



**Association of  
American Medical Colleges**  
2450 N Street, N.W., Washington, D.C. 20037-1127  
T 202 828 0460 F 202 862 6161  
www.aamc.org

**Darrell G. Kirch, M.D.**  
President and Chief Executive Officer

July 9, 2013

The Honorable Fred Upton  
Chairman  
Energy and Commerce Committee  
U.S. House of Representatives  
Washington, DC 20515

The Honorable Joe Pitts  
Chairman, Health Subcommittee  
Energy and Commerce Committee  
U.S. House of Representatives  
Washington, DC 20515

Dear Chairmen Upton and Pitts:

On behalf of the Association of American Medical Colleges (AAMC), thank you for your continued efforts to reform the Medicare physician payment system. We appreciate your dedication to addressing the serious challenges involved in replacing the current system and have submitted comments throughout this process. After reviewing stakeholder feedback on the Energy and Commerce Committee's May 28 discussion draft legislation, the Committee has refined and built on that draft, including providing greater detail on the proposed Update Incentive Program (UIP) and the alternative payment models (APM) used to calculate physician payment updates. The Committee also released a series of questions about the proposed legislative framework. The AAMC will not address all of the questions, but will focus on a few that particularly affect academic clinical practices.

The AAMC is a not-for-profit association representing all 141 accredited U.S. medical schools; nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans Affairs medical centers; and nearly 90 academic and scientific societies. Through these institutions and organizations, the AAMC represents 128,000 faculty members, 75,000 medical students, and 110,000 resident physicians. Clinical faculty practices often work closely with their teaching hospital partners in systems to provide coordinated care for complex and vulnerable patients while also performing research and training the next generation of clinicians. Our comments center around the following themes:

- The opportunity to address physician workforce;
- The role of the large multispecialty group practices in the UIP;
- Considerations for incorporating quality measurement into payment for practices, particularly for practices that care for complex and vulnerable patients;
- Considerations for selecting and evaluating APM; and,
- Paying for SGR reform.

### **Opportunity to Address Physician Workforce in Physician Payment Reform**

One critical component that is not addressed in the current framework is the need to ensure there are enough physicians to meet the health care requirements of a growing number of Medicare beneficiaries. The AAMC estimates that by 2020 the United States will face a shortage of more than 91,000 physicians, equally distributed between primary care and subspecialist physicians. These are the doctors that Medicare beneficiaries disproportionately rely upon for health care. To address this shortage, our nation's medical schools and teaching hospitals have increased their capacity to train new doctors and continue to fund approximately 10,000 positions over their residency caps. However, they are unable to fund by themselves an increase in residency positions to the number necessary to train additional new physicians that will be needed in the coming years. I urge you to capitalize on this opportunity to address the physician shortage by increasing the number of Medicare-supported Graduate Medical Education (GME) positions. Incorporating GME expansion provisions, such as those included in the "Training Tomorrow's Doctors Today Act" (H.R. 1201) and "The Resident Physician Shortage Reduction Act of 2013" (H.R. 1180), will guarantee provider access to Medicare beneficiaries and all patients.

### **Role of Large Multispecialty Group Practices in the Update Incentive Program**

The AAMC appreciates that the latest draft legislation offers providers the option to apply measures, scores, and performance at the group-practice level for the UIP (see section 1848A(a)(4)). Academic faculty practices are comprised of hundreds, and in some cases, thousands of individual physicians. Tracking separate measures for each individual physician is administratively burdensome; therefore, the AAMC supports having a single group-level reporting option. While the legislation offers the opportunity for a group option, the way in which the multispecialty practices would fit into the proposed UIP policy remains unclear.

#### Specific Energy and Commerce Committee Questions:

- *Do you think the [UIP] policy, as outlined in the discussion draft, can accommodate early adopters and those with minimal quality standards by the time Phase II goes into effect?*

As noted above, we are concerned about whether multi-specialty group practices can be accommodated in the current UIP framework. The issue is not whether there are adequate measures for the groups, but rather *which* measures or competencies apply to a group. The discussion draft seems to define "peer cohorts" and "measures sets" by specialty; yet, academic practices often have a variety of specialties and subspecialties that seem unlikely to be accounted for within this framework. How does the peer cohort and measure set concepts translate to the large multispecialty practices?

- *Should the new quality system align with Physician Quality Reporting System (PQRS) in the manner in which provides feedback at the group level?*

The draft legislative language ties the definition of "groups" to PQRS, yet sections of the bill appear at odds with a true group measurement option. For example, section 1848A(j)(1)(D) states that each individual provider will receive feedback, regardless of whether the provider is reporting individually or as part of the group. The AAMC supports providing feedback at the group-level, with supplemental detailed information about the individual provider where possible, rather than requiring reports for each individual provider. It is important that the

performance data be reported at the same unit of measurement that will be used for payment purposes.

### **Incorporating Quality Measurement into Payment**

The Committee presented two different options for incorporating composite quality measures into payment. The first option is a “threshold” or “benchmark” UIP model, where provider payment is based on performance relative to predetermined benchmarks. The second option is a “percentile” UIP option, where a provider’s performance is ranked according to the performance within the peer cohort. Providers in the highest percentile would receive the highest update and those in the lowest percentile would receive the lowest possible update.

#### Specific Energy and Commerce Committee Questions:

- *Can you provide feedback on how the draft addresses tying measurement to payment? Do you prefer one type of payment model over the other? Are there other ways to link quality to payment?*

The AAMC believes the “benchmark” UIP model is more appropriate than the “percentile” UIP model for linking quality measurements to payment. It is critical that practices know the benchmarks for all quality measures at least sixty days prior to the performance period. This ensures physicians know what they need to achieve and can manage their quality improvement efforts appropriately. In contrast, it is very difficult to manage performance relative to other providers which can be a moving target. Given the variability between physician practices both in the services they provide and the patients they treat, it is not appropriate to reward performance based on comparison to peer group ranking.

The AAMC also believes that providers should receive credit for improving performance compared to their own baseline. This incorporates an incentive for all providers to improve their quality performance. The AAMC encourages the Committee to adopt an improvement score into future UIP models.

- *People have expressed concerns about the effect of non-compliant patients on outcomes and thus outcome measures. Do you believe the draft policy adequately addresses the issue and protects providers who are reporting on quality outcome measures in the setting of non-compliant patient (i.e., one of many aspects of risk-adjustment)?*

The AAMC appreciates that the Committee is concerned about the effect of non-compliant patients on outcome measures. However, we suggest that other factors also affect outcome scores and should be taken into account. Patients with complex medical conditions, mental health conditions, low literacy rates, low income, or a lack of family support are challenged to achieve “good outcomes.”

The draft legislation states that weighting of measures “shall provide for risk adjustment to account for differences in geographic location and patient populations.” The AAMC does not believe this is sufficient. At a minimum, outcome measures used for payment must be adjusted for socio-economic status (SES). As mentioned above, despite the best efforts of clinicians, patients with low SES often fail to achieve quality health outcomes.

- *Do you think the IG report will bring integrity to the reporting process? Does this process meet the required level of oversight? Are there any other safeguards, besides the IG, that could be implemented to ensure integrity in the reporting process?*

The AAMC supports a reporting process that ensures integrity. The AAMC does not believe that it is the role of the OIG to conduct audits prior to determining the applicable update adjustment. It is preferable to ensure integrity by requiring CMS to adequately engage stakeholders in the development of the process which supports the goal of financially recognizing fee schedule providers for providing high quality care. CMS should work with stakeholders to develop mechanisms to ensure the integrity of the system.

### **Selecting and Evaluating Alternative Payment Models**

The most recent draft created a new section (Section 1848B) about payments through APM. It establishes a process with an “APM contracting entity” to solicit and evaluate possible APMs.

#### Specific Energy and Commerce Committee Questions:

- *The draft policy envisions an updated and streamlined process to submit and test alternative payment models outside the traditional pathway. Do you think the draft policy method provides ample opportunity for formulating and submitting alternative payment models?*

The policy suggests entering into a contract with an APM contracting entity in accordance with the process under section 1890(a). This section refers to “...a contract with a consensus-based entity, such as the National Quality Forum...” (NQF). The AAMC seeks clarification about which organization would do this evaluation. The NQF has been an important resource to review and endorse quality measures; however, it does not have experience reviewing the effectiveness of payment models.

The AAMC also seeks clarification about how the work of this APM contracting entity for testing and evaluating models intersects with the evaluation work of the Center for Medicare and Medicaid Innovation (CMMI) as well as CMS’ current demonstration authority. The AAMC believes testing APMs is consistent with the statutory authority of CMMI as well as CMS’ current demonstration authority and another entity is not necessary for this activity.

### **Paying for SGR Repeal**

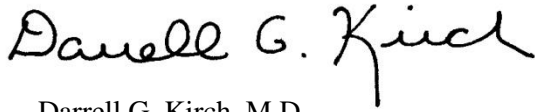
The AAMC remains concerned that Congress will look exclusively to the Medicare program to find the required savings. This approach would have an adverse effect on beneficiaries and on the teaching hospitals and teaching physicians that provide care to them. Using cuts in Medicare support for teaching hospitals’ missions to address physician reimbursement inequities is counterproductive and shortsighted, damaging institutions that are critical components of our health care system. **The AAMC cannot support any new payment system that is financed by redirecting funds currently supporting critical health care expenditures, particularly cuts that would disproportionately impact the nation’s teaching hospitals and teaching physicians.**

The AAMC appreciates and supports your efforts to address important issues associated with repealing and reforming the SGR. The Association looks forward to working with you to design and implement a system that preserves care access for Medicare beneficiaries; responsibly slows the Medicare growth rate;

Chairmen Upton and Pitts  
July 9, 2013  
Page 5

and pays physicians and all providers fairly. If you would like to discuss any of these comments in greater detail, please contact Leonard Marquez, AAMC Director of Government Relations, at [lm Marquez@aamc.org](mailto:lm Marquez@aamc.org) or 202-862-6281.

Sincerely,

A handwritten signature in black ink that reads "Darrell G. Kirch". The signature is written in a cursive style with a large, prominent "K".

Darrell G. Kirch, M.D.

cc: Atul Grover  
Leonard Marquez  
Ivy Baer  
Mary Wheatley