Memo

AMERICAN **OSTEOPATHIC** ASSOCIATION

Date: September 25, 2012

C: John Crosby; State and Socioeconomic Affairs; Government Relations

To: George Thomas, D.O., BOFHP Chairman; BOFHP members

From: Carol Monaco, Director of Federal Affairs

RE: Regulatory Challenges

In an effort to help ease the regulatory burdens faced by physicians, the AOA continuously communicates with the Department of Health & Human Services to discuss potential solutions. In preparation, we would appreciate the Bureau's input on what it deems to be the most challenging regulatory requirements and their impact on the physician's practice. Please provide examples to help quantify the impact. In addition, please include recommendations for reducing and streamlining current requirements. Below are examples of current regulatory requirements, but they are not all inclusive.

Fraud and Abuse Laws

Physicians are expected to take on a range of duties aimed at protecting the Medicare and Medicaid programs from potential fraud by other providers. Costs frequently exceed benefits. ***Should physicians be required to have a role in combating fraud and abuse outside of their own practices?***

The Recovery Audit Contractor program continues to be extremely burdensome, prompting physicians and their staff to spend an inordinate amount of time responding to RAC requests, and even more time if an appeal is necessary. ***Have our osteopathic physicians experienced a RAC audit?***

Stark & Antitrust Laws

The current antitrust and Stark laws, which are a set of regulations intended to restrict financial considerations from influencing certain physician referral decisions, prohibit compensation arrangements between physicians and hospitals that would foster better care coordination. ***What is our recommendation?***

Medicare Economic Index (MEI)

The MEI measures practice cost inflation using only inputs that were present when it was created in 1973. It does not account for the recent influx of regulations -- which require the hiring of additional staff, investment in health information technology (HIT), payments to practice management firms, legal and billing service fees, etc.—and therefore undervalues actual medical cost increases. ***Can we quantify the influx of regulations on a practice? What changes do we recommend for the MEI?***

Incompatible Quality Incentive Programs

While CMS announced through recent rulemaking preliminary steps to better align the PQRS and EHR Incentive programs, there are still inconsistencies between CMS' multiple quality reporting programs, which span various settings (e.g., inpatient, outpatient, nursing homes, etc.). These inconsistencies cause confusion,

discourage engagement, and divert valuable time and resources away from direct patient care. ***Can we provide examples from actual physician practice experience?***

Most of these quality programs will soon include penalties for non-participation or insufficient participation. While penalties must start by a certain date under statute, CMS has the flexibility to determine the application start date and, in many instances, has decided to base penalties on data collected a year or two before the year specified in statute. Not only is this confusing to physicians, but the rushed timeline gives physicians very little time to prepare for meeting the requirements of programs that have questionable ties to true quality improvement. ***We oppose the use of two-year-old data. Can we provide examples of why the use of this data is harmful to the practice?***

Physician Value-Based Payment Modifier

HHS is required to apply a separate, budget-neutral payment modifier to the Medicare physician fee schedule. CMS recently announced plans to start applying the modifier to large group practices beginning in 2015 despite earlier concerns that it is unprepared to implement such a complicated policy and that it needs more time to evaluate ongoing demonstration projects, such as the physician resource use feedback program, which, to date, has demonstrated multiple serious challenges related to measuring appropriate resource at the individual physician level.

ICD-10

Many remain concerned that a one year delay is insufficient and that CMS needs to do more to reduce the regulatory burdens on physician practices. Implementing ICD-10, alone, requires physicians and their office staff to contend with 68,000 codes – a five-fold increase from the current set of 13,000 codes. ***What are practices doing to prepare for ICD-10 and what is the cost?***

National Coverage Determinations

Medicare's National Coverage Determinations (NCDs) process requires the collection of a limited and often arbitrary set of data, which is usually not useful or meaningful to providers or CMS. Many feel CMS should instead work with specialty societies and those who are clinical experts in the field to determine the most relevant data points and to ensure that data collection can be done efficiently and in a manner that does not interfere with the daily practice of medicine. ***What is the impact?***

Health Information Technology

While the AOA supports the adoption of HIT, we are concerned that the Stage 2 goals for "meaningful use" of EHR may be too ambitious for small practices. This is a critical issue that could affect thousands of small practices. A study in the March 2011 edition of *Health Affairs* estimated that the total first-year costs of EHR implementation for a five-physician practice to be $233,297, with average per-physician costs of $46,659 – a large expense for any small business to incur. ***What impact has HIT adoption had on practice productivity?***