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February 2, 2012

The Honorable Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Sebelius:

On behalf of the physician and medical student members of the American Medical Association (AMA), I am writing to urge you to immediately halt the Health Insurance Portability and Accountability Act (HIPAA) required implementation of ICD-10, and re-evaluate the penalty program timelines associated with the number of Medicare health IT programs underway today. Congress has passed multiple health IT programs under separate laws affecting physician practices and provided you with the discretionary authority to come up with appropriate reporting requirements for these separate federal health IT programs. We believe that the discretionary authority provided by Congress enables you to examine the administrative and financial burdens and intersection of these various federal health IT regulatory programs and develop solutions for synchronizing these programs in order to minimize burdens to physician practices. **Moreover, the Department of Health and Human Services (HHS) recently announced its continued commitment to complying with President Obama's January 18, 2011, Executive Order calling on federal agencies to reassess and streamline regulations. This is a perfect opportunity for HHS to make good on its commitment to improve the regulatory climate for physicians.**

Implementing ICD-10 is not just a technology project. It will impact most business processes within a physician's practice, including verifying eligibility, obtaining pre-authorization for services, documentation of the patient's visit, research activities, public health reporting, quality reporting, and, most of all, submitting claims. Implementing ICD-10 requires physicians and their office staff to contend with 68,000 diagnosis codes – a five-fold increase from the current approximately 13,000 diagnosis codes. This is a massive administrative and financial undertaking for physicians, requiring education, software, coder training, and testing with payers. As HIPAA-covered entities, physicians are responsible for complying with this ICD-10 mandate, and therefore must bear the entire cost of such a transition, without any financial aid from the government. Depending on the size of a medical practice, the total cost of implementing ICD-10 ranges from $83,290 to more than $2.7 million. The Centers for Medicare & Medicaid Services' (CMS) own assessment of the move to ICD-10 acknowledges that there are significant claims processing and payment disruption risks to physicians undergoing a transition of this magnitude. History has shown how disruptive industry-wide regulatory transitions can be to the processing and payment of health care claims. Thousands of

physician practices faced claims processing and financial challenges during the transition to the National Provider Identifier (NPI) in 2007.

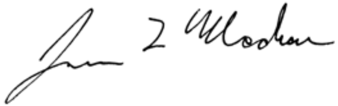
Even the January 1, 2012, transition to Version 5010, a HIPAA electronic transactions upgrade that is necessary for supporting ICD-10, is facing challenges. CMS announced a 90-day enforcement delay for the transition to Version 5010 on November 17, 2011, out of concerns that HIPAA-covered entities, including physicians and public and private payers, were not ready to transition to 5010 by the January 1, 2012. We are already hearing about claims processing and payment disruptions due to the Version 5010 transition, despite CMS' implementation of a 90-day enforcement grace period. These transitions are especially burdensome for small physician practices, which lack the financial means to handle payment interruptions that could last for several weeks or months following a compliance deadline.

The timing of the ICD-10 transition that is scheduled for October 1, 2013, could not be worse as many physicians are currently spending significant time and resources implementing electronic health records (EHRs) into their practices. It is important to keep in mind that physicians must significantly invest in health IT while Medicare payment rates are falling farther below practice cost inflation each year because of the Medicare sustainable growth rate formula (SGR). Physicians are also facing present and future financial penalties if they do not successfully participate in multiple Medicare programs underway, including the e-prescribing program, the EHR meaningful use program, and the Physician Quality Reporting System (PQRS) program. Physicians are being required to meet separate requirements under these three overlapping health IT programs and have been and will be unfairly penalized if they decide to participate in one program over the other. CMS has also decided to back-date the reporting requirements under the penalty programs so that a physician will face a penalty based on activity in the year prior to the year of the penalty specified in the law. For example, CMS is basing the 2012 e-prescribing penalty on a physician's e-prescribing activity in 2011. In addition, CMS is basing the 2015 PQRS penalty on clinical quality measure reporting that occurs in 2013, and using the 2013 year as the basis for the payment adjustments for the 2015 value based payment modifier. CMS has essentially pushed up deadlines for participation by a full year or more due largely to its own data processing limitations. This back-dating policy will subject a significant number of physicians to financial penalties and slow down the adoption and implementation rates of EHRs. In addition, the struggle to keep up with the various health IT use and reporting requirements leaves little time for physicians to get engaged in the practice redesign and payment and delivery reforms envisioned in the Affordable Care Act. We have enclosed a table and timeline to illustrate the drastic volume of financial penalties associated with various federal programs that physicians will be facing all at once if they do not successfully participate in these programs.

In the wake of this onslaught of overlapping regulatory mandates and reporting requirements, HHS has an opportunity to ease the burdens on physician practices by halting the implementation of ICD-10 and calling on appropriate stakeholders, including physicians, hospitals, payers to assess an appropriate replacement for ICD-9 within a reasonable timeframe. Given the mass confusion that has resulted in the back-dating of the multiple health IT penalty programs, we also urge HHS to not back-date penalty programs and better synchronize the incentive and penalty programs so that physicians who successfully participate in one health IT program are protected from penalties associated with the other health IT programs. Physicians will be forced to close their Medicare patient panel or limit the number of Medicare patients that they treat in order to minimize the aggregate financial and administrative blows to their practice due to unfunded regulatory mandates and the unfair penalty programs that are being and will be administered.

Thank you for considering our recommendations, and we look forward to discussing these urgent matters with you. Please feel free to contact Mari Savickis, Assistant Director of Federal Affairs, at mari.savickis@ama-assn.org or (202) 789-7414 for more information.

Sincerely,



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Attachment

Medicare Physician Incentives and Penalties

Year	Deficit Reduction Sequester*	E-Prescribing	Health Information Technology	Physician Quality Reporting System, including Maintenance of Certification (MOC) Program	ICD-10 Implementation
2009		**2%**		**2%**	
2010		**2%**		**2%**	
2011		**1%**	**$18K**	**1% if no MOC; 1.5% if MOC**	
2012		**1% (-1%)**	**$12-18K**	**0.5% if no MOC; 1.0% if MOC**	
2013	**(-2%)**	**0.5% (-1.5%)**	**$8-15K**	**0.5% if no MOC; 1.0% if MOC**	
2014	**(-2%)**	**(-2%)**	**$4-12K**	**0.5% if no MOC; 1.0% if MOC**	**$100 to $50,000 penalty per HIPAA violation, depending on if it is knowing, willful & corrected**
2015	**(-2%)**		**$2-8K (-1%)**	**(-1.5%)**	
2016	**(-2%)**		**$2-4K (-2%)**	**(-2%)**	
2017	**(-2%)**		**(-3%)**	**(-2%)**	
2018	**(-2%)**		**(-3%)**	**(-2%)**	

Additional Penalties

Deficit Reduction Sequester: The Budget Control Act of 2011 required automatic spending cuts of about $1.2 billion from 2013-2021 unless Congress enacted legislation reducing the federal deficit by that amount. Medicare cuts cannot exceed 2% of total program expenditures, not just claims for health care services. Thus actual cuts in payments to physicians and other providers could slightly exceed 2%. Note: the 2% would come on top of whatever cuts are scheduled for that year under the Medicare sustainable growth rate formula which is currently approaching 30 percent.

Value Modifier: Beginning for some physicians in 2015 and all physicians in 2017, payment rates will be subject to a "value modifier." The modifier is budget neutral overall, so it will increase some physicians payments and decrease others. It is not known how steep these decreases will be.

IPAB: The Independent Payment Advisory Board or IPAB is authorized to make reductions in payments starting in 2015 in order to meet statutory targets for Medicare spending growth as a percent of GDP. It is not known whether or how much physician payment rates will be affected.