MPFS) is based on a foundation of resource-based relative value units (RVUs) describing the costs associated with providing each individual physician service. The RVU system was established to ensure that payments for individual services are appropriate relative to all other physician services. Specific payment amounts are driven by a monetary conversion factor which is determined using a complicated formula and adjusted by the SGR, which has had the effect of reducing them. While the costs of running a physician practice have escalated by 25 percent, the actual conversion factor that assigns a payment amount to individual services is currently only four percent higher than it was in 2001. This is further reduced by an additional two percent due to the sequester. **Given that all physician payments have lagged behind inflation by a considerable amount, fee schedule payment amounts are inaccurate across the board. As to the accuracy of**

the relativity of those amounts, we believe that they are as accurate as possible given the statutorily defined components that are required to be considered.

When considering criticisms that there are inaccuracies in the valuation of services under the MPFS, it is imperative that the discussion be based on recent data with an understanding that the Resource Based Relative Value Scale is in a constant state of refinement as the practice of medicine changes. Additionally, as discussed below, organized medicine has made significant efforts to address misvaluations and continues to do so.

Background

As required by law, each RVU is composed of three individual components: physician work (48.3 percent of total RVU payment pool); practice expense (47.4 percent); and professional liability insurance (4.3 percent). Underlying each RVU are dozens of data elements required to compute the value of each service. More than 7,000 services are paid under the MPFS, with RVUs established for each service provided in the facility and non-facility setting. Hundreds of thousands of specific data elements have been described since the inception of the RBRVS.

To ensure maximum clinical input in describing what resources are required to provide a particular physician service, the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC) was established in 1991. In addition to the RUC's 31 members representing specialty societies whose members derive more than half of their revenue from Medicare, the RUC process includes input from nearly 100 specialty societies via a formal Advisory Committee, other health care professionals (e.g., physical therapists, nurses) through a Health Care Professionals Advisory Committee, and a number of subcommittees and workgroups formed to improve methodology, process, and the data utilized in developing RVU recommendations and various data elements. Each specialty society employs staff and engages volunteer physicians to support their data collection processes and presentations to the RUC. Thousands of physicians and health care professionals throughout the United States are involved in these efforts. More than 300 individuals attend each of three annual RUC meetings, including observers from government agencies, researchers, and international delegations.

When first established, the RUC focused on reviewing newly described physician services and evaluating services not reviewed in the RBRVS originating Harvard study. The physician work component was the only element defined and developed by Harvard and the Centers for Medicare & Medicaid Services (CMS), then the Health Care Financing Administration (HCFA), as resource-based. The RUC utilized these definitions and similar survey techniques to continue the work started by Harvard. In fact, most of the original RUC members were the primary physician volunteers engaged in the Harvard clinical panels. As statutorily required, CMS called for public comments on potentially misvalued services in four, five-year reviews of the RBRVS (implemented 1997, 2002, 2007, and 2012). These opportunities allowed the RUC to provide recommendations for improvements in the work RVUs. Significantly, the RUC recommended significant increases in office and hospital visits in both 1997 and 2007 (the only years in which comments were received by the public to review these services), resulting in significant redistribution to these primary care services. Additionally, the RUC reduced the work RVUs for nearly 400 services during these formal review processes.

In 1999, CMS began a transition to resource-based practice expense RVUs. The initial implementation was based on data collected by a firm under contract to HCFA in a process criticized for its lack of definition or standardized methodology, poor response rate, and inaccurate results. Soon after implementation, the RUC agreed it was necessary for organized medicine to invest significant volunteer time and specialty society resources to re-review the direct practice expenses (clinical staff, medical supplies and medical equipment). This initial multi-year process to review nearly 7,000 codes concluded in 2004. The AMA and the national specialty societies also financed a new practice expense survey to collect cost data used to allocate indirect costs to individual physician services. Both of these activities resulted in additional redistribution to primary care services. Most recently, the RUC has continued its review of direct practice expenses for new services and for services identified as potentially misvalued.

In addition to exhaustive reviews of practice costs, the RUC has recommended specific improvements to the practice expense methodology employed by CMS, the equipment utilization rate, changes to interest rate computations, and refinement of the professional liability insurance RVUs. Although the RUC identifies the type and quantity of medical supplies and equipment utilized in the provision of a service, it does not review the pricing of these items.

Current Efforts on Misvaluations

As the exhaustive initial review of direct practice expenses and the 2005 review of the work RVUs were concluding, the RUC determined that a formal process should be developed to identify potentially misvalued services that would otherwise be unlikely to be identified by the public. In 2006, the RUC created the Relativity Assessment Workgroup to develop objective screens and establish a formal process to identify misvalued services. During this same timeframe, the Medicare Payment Advisory Committee (MedPAC) issued critical statements that the first three five-year reviews had produced few public comments for services to be reduced. The RUC agreed and established this process to ensure that potentially misvalued services were identified systematically using relevant and objective screening criteria, including:

- Bundled CPT services – services often billed together;
- Site-of-Service anomalies – services with site of service shifts (i.e., services that were typically in the inpatient setting and are now typically performed in the outpatient setting or physician office);
- Harvard-Valued – services performed over 30,000 times a year that still have the original Harvard established value;
- Services surveyed by one specialty but are now predominantly performed by a different specialty;
- High Volume Growth – services with a utilization increase of 100 percent or more in a three year period;
- High Intra-service Work Per Unit of Time (IWPUT) – services with high intensity relative to other services;

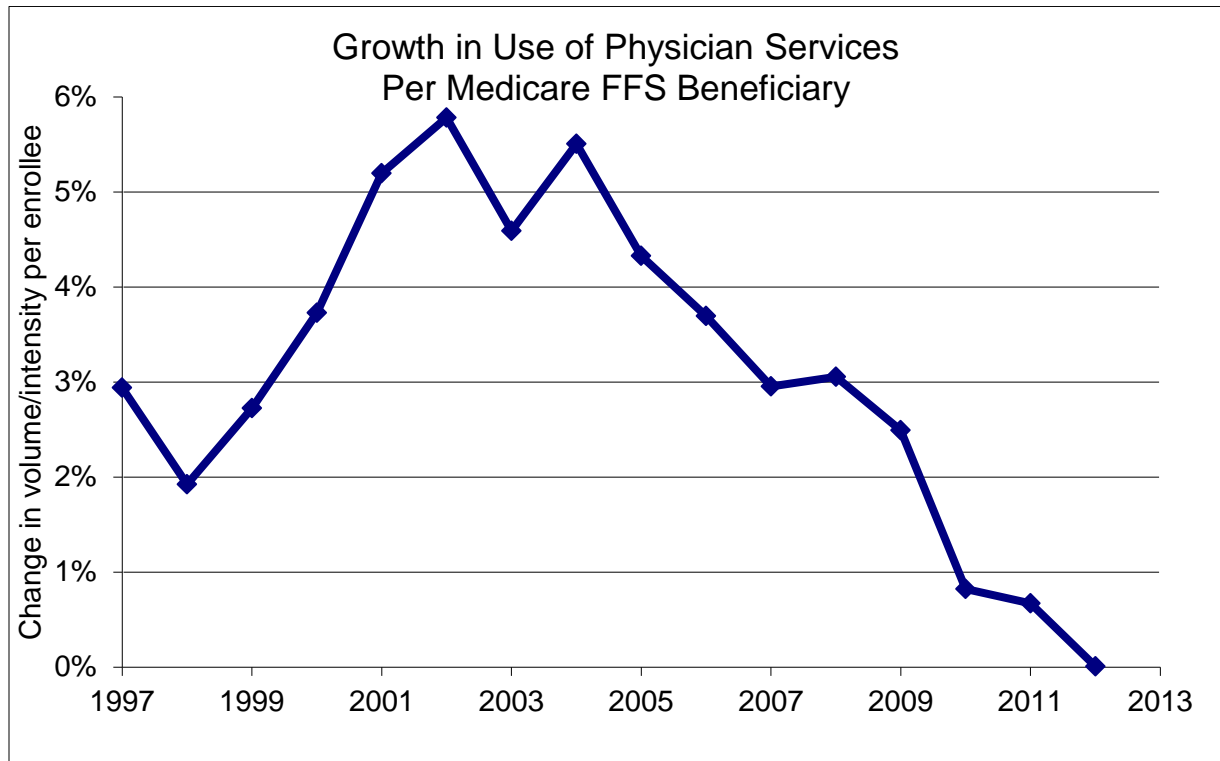
- Services with low work RVUs that are billed in multiple units per patient;
- Services with low work RVUs that have high utilization;
- Services identified on the RUC Multi-Specialty Points of Comparison (MPC) List - a list of common services performed by specialties and used for comparison during the RUC survey process;
- High Expenditure Procedural Codes – codes under the Medicare Physician Payment Schedule that have not been reviewed since 2006 with the highest payments per specialty; and
- New Technology – a re-review of physician services after technology diffusion.

To date, nearly 1,500 services have been identified from the above listed screens, resulting in annual redistribution of \$2.5 billion. The effort is significant and often requires a multi-year effort to redefine the physician service with new or revised Current Procedural Terminology (CPT) codes. For example, all gastrointestinal endoscopy services are under review, first requiring re-definition within CPT and then surveying for updated physician time data and valuation. Nearly all specialties have been impacted by this process. Cooperation has been impressive, and it should be noted that this engagement is critical to ensure fairness and to obtain maximum clinical input. In addition to the ongoing review of services that fall under the above screens, the RUC continues to look for mechanisms to ensure relativity in physician time, including the formulation of further standardization and identification of extant data to validate these mechanisms.

Question: What specific policies should be implemented that could co-exist with the current FFS physician payment system and would identify and reduce unnecessary utilization to improve health and reduce Medicare spending growth?

The premise of many proposals to replace the SGR is based on the notion that Medicare should pay for value rather than volume. Extensive efforts are currently underway at the Department of Health and Human Services and in the private sector to test models that align incentives for value over volume. Furthermore, physician specialties have recognized this imperative and are leading the way with efforts to ensure that beneficiaries receive high value care. These efforts are showing results. In fact, an AMA analysis of data provided by CMS indicates that in 2012, there was no growth in the volume of physician services per Medicare beneficiary.

Moreover, as shown below, growth in physician service volume and intensity per fee-for-service (FFS) beneficiary has been declining every year since 2004, when it was about six percent, to less than one percent in 2010 and 2011, and zero in 2012. MedPAC analyses using slightly different data sets show a similar downward trend.



Source: AMA, Economic and Health Policy Research analyses of annual Medicare Physician/Supplier Procedure Summary Files.

This trend is consistent across all categories of physician services, including services such as physical therapy and imaging which MedPAC and other policymakers have frequently cited as high growth and potentially overused services. Physical therapy, after rising by about 10 percent a year in 2008 and 2009, showed no change in utilization in 2012. Annual growth in use of imaging services has been declining since 2007, and in 2012, volume for essentially all outpatient imaging, including CT, MRI, and PET, was either the same as or lower than in 2011. Total evaluation and management service use was also unchanged as a two percent decline in inpatient visits was offset by small increases in office, home, emergency department, and other visits. Major procedures rose by just one percent and in many categories, such as cardiovascular and orthopedic procedures, volume actually dropped, sometimes significantly.

Overall Medicare Volume is also Low

This decline in the volume of physicians' services has persisted despite a continued shift of care from the inpatient to the outpatient setting. According to MedPAC's March 2012 report, for example, inpatient admissions per Medicare beneficiary declined by 7.8 percent between 2004 and 2011 with the average length of stay also dropping slightly in recent years. Additionally, in its most recent baseline, the Congressional Budget Office, citing lower than anticipated spending in 2013, has reduced its 10-year projections of expected spending for Medicare by about one percent and lowered its projections for "all major components of the program."

Reflected across private payers as well, the moderation of health care cost growth was initially attributed to the economic downturn by a number of economists. However, a number of experts have hypothesized that something more fundamental and lasting is happening. For example, two teams of Harvard economists recently concluded that other factors, including less rapid technological development, increased patient cost-sharing and greater provider efficiency, were responsible for a large part of the slow-down. (*Health Affairs*, 32, no. 5 (2013): 835-840; 841-850)

Physician Efforts Have Helped Slow Growth

Work of the RUC: Physicians have played a key role in the moderation of health care costs and have contributed significantly to the decline in overall Medicare spending and utilization growth over the last several years. As detailed in the preceding section, many of these efforts have involved the RUC's efforts to improve the relative values within the physician fee schedule to ensure equity among physicians and eliminate incentives for overuse of services that appear to be more generously reimbursed than other services requiring similar resources. Another joint RUC-CPT effort to create and value new care coordination codes discussed later in this letter also has the potential to curb growth of Medicare services, primarily through the avoidance of hospital readmissions.

Registries, Guidelines & Measures: Following the lead of the thoracic surgeons, more than 25 specialty societies now have created or are in various stages of developing registries where their members report data that facilitates quality assessment, evaluation of various treatments, identification of best practices, and the development of appropriate use guidelines. Other early adopters include the American College of Cardiology with its PINNACLE Registry®, a centralized system for clinical practices to promote practice innovations and achieve clinical excellence in areas such as coronary artery disease, hypertension, heart failure and atrial fibrillation, and the American College of Radiology, whose National Oncologic PET Registry (NOPR) reports on a variety of issues related to imaging, including radiation dose indices for patients undergoing CTs and interpretive quality on screening and diagnostic mammograms. Use of registry data, along with growing evidence-based clinical guidelines have contributed to the declining use rates for certain health care services, like imaging, and are now being enhanced through programs that provide other specialties with advice on when and which imaging should be ordered.

Many specialties have developed or are in the process of developing appropriate use guidelines. These evidence-based guidelines serve as the basis for developing quality measures, which are defined by the Agency for Healthcare Research and Quality (AHRQ) as “mechanisms that enable the user to quantify the quality of a selected aspect of care by comparing it to an evidence-based criterion that specifies what is better quality.” Guidelines typically identify areas of underuse, misuse and overuse. Better research can help produce more scientifically sound and rigorous guidelines, resulting in the enhancement of quality measures for use at the point of care. These combined efforts can lead to reduced use of other types of care, and therefore produce overall healthcare savings in the process. Also, although quality measures based on the guidelines initially focused on underuse and misuse, more recent efforts have honed in on overuse. The AMA-convened Physician Consortium for Performance Improvement (PCPI), began to develop appropriate use measures in 2009 covering five topics: Sinusitis, Maternity Care, Percutaneous Coronary Intervention, Non-Cardiac Diagnostic Imaging, and Cardiac Diagnostic Imaging. Since 2000, the AMA-PCPI has developed a total of 353 clinical performance measures, covering 49 clinical topics. Many of these patient-focused measures have been implemented across both public and private quality performance programs.

As a result of your efforts, Congress has made an important contribution to improving how physicians meaningfully report, collect, and analyze quality performance data with the enactment of legislation that allows physicians to meet Medicare quality reporting requirements through participation in qualified registries. Development of registries, plus the creation and enhancement of appropriate use guidelines and quality measures, is an ongoing and resource-intensive undertaking, however, and additional resources and time are necessary to expand and maintain the efforts that have taken place to date. As detailed in the attached response to CMS's request for information on meaningful physician quality initiatives, we have urged the agency to allow physicians to meet federal reporting requirements through a variety of "deemed" quality improvement and assurance activities that meet some basic standards but allow the developers of registries and other such initiatives to ramp up their activities over time.

In another recent effort, 35 specialties representing 500,000 physicians have been involved in a more public campaign sponsored by the American Board of Internal Medicine. Specialties participating in the "Choosing Wisely" Campaign each identified several services that are provided by their members and are often overused. The list of such services was then promoted to the societies' physician members. In a new and important initiative, the campaign worked with *Consumer Reports* to provide the list of overused services along with educational materials that are available to patients as well.

Continued Congressional oversight and support, including funding for CMS and support for measure and registry development, could provide a valuable boost to volume-restraining efforts of the medical profession. The AMA strongly supports proposals to ensure a stable source of funding for quality measure development, testing, and maintenance that can support the various quality reporting, value-based purchasing initiatives, and emerging alternative payment models. Specifically, we support using \$10 million from the Medicare trust funds annually in FY2014 through 2018.

Medical Liability Reforms: As an additional incentive, government should reform the medical liability system to reduce incentives for physicians to practice defensive medicine by providing services that protect them against lawsuits in high-risk cases such as head injuries. Potential savings to Medicare from medical liability reform have been estimated at \$17 to \$31 billion a year depending on the specific reform that is chosen. Other estimates show that liability reforms could reduce the federal deficit by as much as \$62.4 billion over a 10-year period.

Expanded Payment and Delivery Options for Physicians: We anticipate that physicians participating in the current shared savings program and new models that have been approved by the Center for Medicare and Medicaid Innovation will apply any successful measures to improve care and/or reduce costs to other patients who are not covered in the new programs. This beneficial spill-over could be enhanced through **the adoption of legislation that would expand and accelerate the adoption of new payment and delivery options as outlined in the next section of this letter.** For example, if a physician managing the care of a particular condition was able to reduce hospitalizations or emergency room visits by hiring a nurse to contact patients regarding medication adherence or follow-up visits following hospitalization, the practice is likely to be extended to patients with other conditions as well.

The Patient Piece of the Equation: Several provisions in the Affordable Care Act—including the creation of the Patient Centered Outcomes Research Institute and the elimination of patient co-pays

for screening services that receive an A or B rating from the United States Preventive Services Task Force (USPSTF)—take important steps to encourage more cost-effective care choices by Medicare patients. However, there are a variety of other options, many of which have been proposed as part of various deficit reduction and comprehensive Medicare reform packages, that could enhance more appropriate choices by beneficiaries.

While the AMA's support for any particular option would depend to some extent on the details of a specific proposal, there are a number of strategies that we believe could be explored. Although most have been suggested as ways to reduce federal spending, it would also be possible to develop budget neutral proposals, such as using revenues from any increases in beneficiaries' financial liability to create an annual or lifetime cap on beneficiary liability. **Options that the committee could explore include:**

- **Funding ACA-authorized demonstrations to evaluate the impact of shared decision making initiatives.**
- **Applying a co-payment to home health services.**
- **Introducing more value-based cost-sharing into Medicare. For example, cost-sharing could be reduced or eliminated for drugs that treat diabetes and/or hypertension.**
- **Combining and restructuring program deductibles.**
- **Restructuring Medicare supplemental policies.**
- **Potential incentives to encourage beneficiaries to participate in existing and future alternative payment and delivery models.**

Question: Shifting from a FFS system to an alternative payment model will be a major change for many physicians. Within the context of the current FFS system, how specifically can Medicare most effectively incentivize physician practices to undertake the structural, behavioral, and other changes needed to participate in alternative payment models?

The AMA strongly supports the Committee's goal to identify alternative payment models (APMs) that can support physicians who provide high quality, affordable care to seniors. We also agree that a transition process is needed that will allow physicians to gain experience with APMs and shift to them in a gradual way instead of forcing abrupt changes in the way care is delivered or compensated. Medicare patients' access to physicians has been placed in jeopardy annually due to the threat of steep SGR cuts. It is important that the SGR replacement process avoid similar disruptions to medical practices and provide adequate resources for this undertaking.

By design, the current Medicare FFS payment system pays more to physicians, hospitals, and other Medicare providers as patients become sicker and their conditions become more complicated. Although Medicare covers screening services to identify conditions like cancer, heart disease, diabetes, and osteoporosis, the more advanced the patient's disease becomes, the more comorbidities the patient develops, the more episodes of acute care occur, and the greater the overall severity of the patient's disease, the more Medicare will spend for the patient's care. In contrast, Medicare generally

pays neither for the services needed to, nor rewards physicians who, succeed in keeping patients healthy, preventing their conditions from getting worse, and preventing acute care episodes from occurring. It generally provides no payment for phone calls or e-mails with patients, coordinating care among physicians and other members of the care team, or for support services to help patients with self-management. It also does not reward physicians or patients who jointly choose lower cost facilities or treatment plans. For example:

- A primary care physician managing an elderly patient with hypertension who adjusts the patient's medication regimen over the phone due to the patient's medication-related hypotension and fatigue may be preventing falls, depression and stress that could lead to expensive complications, but the physician will receive no payment from Medicare for the phone consultation.
- Physicians who redesign their practices and hire additional staff to allow them to take phone calls from patients overnight and on weekends and schedule next day office visits would be unable to recoup the costs of those systems under the current fee schedule, even if they save money for Medicare by preventing costly hospital services.
- Medicare does not cover services provided by psychiatrists to help other physicians manage patients with depression or services provided by endocrinologists to help other physicians manage patients with diabetes unless the psychiatrist or endocrinologist has their own face-to-face encounter with the patient.
- Medicare will pay more to a team of specialists and a hospital if a patient is treated with multiple operations and hospital stays than if the team is able to efficiently treat the patient in a single operation and achieve a successful outcome.
- The more primary care physicians, cardiologists, neurologists and vascular specialists treat a patient with a transient ischemic attack, the more Medicare will pay, but Medicare will not pay any physician to serve as a team leader and coordinate the patient's care.

Below we make specific recommendations on the types of transitional activities that would help physicians move into alternative payment models followed by specific resources necessary to achieve this goal.

Coverage of Care Coordination Services

One way to begin to address these problems in the Medicare FFS system would be to **start paying for non-face-to-face and care coordination services**. Within the context of the current FFS system, adoption of such a policy is one way that Medicare could begin to promote the care improvements and lower spending that physicians can achieve through participation in APMs. For example, in 2013 the Medicare program began covering new codes for "Transition Care Management" that compensate physicians for care coordination services they provide to patients following a hospital stay in order to help reduce the need for a hospital readmission. If Medicare began paying physicians for other non-face-to-face services, it could significantly improve the FFS program.

There are a number of non-face-to-face physician services for which codes and relative values have been developed by the RUC that Medicare does not currently cover. For example, two codes were developed several years ago for 90 days of anticoagulation management. Anticoagulation management services are cost effective, and their coverage would eliminate the face-to-face physician services which are currently required as a substitute to a more common sense strategy of paying for the management of these patients. The CMS has previously stated that the standard of care for anticoagulant services is suboptimal. Current payment policy requires the physician to have the beneficiary schedule an office visit to discuss prothrombin time test results and needed adjustments. Although it is clinically optimal for a physician to discuss results with a patient and make an adjustment during a face-to-face encounter, under some circumstances physicians engage in these activities outside of a face-to-face encounter with the patient. However, if they do so in the current system their services will be uncompensated. The current policy does not support long-term physician management of patients on anticoagulant and may contribute to the problem of underutilization of anticoagulant drugs, which can increase patient risk of thrombosis and embolism.

Codes are also available for education and training for patient self-management, medical team conferences, and telephone services, but none of these services is covered under the current Medicare FFS system. **Extending coverage to these services has the potential to significantly improve coordination and quality of patient care for seniors, and could be a significant step forward in reforming the delivery of care.**

Most recently, three new codes were developed for complex **chronic care coordination services** that are patient centered management support services provided by physicians and other qualified health care professionals to an individual who resides at home, in a domiciliary rest home or assisted living facility, per calendar month. These complex chronic care coordination services are provided to patients who typically have multiple comorbidities, and frequently, multiple medications requiring ongoing non face-to-face care coordination. The typical patient who would be eligible for these services has several chronic conditions, sees multiple care providers, requires a variety of therapeutic and diagnostic services, and has a management plan that requires frequent revisions. The goals of these services are to efficiently integrate care, maximize the patient's potential function and well-being and prevent hospitalization. **We recommend coverage of these services.**

Expanding Availability and Types of Alternative Payment Models

Another approach would be to **allow those physicians who choose to do so to move into APMs in an incremental fashion, with a portion of the physician's Medicare practice being part of an APM and the remainder still being in FFS.** This type of transition could be accomplished by developing APMs that address specific episodes of care, diseases or conditions, or particular savings and quality improvement opportunities that physicians choose to target. In addition to providing for a smooth transition process, a "bottom up" approach in which physicians develop experience, skill and confidence by taking accountability for specific elements of health care quality and costs where they can have a significant impact is more likely to achieve meaningful improvements in care delivery and costs than a "top down" approach using global payments that requires physicians to reduce total costs of care for a patient population. This is particularly true given the lack of real time data available to physicians to manage total care costs under global or capitated models.

While APMs should be focused on specific opportunities to improve care delivery, they should not be limited to Medicare physician fee schedule services. **APMs that deal with particular episodes of care or managing particular conditions can give physicians the flexibility and resources to lower utilization of services that are outside of the physician fee schedule, like hospital outpatient and inpatient services and post-acute care. Physicians should be able to be rewarded when they achieve these savings.**

Developing APMs for Conditions, Episodes and Other Care Improvements

Models that Medicare has made available to date include accountable care organizations (ACOs), bundled payments for acute care episodes, and patient-centered primary care medical homes. **APMs should include additional models, such as bundled payments for episodes that do not include a hospital stay, and condition-based payments covering all the costs of care associated with managing or treating a particular health problem.** A process can be established that would require CMS to issue Requests for Proposals that would provide certain parameters, such as defining the key elements of a condition-based payment model. Specialty societies and multispecialty organizations would then propose specific APM proposals that meet the CMS criteria. This approach would allow physicians to determine the diseases or procedures and patient populations covered by the APMs, the length of time that is appropriate for the APM to cover, and how to ensure quality standards are met. Requests for proposals should also be flexible enough to allow the organizations proposing the APMs to indicate the level of savings that will be achieved relative to what Medicare currently spends for the episode or condition and the patient population covered by the model. Participation in an APM should be voluntary for physicians.

The AMA has been discussing with specialty societies how an approach like this one could work in Medicare. First, the specialists or practice would need to consider which conditions it most often manages in its Medicare patients. APMs should be aimed at improving the health of a patient population and not just focused on individual services provided to individual patients. There need to be enough patients with the condition or episode that the APM will cover to make it feasible to develop meaningful estimates of average costs associated with alternative clinical pathways for the patient population. For conditions that affect a sufficient number of Medicare patients and have multiple treatment plan options with different costs, an APM that pays for overall management of the condition over a period of time independent of the specific treatment selected can provide physicians with considerably more flexibility to improve results for patients and lower costs for Medicare than does the current FFS system. Condition-based payments can address a major shortcoming of the FFS system by rewarding physicians who are able to treat or work with patients to prevent their conditions from getting worse and manage conditions to prevent acute care episodes from occurring. Although there have only been very preliminary discussions to date, some of the major Medicare conditions that may ultimately prove to be viable candidates for a condition-based APM include congestive heart failure, ischemic heart disease, chronic obstructive pulmonary disease, hepatitis C virus infection, several types of cancer, stroke, and diabetes. **The process that Congress develops to promote development of new APMs should be decentralized, placing major responsibility for their design and implementation with specialty societies, groups of physicians, and multistakeholder regional health improvement collaboratives.**

APMs Should Be Widely and Regularly Available

Although the Committee recognizes and the AMA agrees, that FFS will remain the standard payment method for the foreseeable future, the AMA feels strongly that **APMs should not be limited to demonstration projects or tests**. The more experience physicians gain with these new models, the more lessons will be learned and refinements can be made. APMs need to reach a threshold level of participation by physicians so that there will be enough experience with them that other physicians will want to get involved. If APM diffusion is held back while each test site is evaluated, they will never reach this threshold.

For this reason, the AMA recommends that the SGR replacement legislation allow any physician practice or organization that provides the types of services to the types of patients that are the focus of an APM to apply to participate in such an APM. No limits should be imposed on the number of participating physicians, practices or geographic areas. Once an APM is offered, additional physicians should be permitted to apply for participation in that APM at regular intervals, such as annually.

Linking Physicians' APM Participation to FFS Payment Updates

To support the infrastructure improvements and care redesign that physicians need to succeed in APMs, they will need to receive adequate revenues. APMs should be designed to save money for Medicare relative to the spending growth that would occur across the entire system, but APM-participating physicians should then be able to benefit financially from reductions they achieve in hospital admissions and other expensive Medicare services. As physicians proceed through the transition period into the payment system of the future, they are likely to have some percentage of their revenues derive from APMs and the remainder from Medicare FFS. **Physicians involved in APMs that are significantly reducing overall Medicare spending outside the physician fee schedule should get higher FFS payment updates than those who are not in APMs.**

Supporting Physician Participation in APMs

Several specific provisions will be needed in order to support organizations developing and physicians participating in APMs. We recommend the following provisions to support this effort.

1. Availability of Medicare Data

- The Finance Committee took a major step forward in providing physicians with needed data when it enacted Section 609(b) of the American Taxpayer Relief Act of 2012. Future legislation should further **charge CMS with making analyses of Medicare claims data available at no cost to any physician organization that submits a preliminary application to participate in an APM**. The analyses should be specifically designed to enable the practice to identify the opportunities to improve care coordination and quality for their patients, understand the most recent spending associated with the services and patients that would be affected by the APM, and to calculate how payments and spending under the APM would compare to current levels.

- CMS should also **make Medicare claims files available at no cost to medical societies and multi-stakeholder regional health improvement collaboratives** so that they can provide analyses that will (a) assist physicians in applying to participate in existing APMs and (b) enable physicians to propose additional APMs, particularly for specialties where an APM has yet to be created. (It would be important, however, that these analyses not be used for public reporting about individual physicians or groups of physicians, unless the organization and the reporting meet the standards for Qualified Entities.)
- **For approved APMs, CMS should provide updated data on utilization and spending related to the patients, conditions, and services covered on a quarterly basis.**

2. Technical Assistance and Consumer Engagement

A program of grants should be created for medical societies, Regional Health Improvement Collaboratives, and similar multi-stakeholder organizations to:

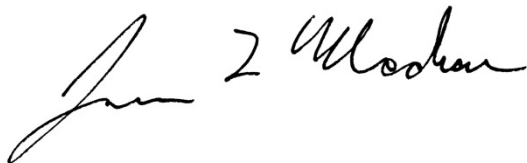
- Provide technical assistance to physicians in applying to participate in APMs;
- Provide technical assistance to physician organizations in successfully implementing an approved APM, including redesign of care and management of finances;
- Enable them to receive, store, and analyze claims data from Medicare and other payers to help design and participate in APMs; and
- Educate patients about the advantages of improved care models that are supported by APMs.

3. Guaranteed Loans for Small Physician Practices

A program should be established to guarantee loans to small, independent physician practices to help them cover the infrastructure investments and cash flow they may need to successfully implement APMs.

Thank you for the opportunity to share these thoughts with the Committee. We look forward to continuing to work with you and your staff and to the successful enactment of Medicare physician payment and delivery reforms this year.

Sincerely,

A handwritten signature in black ink, appearing to read "James L. Madara". The signature is written in a cursive, flowing style.

James L. Madara, MD