



December 29, 2005

Mark McClellan, M.D., Ph.D.  
Administrator  
Centers for Medicare and Medicaid Services  
Hubert Humphrey Building  
200 Independence Avenue, S.W.  
Washington, D.C. 20201

Dear Dr. McClellan:

The American Medical Group Association (AMGA) agrees with the Center for Medicare and Medicaid Services' (CMS) desire to transform the Medicare program into a value-based purchaser of care. AMGA members, large multi-specialty medical groups, are well suited to thrive in a value-based environment because of their use of information technology, care coordination, team concept, and evidence-based guidelines.

CMS took a first step to transforming Medicare into a value-based purchaser when it unveiled its Physician Voluntary Reporting Program (Program). However, based on feedback from several AMGA members, we do not believe the Program will be effective in achieving CMS' goals of developing and measuring better health care, encouraging physician adoption of IT, or transforming Medicare into a value-based purchaser. AMGA members' comments stressed the significant obstacles to their participation in the Program, including administrative and financial burden, information technology challenges, and general policy issues related to advancing quality care.

#### **Administrative and Financial Burden**

Each responding medical group, including those with fully functioning electronic medical record systems (EMR), indicated that the administrative burden in collecting and reporting the data for the Program would be overwhelming. One medical group estimated that it would cost more than \$500,000 to incorporate G-codes in its current EMR system. Another medical group estimated it would take more than 2000 FTE hours to reformat its EMR to accept the new codes and provide the necessary training for its medical staff and coding staff. Without financial or other incentives to help defray these significant costs, the vast majority of medical groups indicated it would be extraordinarily difficult for them to participate in the Program.

#### **HIT/EMR Issues**

As noted above, there are significant challenges for medical groups with EMRs to participate in the Program. To capture the necessary data, significant reformatting of EMR systems is necessary to pull in the clinical information. For medical groups with separate billing and EMR systems, new interfaces connecting both systems have to be created. Vendors are likely to charge medical groups for creating the additional functionality needed in the updated EMR and billing system. Labor content for training staff and physicians to enter and capture this data would be substantial, especially for medical groups with large medical staffs. For groups with fixed resources, revenue enhancing activities would have to be deferred to take the necessary steps to participate. This is problematic, especially given the uneven reimbursement environment medical groups face.

Many medical groups already capture HEDIS and outcomes measures to rate physician performance. This data is regularly provided to medical group physicians to positively affect their behavior. Similarly, other medical groups participate in independent "pay for performance" programs such as the Integrated Healthcare Association's program in California. And, as you readily know, ten medical groups are currently participating in the CMS' Physician Group Practice Demonstration. These medical groups are already involved in the process of collecting and reporting data, measuring performance and achieving tangible results. Participation in the Program, with the additional requirement to collect and report on 36 measures, represents significant add-on time and costs to these medical groups with a limited return on investment.

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## **Policy Concerns**

### Single Disease State Guidelines

From a policy perspective, AMGA is concerned that the Program's adherence to single disease measures can lead to unintended results. If the Program bases physician "performance" on adherence to some of the 36 measures, it may create incentives for physicians to treat patients suffering from one disease or focus on treating younger, healthier Medicare beneficiaries. Non-compliant patients may be dismissed from physician's panels. Older patients who can not understand complex medication schedules may have more difficulty finding physician care. Consequently, physicians that care for the sickest patients may appear to be low performers on the performance "scorecard." Moreover, focusing on individual measures discourages more integrated quality improvement efforts that ultimately may be more effective and cost efficient.

If CMS initially relies on these single disease state guidelines to gauge performance, AMGA respectfully suggests that testing the efficacy of these measures should be conducted in the medical group setting. Multi-specialty medical groups provide care across specialties, and provide care to patients with multiple co-morbid conditions. Thus, medical groups are best suited to determine if single disease guidelines are effective across the various physician specialties as well as with patients with multiple chronic conditions.

### Measurement at the Individual Physician Level

AMGA is very concerned with the Program's focus on measuring performance at the individual physician level. Measurement at this level of care may discourage the formation of integrated delivery systems. Such a result would be ironic given the Institute of Medicine's emphasis on health care system redesign that focuses on care coordination across settings, development of teams, care processes, and other design principals often incorporated in medical groups.

Importantly, because most individual physicians treat an insufficient number of patients, outliers may dramatically skew the data set. Moreover, insufficient inputs into the numerator and dominator will result in inaccurate data measurement. Measurement at the medical group level will, however, provide CMS and participating physicians with statistically valid data for benchmarking, comparative and quality improvement purposes.

## **Chronic Care Proposal**

While applying and monitoring adherence to disease specific guidelines may decrease treatment variation for a particular disease and increase quality of care for some patients, AMGA believes this strategy does not take into account the needs of a majority of Medicare beneficiaries, those with multiple chronic conditions.

AMGA has developed a Chronic Care Proposal that encourages care coordination across practice settings and disease conditions. AMGA's model focuses on patient-centered care that includes: Proactive daily monitoring of health status; reinforcement of self-care behaviors; early detection of problems and early intervention; and coordination of and collaboration among health care disciplines. Treating the "whole" patient is most successful when supported by centralized electronic medical records or registries that allow the sharing of patient specific information when and where it is needed.

We believe incorporation of this Model as a supplement to the Program will lead to improved care for these beneficiaries and will also result in decreased utilization and duplication of services.

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### Conclusion

Thank you very much for considering our views on this important matter. We would be happy to facilitate a meeting with AMGA members with experience in care management and EMR systems in order to assist you in improving the Program. We also look forward to discussing AMGA's Chronic Care Proposal with you in the near future. If you have any questions regarding this matter, please feel free to contact me or Chet Speed at (703) 838-0033 ex. 364 or [cspeed@amga.org](mailto:cspeed@amga.org).

Sincerely,

Donald W. Fisher, Ph.D.  
President and CEO  
American Medical Group Association

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