November 12, 2013

The Honorable Max Baucus
Chair
Senate Finance Committee
Dirksen Senate Office Building
Washington, DC 20510

The Honorable Orin Hatch
Ranking Member
Senate Finance Committee
Dirksen Senate Office Building
Washington, DC 20510

The Honorable Dave Camp
Chair
House Ways and Means Committee
Longworth House Office Building
Washington, DC 20515

The Honorable Sander Levin
Ranking Member
House Ways and Means Committee
Longworth House Office Building
Washington, DC 20515

Dear Senators Baucus and Hatch and Representatives Camp and Levin

On behalf of the Healthcare Billing and Management Association (HBMA) we want to acknowledge and thank you for the commitment you and your colleagues in the 113th Congress have shown to repealing the flawed SGR update mechanism. We appreciate all of the many hours you and your respective staffs have put into developing this proposal. We respect the work that you've done and the sincere effort you have made to address a problem that pre-dates your ascendancy to the leadership positions you now hold.

HBMA is a non-profit trade association of companies providing medical billing and related services to physicians, hospitals, non-physicians (ambulance, DME, ASC, IDTF, Rural Health Clinics, FQHCs, etc.) and other health care organizations throughout the United States. For nearly twenty years HBMA has been the billing industry organization recognized for education, advocacy and cooperation in all matters that affect the processing of provider claim-related data, compliance and management services. Our member companies process in excess of 350 million claims annually and serve virtually every clinical specialty, in every setting, in every state.

Our members include companies with over three thousand employees and dozens of branch offices as well as small businesses with solo practices as clients. The average member billing company employs approximately thirty people, serves 100 or more physicians and processes 40,000 or more claims per month. Some of our members supply the practice management systems used by their office-based clients, while others receive information in electronic, as well as paper forms on behalf of their hospital-based, office-based and non-physician clients. As it is with practices handling their own billing, data arrives, moves and leaves by a host of means, not all of it electronic.

For over fifteen years, HBMA has worked closely with CMS and other federal agencies on all matters related to Medicare, including but not limited to, billing rules, payment policy and

compliance. We have provided comments, testimony, private and public input related to patient privacy as well as offering a wide array of education materials, conference programs, references, announcements and targeted training for our member companies and their employees and clients. Our members routinely assist their physician clients with the transition, implementation and compliance with Medicare rules and regulations and strive to be a trusted advisor and reliable source of expertise on the Medicare program's requirements.

We submit these comments with the full knowledge that it is far easier to "kill a play" than it is to "write one."

As you may know, when the Medicare program was created nearly 50 years ago, the Congress and President were concerned about the impact the new initiative would have on the way providers delivered care. Medicare was, and is, a program fundamentally designed to help pay for healthcare provided to our nation's seniors and was never intended to dictate how healthcare was provided.

The importance of that distinction cannot be overstated. It was such a driving force behind the creation of the Medicare program that the authors put the following sentence as the first sentence of the Medicare statute:

> "Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided..."

The proposal before us violates this very clear articulation of Medicare's purpose and role.

Value vs. Volume

This proposal seeks to replace a Medicare fee-for-service payment system that you characterize as one rewarding "volume" with one that would reward "value". In the summary, you specifically state that the goal is to "reform the fee-for-service (FFS) payment system through greater focus on value over volume."

In many respects your characterization of this as an either/or proposition is similar to the And/Or Ford Motor company commercial. We have to choose. We can have either Value OR Volume – which do you want? Just as the commercial says, "AND is better" and we suggest that in this debate "and" is better. We recommend a methodology that allows for both Value AND Volume. It does not have to be one or the other.

What is Value?

It is difficult to argue with the premise that we should try to build value into the payment methodology. Who can argue with that premise? We always want "value" in our purchases, whether it is healthcare or automobiles.

So, seeking to incorporate "value" as part of the payment methodology is not a bad concept. But neither were the original designs for airplanes "bad concepts." The problem was that when you go from "concept" to production, you realize that sometimes what looked good on paper doesn't translate well to the real world. We fear that this is what will happen with this proposal. It looks nice on paper but when you try to translate it to the real world, it will do serious harm to our nation's healthcare delivery system.

The problem with attempting to define "value" is that there is no single definition. Value is something we want and hope we receive with every product or service we purchase but how each consumer defines "value" is a composite score of a myriad of factors that are unique to that consumer.

We do not dispute the 4 factors that are identified as being part of a value proposition. But you fail to include other substantive elements necessary to achieve a high quality value proposition.

These limited attributes appear to have been chosen simply because they can be measured and quantified and thus translated into a financial formula, as opposed to being a summation of tests that would appropriately fulfill the desired tests for quality and value.

Albert Einstein once said, "Not everything that matters can be measured and not everything that can be measured, matters." We see this time and time again in healthcare. We ask providers to submit reports and check-off boxes indicating that they've provided/documented/reported 'value' and reward them for checking boxes. But does any of this improve quality? Is this really value?

Herein lies the flaw in the methodology. You are including "things that matter" because they can be measured but you are excluding other, equally or more important things that matter, because they cannot be measured. By doing so, you are saying they don't matter.

What other factors affect how a consumer determines value? What about access?

Someone sitting in Washington, DC, with dozens of top rated hospitals within a few miles of the Capitol might not think about access to a hospital or specialist's services as being part of a value proposition. Someone sitting in the Russell Senate Office Building, with hundreds of primary care and specialty physicians within minutes of their office might not think about access to physician (or NP or PA services) as being an example of value.

Your proposal defines healthcare "value", as a combination of:

a. Quality
b. Resource Use
c. Clinical Practice Improvement
d. EHR Meaningful Use

But suppose instead of sitting in an office in Washington, DC, you are sitting in a farmhouse in Winterset, Iowa? For that person, the value proposition might be different. The physician's

quality score or ability to achieve Stage 3 of meaningful use might not even be on his/her top ten list of things that define healthcare "value."

For this person, having access to a physician or hospital that is only 10 miles away is their primary test of "value."

Is this person wrong? And what if the inability of the local physician to meet the Washington DC definition of value results in payments that are so low, the physician can't stay in business and closes? Who tells that community, that the loss of their local physician is actually a good thing? Who is charged with convincing the Medicare population in that small town that it is a good thing that instead of having a physician who spends too much time talking to them and not enough time on the computer meeting the meaningful use criteria, they now have access to a high quality physician who uses the most modern technology and is a highly valued physician and, the really good news, she is only 40 miles away!

In other words, for many people, value also includes access and availability. How can the definition of value be justifiably limited to a set of scores on supposedly objective measures and exclude from its definition any notion that Medicare beneficiaries would have access to a health professional or healthcare facility as part of that calculation?

This is just one example of the complex and individualized nature of the term "value". This is also why the people who created the Medicare program attempted to stay out of this debate. They recognized that it was impossible to create a single government approved definition of "value" that would satisfy the millions of personal definitions of value.

Administrative Burden

During the debate leading up to the enactment of the Patient Protection and Affordable Care Act, it was not unusual to hear elected officials talk about the fact that healthcare costs are the leading cause of personal bankruptcy in the United States. Ensuring that individuals had adequate health insurance would, it was argued, largely eliminate this threat hanging over the heads of millions of Americans.

How ironic it is that on the cusp of ensuring that millions of individual healthcare consumers have health insurance that will help prevent personal bankruptcy, you are putting forward legislation that has a very predictable likelihood of creating so much administrative burden and financial stress, that literally thousands of healthcare providers will be motivated to retire or be forced to abandon the practice of medicine.

It would appear that a significant purpose in establishing the administratively complex method for replacing annual inflationary adjustments with composite "incentive" payments is to "encourage" more physicians to move from the independent practice of medicine into more organized delivery models (Hospital owned health systems and ACOs or similar models) where the physician is either an employee of the organization or part of a large physician organization where the group is paid using some type of risk-sharing or risk-bearing model.

Based upon previous Medicare incentive payment programs that have been used as a proxy for annual updates (PQRS and E-prescribing), we estimate that that the maximum update available under this proposed system will be 2%. Our preliminary assessment of the administrative cost of collecting, analyzing and reporting all of the data necessary to compute the composite score will be no less than 2% and likely closer to 3 – 4%.

Regardless of the exact number, the question for you and your colleagues is whether Congress is prepared to offer an annual quality/value incentive payment **that is higher than the cost of earning that incentive**? Given that Congress promoted both the PQRS and E-prescribing incentive programs despite the fact that that for most providers, the cost of meeting the PQRS and E-prescribing thresholds was higher than the incentive payments available, we have little confidence that this will be any different.

Therefore, we can only conclude that if a provider wants to see any increase in Medicare payments, their best hope resides in moving to one of the Alternative Payment Models referenced in the summary.

Although we are provided no specific details on these APMs, we note that you are prepared to offer a 5% annual update to physicians who substantially participate in an APM with "two-sided financial risk and a quality measurement component" between 2016 and 2021. In addition, beginning in 2023, providers (physicians, PAs and NPs) who participate in "advanced APMs" would receive an annual update of 2% whereas those not participating in such models would get a 1% update.

Finally, we cannot overlook the fact that the proposal, if enacted as written, would impose a hard freeze on physician payments for 2014, 2015 and 2016.

In meetings with HBMA representatives, the Senate Finance Committee staff and House Ways and Means Committee staff, have heard concerns about the increasing administrative burdens placed on physicians. Individually, many of the causes of these administrative burdens are justifiable. Collectively, they are crushing physician practices financially by adding more and more administration and overhead costs. When coupled with virtual freezes in provider payments, many health professionals have decided to leave the practice of medicine.

For those physicians who wish to continue to practice medicine but find none of these SGR related reforms attractive, we expect they will either exit the system or may opt to move to a concierge style of medicine and only accept cash payments for services rendered, a trend that is already beginning to gain traction.

Availability of Data

This proposal will largely succeed or fail based upon the ability of providers to meet certain markers. The higher the composite score, the higher the annual update. The lower the composite score, the lower the update. And, for some providers, a negative update (i.e. reduction).

It seems clear, however, that the measures necessary to establish the markers have not been developed and you are looking to the various physician organizations, in particular specialty societies, to develop the specialty-specific measures. While we applaud the decision to allow these to be developed by specialty societies, we are not confident that the measurements can be developed, tested and available by the time this system goes live in 2017.

Were this proposal the only operation change that was occurring in healthcare over the next few years, the undertaking would be massive. In light of other operational changes (ICD-10 implementation, adoption and use of Stage III Meaningful Use, expanded e-health initiatives to name a few), asking physician organizations and their members to divert attention to developing the measures necessary to operationalize this new payment model will be virtually impossible.

We are very concerned that the data to do this does not currently exist and the time, money and resources are simply not there to do this in the timeframe laid out in this proposal.

Testing the Process

Making sure we have the right measures is only part of the challenge we face in implementing these types of payment reforms. We must ask – will it work? Will the pieces fit together and result in accurate and timely updates? Will physicians entitled to increases get those increases and will those subject to penalties, see those reductions.

This is a major administrative undertaking and we need to know if the composite scoring process will work as intended.

<u>This means full end-to-end testing!</u>

Over the past few weeks, we have seen what happens when the government tries to make changes in the marketplace and does not adequately test the new system – it crashes.

We must test this system in the real world to make sure it works as advertised. The testing must be complete, **<u>end-to-end testing</u>**. Does this composite scoring system produce the payments the provider was expecting? Does this affect provider payments in the way they are intended? Did providers who were expecting a positive update get it?

Many physicians' offices are small businesses and cash flow is a critical factor on maintaining the economic viability of that practice. If payments are not correct or different than what the provider was expecting, you run the very real risk of doing financial harm – unintended financial harm - to the practice.

Should this proposal be adopted, the timeframe for implementation must build in time for testing the composite scoring process to make sure it works.

Impact over Time

The recommended process for annual increases and reductions based upon quality/value will be extremely disruptive and difficult for providers to predict. Providers will not know what score will be sufficient in one year to translate into either an increase or decrease in payments in a future year. The proposal makes reference to scores in prior years being used to determine incentives in future years but provides no specific timeframe.

Furthermore, over time, even good providers will find it difficult, if not impossible, to avoid a payment reduction or freeze.

Based upon the summary, it appears that each year, the lowest scoring physicians will see a reduction in their Medicare payments - a negative update. It would seem that at one level, this is a goal of this initiative – remove poorly performing providers from the system.

But in removing these low scoring providers from the system, you would be newly exposing higher scoring physicians to being cast into the lowest quartile in the next or subsequent year.

The way the system is described, it appears that in order for one group of physicians to always get rewarded for achieving the top score, another group of physicians will be penalized for low scores. Because the system is internally revenue neutral, there will always be a redistributive effect and thus those judged in the lowest quartile will always be subject to lower payments. The "savings" generated by paying some physicians less will be used to reward those achieving higher scores.

As low scoring physicians leave the Medicare program, the higher scoring physicians remaining become increasingly exposed to a reduction because they now become the "low scoring" physicians. As currently described there is no scoring floor, above which no penalty is levied.

This establishes a predictable and negative pattern that arguably has no end.

Conclusion

Finally, we would ask, what will this mean for patients?

Academicians and researchers can run all of the computer models you want to assess what the financial impact of these changes will be on total Medicare costs and total Medicare expenditures. No doubt the Congressional Budget Office is already working on that for you.

But we have yet to see a model that assesses the impact of changes such as this on patients and their ability to access the healthcare delivery system.

Ironically, because of the way CBO does it's scoring, putting physicians out of business will likely show up as saving the Medicare program money. Fewer providers, fewer patient visits. Fewer patient visits, lower volume. Lower volume, lower Medicare spending. Problem solved.

If Congress is concerned that people are angry because government policies that are leading to their insurance company canceling their insurance, one can only wonder how people will react

when they are told by their Doctor that Medicare payment policies have lead their physician to decide to leave the practice of medicine.

As we stated at the outset, we appreciate the hard work and dedication you have demonstrated to offering a substantive proposal for repealing and replacing the SGR formula. Despite our serious concerns about this particular proposal, we remain committed to working with you on coming up with a workable solution.

The HBMA remains eager and willing to be involved in stakeholder round table discussions and/or meetings to further explore how to assure physicians are fairly compensated for the services they provide to assure our nation's Medicare beneficiaries continue to have access to quality care.

Respectfully,

Judson Neal, CHBME
President
HBMA