

November 11, 2013

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

The Honorable Dave Camp  
Chairman  
Committee on Ways and Means  
1102 Longworth House Office Building  
Washington, DC 20515

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

The Honorable Sander Levin  
Ranking Member  
Committee on Ways and Means  
1106 Longworth House Office Building  
Washington, DC 20515

Dear Chairman Baucus, Chairman Camp, Ranking Member Hatch, and Ranking Member Levin:

On behalf of the physician and medical student members of the American Medical Association (AMA), I am writing to express our sincere appreciation for your leadership and efforts to repeal and replace the failed Medicare funding formula known as the sustainable growth rate, or SGR.

The AMA commends the Senate Finance Committee and House Ways and Means Committee for collaborating in a bipartisan, bicameral process to develop legislation to improve the Medicare program for patients and physicians. We are highly encouraged by the extensive stakeholder outreach that has taken place with you and your staff. The framework you released is a significant development, and represents a pivotal step toward the adoption of health care delivery and payment reforms that will improve health care for America's seniors and help rein in overall costs.

Most significantly, your legislative framework permanently repeals the SGR and takes significant steps toward allowing physicians and other health care providers to design systems of care that best serve their patient populations through new and innovative care delivery models. We appreciate that a number of suggestions made by the AMA and other stakeholders have been incorporated into the proposal.

We thank you for the opportunity to offer constructive recommendations to build upon and strengthen your initial proposal to best achieve our shared goal of developing a new, and more stable, Medicare payment and delivery system that enables physicians to provide high quality and efficient health care to patients. Research conducted recently by the RAND Corporation on behalf of the AMA reveals that the main driver of professional satisfaction for physicians is practicing in an environment that enables them to provide high-quality care to their patients, and the most often cited factor that interferes with high-quality care delivery is onerous administrative burdens. With these thoughts in mind, we are offering recommendations intended to better support patient-centered care and streamline regulatory requirements.

While detailed recommendations are attached, our key suggestions include:

- The AMA strongly advocates for inclusion of positive updates to reflect the increasing costs of practicing medicine, the expense of purchasing, upgrading, and maintaining electronic health records, quality reporting programs, and other regulatory requirements. Average annual updates have been close to zero for over a decade. The AMA strongly advocates for inclusion of positive updates.

Payment updates are needed to support practice investments that allow for advancements in care delivery and clinical practice improvement activities. The transition to and the adoption of Alternative Payment Models (APMs) will require medical practices to make new investments in care management systems staff, decision support tools, patient registries, and data analysis capabilities.

- We urge that the maximum penalty under the proposed Value-Based Performance (VBP) program be set at four percent. This would still serve as a strong incentive for physicians to improve quality and participate in new APMs, while simultaneously helping to prevent further erosion of access to care for seniors and the disabled.
- Performance comparisons for the VBP program should be made among practices of similar size, based upon groupings of the number of eligible professionals (EPs). Tiers of physician practices should be established that would allow similarly situated practices to be compared with each other (e.g., practices with fewer than 10 EPs, those with 10-50 EPs, those larger than 50). The Secretary of Health and Human Services should also be directed to establish separate VBP categories as needed for subspecialists for whom applicable quality measures and electronic medical record systems are lacking.
- The AMA proposes a provision directing the Secretary to develop a methodology for *prospectively* determining physicians' level of involvement in APMs in a way that allows multiple pathways to reach various thresholds that would qualify for the five percent APM participation bonus payment, exemption from VBP penalties, and/or credit towards clinical practice improvement activities. In addition to APMs-related revenue shares, factors to consider in assessing the level of participation could include: the number or percentage of the physician's patients involved in APMs; the percentage of total Medicare spending for the physician's patients that is affected by APMs; and the dollar amount or percentage by which total spending for the physician's patients is lower than it otherwise would be due to the physician's participation in APMs.
- The AMA recommends eliminating the proposed provisions that would require a reduction in fee schedule payments of up to one percent in the years 2016, 2017, and 2018, unless misvalued services producing one percent in savings can be identified each year. This could potentially lead to the permanent removal over three years of close to three percent of funds from the physician payment pool. Alternatively, the target for identifying savings for misvalued services should be lowered to a more reasonable 0.5 percent in each of the three years. We strongly urge any cuts or value adjustments to be

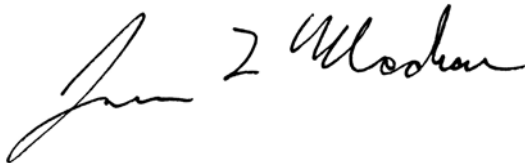
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subject to budget neutrality (as with the VBM program) rather than being permanently removed from the physician payment pool. Since 2006, the Centers for Medicare & Medicaid Services (CMS) and the AMA Specialty Society Relative Value Scale Update Committee (RUC) have identified over 1,500 potentially misvalued services through objective screening criteria. As a consequence, CMS has already decreased the value for 500 services over five years, with a total savings of \$2.5 billion.

- Many small, independent physician practices will require assistance in meeting the standards of the proposed VBP program and to participate in APMs. The AMA recommends the inclusion of a rigorous program of assistance and support for these practices beyond what the proposal provides for in rural areas and health professional shortage areas (HPSAs). Recent AMA research found that 18 percent of physicians are in solo practices and nearly 60 percent are in practices with fewer than 10 physicians. If small practices are to be defined in terms of the number of EPs, the threshold should be increased to 20 EPs. The AMA also suggests that multi-stakeholder Regional Health Improvement Collaboratives be engaged to provide the needed support to small, independent practices in all communities.

The AMA looks forward to continuing the constructive, bipartisan dialogue that has characterized this process as preparations are made for advancing this legislation.

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

Attachment

**Senate Finance/House Ways & Means Committees’  
October 30, 2013 SGR Discussion Draft  
AMA Suggestions  
November 11, 2013**

**I. SGR Repeal & Annual Updates**

***Issue:* The proposal calls for permanent repeal of the SGR and a 10-year payment freeze during that period. The AMA applauds the Committees for proposing a permanent repeal of the SGR. Annual patches have been costly and disruptive.**

*Discussion:* Physician payment rates have not kept pace with the increasing costs of practicing medicine and the expense of electronic health records (EHR), quality reporting programs, and other regulatory requirements. Average annual updates have been close to zero since 2003. Freezing rates for another 10 years will mean that real (inflation adjusted) physician payment rates will have decreased by 37 percent by the time the payments are next updated in 2024. In addition to the need for adequate payment rates to support advancements in care delivery, engagement in clinical practice improvement activities and alternative payment models (APMs) will require medical practices to make new investments in care management systems and staff, decision support tools, patient registries, and data analysis capabilities.

*Recommendation:* The AMA strongly advocates for inclusion of positive updates. We also urge the Committees to consider additional changes, detailed below, that would decrease physicians’ administrative burden under current programs and not increase their vulnerability to additional and/or increased penalties. This may be more affordable, assuming that more recent Part B premium announcement indicates that the rate of Medicare physician spending growth continues to be low.

**II. Value-Based Performance (VBP) Payment Program**

***Issue:* VBP incentive payments and penalties would begin in 2017, based upon performance in 2015.**

*Discussion:* A two-year lag between performance and assessment impedes meaningful quality improvement, reduces an already short time-line for the Centers for Medicare & Medicaid Services (CMS) and physicians to prepare for the VBP and increases the likelihood that many physicians will face large penalties. Also, while we strongly support the requirement for CMS to produce quarterly feedback on performance, we have reservations about the agency’s capacity to do so.

*Recommendation:* We support requiring more timely performance assessment, thereby shortening the current two-year lag, particularly if CMS is providing quarterly feedback. If CMS is not ready in 2015 to collect the requisite data and adjust it for patient risk, physician specialty/sub-specialty, and site of service, we recommend postponing this component of the VBP program for groups not currently subject to the Value-Based Payment Modifier (VBM) until CMS can accurately incorporate this data.

**Issue: Exemptions from VBP are limited to physicians treating “few” Medicare patients.**

*Discussion:* The AMA is concerned that certain physicians at or near retirement would drop out of Medicare—or quit practicing medicine altogether—rather than implement the changes necessary to begin reporting under an entirely new program.

*Recommendation:* We suggest also including an exemption from VBPs requirements and penalties for physicians who attest that they will terminate current practice by December 31, 2019. Additionally, Critical Access Hospitals are not currently required to participate in the Hospital Value-Based Purchasing Program. Physicians in these communities should also be exempt from the VBP Program.

**Issue: Quality Measures**

*Discussion:*

1. The proposal does not specify the amount of funding for measure development.
2. CMS is developing “quality tiering” for the VBM.
3. There are currently delays and backlogs in measure approval due to the National Quality Forum having sole responsibility for this function.
4. Some specialties (e.g., pathology) have very limited quality and/or outcome measures available that are relevant to their practice. Physicians without sufficient, relevant quality and/or outcome measures should not be deemed non-compliant or unsuccessful.
5. It is unclear whether participation in a registry would satisfy the quality measure requirements for the Electronic Health Record (EHR) Incentive Program and the Physician Quality Reporting System (PQRS).
6. The proposal only aligns quality measure reporting for PQRS and meaningful use by reporting on measures through a certified EHR. However, there are only a limited number of measures that may be reported through a certified EHR outside of primary care.

*Recommendations:*

1. The AMA supports allocating \$20 million per year, for 10 years, to fund measure development.
2. It should be clarified that all quality measures should be adopted only after rigorous testing and evaluation, and should come from the AMA-sponsored Physicians’ Consortium for Performance Improvement® (PCPI®), from specialty organizations, or through another forum with direct input from specialty organizations.
3. We also support ensuring the existence of alternative pathways (which meet specific criteria) for measure approval and avoiding an implementation bottleneck that can result from placing that authority with one single entity.
4. We support ensuring that physicians for whom there are no relevant quality and/or outcome measures are not penalized for something beyond their control. They should be incentivized, and eligible for bonuses, for providing high-quality of care.
5. Due to CMS’ required timelines, measures in the PQRS program must be submitted to CMS almost three years prior to implementation. For a new measure to be available in 2017, a developer would need to have its measure(s) ready by 2014 in order to submit the proposal to CMS by 2015, to make it into the 2017 Physician Fee Schedule rule. Therefore, we recommend postponing the higher weight for outcomes based measures.

6. We recommend including assurances that if there is not a clear number of electronic measures available for a physician or group practice to report on through a certified EHR, they may satisfy reporting for both PQRS and meaningful use by meeting the PQRS reporting requirements.

**Issue: Alignment Between Medicare Advantage and Traditional Medicare**

*Discussion:* Currently, there is no alignment under PQRS between Medicare Advantage (MA) and traditional Medicare. Some MA plans have instituted a PQRS type program, but it is optional. Under MA, physicians are eligible for meaningful use (MU) incentives and penalties. CMS only takes into account MA if the physician has not hit the threshold under traditional Medicare.

*Recommendation:* If an MA plan has instituted a PQRS type program, it must be aligned with the Part B PQRS program to reduce the administrative burden on physicians.

**Issue: Resource Use**

*Discussion:* The proposal calls for a substantial payment reduction (10 percent, according to Committee staff) for failing to identify episodes of care and the physician's particular role, on each Medicare claim. This added documentation is unnecessary and excessively punitive. Significant information is already required (specialty, diagnosis, and procedure codes) as a condition of payment. CMS and Centers for Medicare & Medicaid Innovation (CMMI) are already working on identifying episodes of care.

*Recommendation:* We recommend deleting the requirement for physicians to identify their role in each episode of care, and particularly the penalty for failing to do so. Tools must be developed and tested to accomplish accurate attribution of resource use. The application of resource use methodology should be limited to practices currently subject to the VBM until the accuracy and impact of the methodology for smaller groups can be demonstrated.

**Issue: Clinical Practice Improvement Activities**

*Discussion:* These activities can contribute significantly to the transition to alternative payment models, yet the proposal outlines a limited array of activities.

*Recommendation:* We support granting the Secretary discretion to approve additional activities. These could include, for example, medical specialty registry participation, extensive clinical improvement activity required to meet medical board certification/recertification requirements, Regional Health Care Quality Collaborative participation, successful completion of an accreditation program (e.g., The Joint Commission or National Committee for Quality Assurance), consulting appropriate use criteria, etc.

**Issue: Meaningful Use of Electronic Health Records**

*Discussion:* MU is currently an all-or-nothing, pass/fail model. Many physicians have failed to satisfy the requirements of MU Stage 1, despite devoting substantial resources to this effort, due to a flawed regulatory structure. Unlike PQRS, there are no transparent or consistent timelines for submission of new quality measures in the EHR Incentive Program. The majority of measures in the EHR Incentive

Program that vary from PQRS have been developed by CMS contractors without significant input by the physician community or through a multi-stakeholder process.

*Recommendations:*

1. The Secretary should be directed to change the requirement for having to meet 100 percent of the MU Stage 2 requirements to 75 percent.
2. Physicians should be given credit in this category commensurate with their progress toward achievement of MU.
3. The Secretary should be directed to set clear pathways for developing new electronic specified measures in the MU program.

**Issue: Performance Assessment**

*Discussion:* We understand the Secretary will have considerable discretion in determining successful performance in each of the four categories.

1. The AMA is very concerned that maximum penalties under VBP could reach 8 percent, 9 percent, even 10 percent under this proposal, which could drive many physicians from participating in Medicare. The Secretary would have discretion to increase the funding pool starting in 2020.
2. Consolidating PQRS, VBM, and MU under the new VBP umbrella would increase many physicians' vulnerability to both potential failure and higher aggregate penalties. Currently, their combined results under separate programs can potentially balance one another.
3. The model sets up a tournament-style system where eventually even significantly improved and high-quality practices could still face penalties.
4. It would be inequitable to compare small and medium practices to large, integrated health systems with vastly different levels of resources and administrative support.
5. There is a risk that results of participation in the VBP and other quality reporting programs could be used to allege "substandard" care in judicial and administrative actions.

*Recommendations:*

1. We urge that the proposal set the maximum penalty under VBP at 4 percent. This would still serve as an incentive for physicians to improve quality and participate in APMs, while simultaneously helping to prevent further erosion of access to care for seniors and the disabled. We would also oppose raising the ceiling for maximum penalties in 2020.
2. We further request that the percentage of funding that must be subject to VBP redistribution be reduced at least in the early years and that the Secretary be given discretion to reduce as well as increase the percentage of spending subject to VBP—especially if incentives are to be based strictly on comparisons between groups and not on improvement or attainment of a threshold.
3. We advocate for giving partial credit for partial completion of the requirements within each category, rather than a Pass/Fail or all-or-nothing approach for each requirement.
4. Performance comparisons should be among practices of similar size, based upon groupings of the number of eligible professionals. Tiers of physician practices should be established that would allow similarly situated practices to be compared with each other (e.g., practices with fewer than 10 eligible professionals; those with 10-50 EPs, those larger than 50). The Secretary should also be

directed to establish separate VBP categories as needed for subspecialists for whom applicable quality measures and electronic medical record systems are lacking.

5. The AMA supports incorporation of the “Standard of Care Protection Act” to prevent the inappropriate use of physicians’ performance in the VBP, other quality reporting programs, and practice guidelines from being used as a standard of care or duty owed by a health care provider in any medical liability judicial or administrative actions.

**Issue: Weights for Performance Categories**

*Discussion:* We have concerns regarding the proposed differential weighting for the four different categories.

*Recommendation:* We believe setting the weighting for each at 25 percent would provide greater reliability moving forward and avoid unfairly disadvantaging individual physicians facing considerable challenges meeting the requirements for any single category. For example, the Clinical Practice Improvement category that is currently assigned a 15 percent weight really involves preparation for participation in an APM and could potentially involve significant practice changes that should be more strongly encouraged. Similar to our point above regarding quality measures, we recommend some flexibility and support for physicians who have no way of meeting the requirements for one or more categories. We urge CMS to give serious consideration to individual adjustments requested by particular specialties to level the playing field and provide opportunities for all types of physicians to achieve appropriately high scores for exemplary performance.

**Issue: Assistance to Small Practices**

*Discussion:* Assistance would only be provided to practices of 10 or fewer EPs in rural areas and health professional shortage areas (HPSAs). The AMA believes that many physicians and small, independent physician practices will require assistance in meeting the standards of the VBP and to participate in APMs.

*Recommendation:* There needs to be a rigorous program of assistance and support available for these practices that goes well beyond those in rural areas and HPSAs. Recent AMA research found that 18 percent of physicians are in solo practices and nearly 60 percent of physicians are in practices with fewer than 10 physicians. If small practices are to be defined in terms of the number of EPs, the threshold should be increased to 20 EPs. To achieve a truly substantial movement to APMs and improvement in health outcomes, the AMA suggests that multi-stakeholder Regional Health Improvement Collaboratives be engaged to provide the needed support to small, independent practices in all communities. For example, these collaboratives could help practices undertake quality improvement initiatives (including measure development), participate in registries, obtain data necessary to run simulations of what will happen to practices under APMs, and convene stakeholders to achieve the scale and coordination between physicians in a community that will be needed to put successful APMs together.

### III. Encouraging Alternative Payment Model (APM) Participation

#### **Issue: Determining Physician Participation in APMs**

##### *Discussion:*

- The process outlined in the Discussion Draft relies on revenue share in an APM to assess physicians' level of participation in an advanced APM. Revenue share may be a useful measure for some physicians in some APMs, but will be problematic for others as revenue from an APM may not be known until long after the performance year has ended. In Medicare ACOs and the Comprehensive Primary Care Initiative, patient attribution to the APMs is retroactive, further complicating physicians' ability to determine their revenue share associated with an APM during the measurement period.
- More than 80 percent of Medicare spending pays for benefits such as hospital and post-acute care, not physician services. A major goal of APMs is to reduce spending on services that physicians can influence, such as hospital admissions for ambulatory care sensitive conditions, so the impact of an APM on Medicare spending may far outweigh its impact on physicians' own revenues.
- The Discussion Draft provides partial credit for the VBP Clinical Practice Improvement score to physicians in any Medicare APM and an exemption from the VBP with a 5 percent bonus payment to physicians that get a particular share of their revenues from participation in an advanced APM. The AMA supports these incentives; however, there is likely to be a continuum of physician participation in APMs and incentives should be more varied to reflect different levels of involvement and types of APMs.

*Recommendation:* The AMA proposes that the legislation direct the Secretary to develop a methodology for *prospectively* determining physicians' level of involvement in APMs in a way that allows them multiple pathways to reach various thresholds that would qualify for the 5 percent APM participation bonus payment, exemption from VBP penalties, and/or achievement of the Clinical Practice Improvement score and other components of the VBP. In addition to APM-related revenue shares, factors to consider in assessing the level of participation could include: the number or percentage of the physician's patients involved in an APM; the percentage of total Medicare spending for the physician's patients that is affected by an APM; and the dollar amount or percentage by which total spending for the physician's patients are lower than they otherwise would be due to the physician's participation in an APM. The prospective determination method should provide a means to account for factors outside the physician's control, such as, if CMMI withdraws approval for the APM midway through a performance year. The methodology developed by the Secretary should be subject to notice and comment rulemaking.

#### **Issue: Development of APMs for Specialists**

*Discussion:* Most APMs offered to date by CMS focus on primary care. Although Medicare ACOs' success is judged by their impact on total Medicare spending for the patient population assigned to the ACO, patient attribution to ACOs is based on primary care visits. To make the bonus opportunities available to the greatest number of professionals, the Discussion Draft encourages the Secretary to test APMs relevant to specialist professionals. The AMA agrees strongly that APMs need to be developed and implemented for specialists and offers recommendations to further this objective.

*Recommendation:* The AMA recommends that the legislation establish a process for physicians to develop and submit new proposals for APMs for specialty physicians that would then be subject to approval for implementation by CMS. Consistent with the legislation's requirement that advanced APMs involve two-sided risk, the physicians proposing to implement these models would need to agree to provide (directly or through arrangements) all of the health care services needed for a group of patients for a specific health condition or treatment plan in return for a predetermined bundled payment amount that would be less than what Medicare would have otherwise spent for the patients with the condition or treatment included in the model. These APMs need to be sustainable new programs, not just tests. It is very difficult for physicians to make the investments needed to redesign practices and care delivery for temporary projects, or to take on significant risks under test conditions. Medicare should give specialists the flexibility to implement APMs that produce savings and improve care coordination and quality without fear that they will lose this flexibility when the test period ends.

#### **IV. Encouraging Care Coordination for Individuals with Complex Chronic Care Needs**

*Recommendation:* We support the inclusion of statutory language that clearly defers to CMS to determine the appropriate coding and reimbursement for Complex Chronic Care Management (CCCM) services. The proposal should provide adequate flexibility to accommodate changes that CMS makes as it continues to work on this issue.

#### **V. Ensuring Accurate Valuation of Services Under the Physician Fee Schedule**

***Issue:* The proposal would require a reduction in fee schedule payments of up to one percent in the years 2016, 2017, and 2018, unless misvalued services producing one percent in savings can be identified each year. This would apparently not be budget neutral, so the ultimate reduction over three years could be close to three percent, and these funds would be permanently removed from the physician payment pool.**

*Discussion:* This amounts to a negative update, or could lead to arbitrary or unwarranted selection of services for revaluation, to avoid the across-the-board cut. Payment reductions would also affect primary care and CCCM services. Since 2006, the CMS and the RUC have identified 1,553 potentially misvalued services through 13 different objective screens. The RUC has completed review of 1,281 of these services. The RUC recommended a decrease in value for 36 percent of the services, while recommending an increase for only seven percent. (Some 26 percent were reaffirmed; 18 percent are still under review; and 13 percent were deleted.) As a result of the RUC's efforts for 2009-2014, CMS has decreased the value for 500 services, with a total of \$2.5 billion redistributed within the Medicare Physician Payment Schedule. The services that have not been screened in recent years represent relatively low volume and/or moderate values, so their revaluation would not have a high impact on aggregate Medicare physician spending.

*Recommendation:* The AMA supports deleting this provision. Alternatively, the target for identifying savings for misvalued services should be lowered to a more reasonable 0.5 percent in each of the three years. In any case, any cuts or value adjustments should be subject to budget neutrality (as with VBM) rather than being permanently removed from the physician payment pool.

**Issue: A penalty of 10 percent would be assessed for failure by physicians to provide requested data “to assist in accurate valuation.” Physicians in practices of 10 or fewer professionals (and those that submitted information the prior year) would be exempt.**

*Discussion:* Physicians should not be compelled to provide data to support accurate valuation. The 10 percent penalty for failing to respond is egregious. Many physicians do not respond to RUC surveys because they do not perform the service being surveyed, or have financial conflicts of interest. The Urban Institute is currently collecting time data for the HHS Assistant Secretary for Planning and Evaluation. In addition, both the Urban Institute and RAND have related contracts with CMS. The RUC recently increased its guidelines for the minimum number of responses, but it should be noted that CMS, in the VBM, uses a 20-case minimum. Nearly 60 percent of physicians are in practices with fewer than 10 physicians; around 40 percent are in practices with fewer than 10 professionals.

*Recommendation:* The AMA strongly urges the Committees to redirect the CMS funds required for this duplicative study to provide significant incentive payments to encourage physicians to participate in a new Practice Expense survey, administered by CMS, with input from the medical community. Further, CMS is already required to ensure that “the global payment for the work component of surgical procedures accurately reflects the average number/type of visits following surgery,” so we also recommend dropping the surgical global service language from the draft.

## **VI. Recognizing Appropriate Use Criteria**

**Issue: Medicare would pay for advanced imaging (CT, MRI, PET, and nuclear scans) and echocardiograms only if the ordering physician consulted appropriate use criteria such as clinical decision support (CDS), or prior authorization was obtained by “outlier” physicians who order more procedures outside the appropriate use criteria than their peers. The Secretary could expand appropriate use criteria to other services.**

*Discussion:* The AMA appreciates the Committees’ efforts to work collaboratively with specialty organizations to address concerns about the appropriate use of these services. We understand there will be some exceptions for emergency situations, hospital inpatients, etc. We remain concerned that this poses an additional administrative burden on physicians who order these services, who may also be unfamiliar with these requirements and have limited access to the CDS tools. We are also concerned this could disadvantage physicians who serve patients with diagnoses or complex health needs that warrant frequent imaging. In some cases, failure to consult the appropriate criteria may simply require a phone call to the ordering physician, and a few minutes’ delay while he or she consults the criteria. But when the ordering physician is unavailable, or the schedule cannot accommodate such a delay, imaging will have to be postponed and patients will be inconvenienced, perhaps even required to go back to the ordering physician and obtain a new order. Delaying imaging could lead to more costly procedures and hospital stays, and hinder access to care for patients with significant health or logistical problems, including limited providers in their area.

*Recommendation:* Any required CDS or other appropriate use tools should be available to all physicians electronically, free of charge. Exceptions should be allowed, on a case-by-case basis, for patients with urgent needs for advanced imaging, particularly when the alternative is more costly procedures or care.

We oppose granting the Secretary unfettered discretion to expand appropriate use criteria to additional services. This should occur only with an opportunity for input from physicians, after these requirements have been demonstrated to be effective in decreasing inappropriate services. Prior to being subjected to prior authorization, physicians should have an opportunity to appeal the “outlier” designation.

## **VII. Expanding the Use of Medicare Data for Performance Improvement**

***Issue:* Qualified Entities (QEs) would be provided expanded authority to sell data analyses to physicians, professionals, health insurers, and employers under certain circumstances. Expanded access to Medicare claims data would also be provided to qualified clinical data registries (QCDRs) to support quality improvement activities.**

*Discussion:* The AMA supports expanded authority for QEs and access for QCDRs, subject to certain safeguards.

*Recommendation:* We suggest adding requirements that: (a) When QEs sell analyses to health insurers and employers, these should be solely for internal use, within current safeguards; and (b) QCDRs would be subject to safeguards and limitations on reporting that ensure the quality of the data and are consistent with the existing QE program.

## **VIII. Transparency of Physician Medicare Data**

***Issue:* HHS would be required to publish physicians’ utilization and payment data on the public Physician Compare web site.**

*Discussion:* The AMA has serious concerns about ensuring the reliability of this data. Therefore, we oppose publishing utilization, payment, and resource data without development and testing of accurate, valid risk-adjustment, and attribution tools and limitations on the further use of this information. CMS itself has noted that “data on Physician Compare can take up to 3 to 4 months to be updated after a change has been made in PECOS [Medicare’s Provider Enrollment, Chain, and Ownership System] due to data processing lags. Non-PECOS data can take up to 3 to 8 weeks for the information to be reflected on the site.” There are also significant underlying problems with the website’s demographical data and search function. Adding utilization and payment data would require a substantial lift and necessitates additional safeguards to ensure its reliability and prevent misinterpretation or misuse.

*Recommendation:* The AMA supports allowing opportunities for input from physicians and other stakeholders prior to expansion of Physician Compare. Any publication of physician claims data on the website should require appropriate attribution and risk adjustment, timely correction of errors with appeal rights, and explanatory information to prevent misinterpretation by patients or incorrectly classifying a physician as a “poor performer.” Data should not be republished for public use beyond publication on the website without being subject to the QE programs safeguards. Safeguards should also be required to prevent the use of data in judicial or administrative proceedings in order to prevent meritless lawsuits.