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Association of
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7500 Security Blvd.
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Re: Availability of Medicare Data for Performance Measurement Proposed Rule, File Code CMS-5059-P

Dear Dr. Berwick:

The Association of American Medical Colleges (AAMC or the Association) welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS' or the Agency's) Proposed Rule entitled *Medicare Program; Medicare Data for Performance Measurement*. 76 *Fed. Reg.* 33566 (June 8, 2011). The AAMC represents 100,000 clinical faculty, 75,000 medical students, and 106,000 resident physicians who deliver over one-fifth of all clinical care in the nation. The Association also represents nearly 300 general acute nonfederal major teaching hospitals and health systems; all 134 accredited U.S. medical schools; and nearly 90 academic and scientific societies.

The proposed rule implements section 10332 of the *Patient Protection and Affordable Care Act (ACA or the Act)*, which would allow qualified entities (QEs) to utilize Medicare claims data to create publicly available evaluations and comparisons of provider performance. We appreciate CMS' efforts in developing thorough and stringent criteria for the release and use of the Medicare claims data. The AAMC supports the dissemination of scientifically supported, valid and reliable data to assess the performance of providers. However, the Association has some concerns regarding the use of the data and the ability to apply consistent methodologies across QEs.

RISK-ADJUSTMENT AND ATTRIBUTION METHODOLOGIES

The Act requires QEs to submit to CMS a description of the methodologies they would use to evaluate the performance of providers. CMS proposes that methodologies would include not only the measures, but how the measures are calculated including risk-adjustment and beneficiary attribution. These methodologies would then be subject to CMS approval on a case-by-case basis prior to their use. The AAMC is concerned that CMS is not providing any direction to the QEs on how the attribution and risk-adjustment methodologies should be

constructed. In addition, CMS has not included the criteria by which these methodologies would be evaluated.

CMS should ensure that the attribution and risk-adjustment methodologies are based on expert input, widely tested and applicable to all physicians or physician groups. The AAMC strongly urges CMS to provide clear and thorough guidelines for QEs to follow to ensure that the risk-adjustment and attribution methodologies utilized are sound and consistent. Further, the criteria by which CMS evaluates the QEs' risk-adjustment and attribution methodologies should be made publicly available for stakeholder input.

Any utilization of performance measures to assess providers should contain a risk-adjustment that adequately accounts for differences in patient populations, such as severity of illness (SOI) and socio-economic status (SES). The risk-adjustment methodology should also properly measure the complexity of care provided. Inclusion of these and other indicators is critical to ensuring that providers who treat sicker and more vulnerable patients, such as academic physicians, are accurately assessed.

Significant work has been done both in the public and private sectors regarding patient attribution. Recent work has shown that patient attribution can vary depending upon the condition and whether it is an acute or chronic episode. Any attribution methodologies should be evaluated in context of the measure to be reported. The AAMC also asks CMS to consider how referral patterns could affect attribution. Due to the specialized services they provide, many academic physicians treat referral patients from a wide geographic area.

While the AAMC believes that any risk-adjustment be applied in a standard way to ensure proper evaluation of risk across both providers and payers, we are cognizant that QEs will be limited in their ability to apply a robust risk-adjustment when only utilizing claims data. We recognize that section 10332 of the Act focuses primarily on the release of Medicare claims data. However, the Association encourages CMS to also support the use of clinically-enriched data in order to provide a more complete picture of patient complexity. Clinically-enriched data is increasingly becoming more available through a variety of sources (registries are one such example).

RESOURCE USE METHODOLOGY

Section 10332 allows QEs to evaluate providers on efficiency and resource use in addition to quality measurement. The ability to accurately measure cost and efficiency is a nascent field and the AAMC is very concerned that the complexities in measuring cost and efficiency could yield improper results. In particular, the AAMC strongly believes that policy payments for teaching hospitals including direct graduate medical education (DGME), indirect medical education (IME) and disproportionate share (DSH) payments should be excluded from any approved resource use methodology. Given the intricacies of calculating these measures and the lack of consensus in this area, we recommend efficiency measures not be implemented at this time, and be delayed until further work has been done in this area.

MEASURE STANDARDIZATION

CMS states in the proposed rule that it will allow alternative measures, which have not received endorsement through a consensus based entity, to be used in provider performance evaluations. The AAMC has serious concerns with this proposal. Alternative measures may not meet the scientific soundness, importance, and usability standards that are set by the National Quality Forum (NQF), and therefore could potentially confuse consumers when they are introduced. The AAMC urges CMS to use national, NQF-endorsed measures and recommends that CMS take the necessary steps to standardize and align performance measures used in quality programs across all payers, including Medicare. It is critical that CMS develop standardized specifications for these measures so that they can be used with Medicare and private health plan data. This will ensure that consistent measures and analytics are used in developing public reports that are valid, reliable, and actionable.

IDENTIFYING APPROPRIATE PEER GROUPS

Many academic clinicians provide unique specialty services that are not performed by others within the same specialty. The UHC-AAMC Faculty Practice Solutions Center®, a product which calculates productivity benchmarks for academic faculty, has benchmark data for over 100 clinical specialties. These specialties are far more discrete than current Medicare specialty designations. We ask CMS to provide additional guidance to the QEs to consider not only the specialty designation but the types of services provided within that specialty when assigning peer benchmarks.

In addition, all group practices may not be comparable to each other. It is unclear whether a practice with twenty physicians is the same as an academic faculty practice with over 500 clinical faculty physicians and many specialists and subspecialists. CMS should require QEs to evaluate differences in both the size and scope of the practice.

USE OF CLAIMS DATA

The Association is also concerned with the data protections that are currently in place and ask that CMS take extra precautions to guarantee that the claims data provided is only used for performance measurement and assessment, and not for any other purpose, such as tiering physicians. We urge CMS to ensure that QEs house Medicare claims data separately to guarantee its integrity.

EXPERIENCE WITH MEDICARE DATA

While the proposed rule requires QEs to have a minimum of three years of experience handling claims data, CMS should also ensure that qualified entities demonstrate significant prior experience handling Medicare data, which can be significantly different than the local claims

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QEs currently utilize. It will be critical for CMS to ensure the QEs have the ability to aggregate both Medicare and non-Medicare data to ensure the validity, accuracy, and meaningfulness of the data and public reports.

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The AAMC appreciates the opportunity to provide comments on the proposed Medicare data rule. If you have any questions or issues regarding our comments, please feel free to contact Mary Patton Wheatley at 202-862-6297 or mwheatley@aamc.org.

Sincerely,



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