



**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

June 10, 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

The Honorable Henry Waxman
Ranking Member
Energy and Commerce Committee
U.S. House of Representatives
Washington, DC 20515

The Honorable Frank Pallone
Ranking Member, Health Subcommittee
Energy and Commerce Committee
U.S. House of Representatives
Washington, DC 20515

Dear Chairmen Upton and Pitts and Ranking Members Waxman and Pallone:

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 ongoing efforts to address physician payment reform and recognition of the serious challenges involved in replacing the current system. Throughout 2013, the AAMC has submitted comments on the Sustainable Growth Rate (SGR) Repeal and Reform Proposal presented by the House Energy and Commerce and Ways and Means Committees. After reviewing multiple rounds of stakeholder feedback, the Energy and Commerce Committee has produced discussion draft legislation and additional questions about implementation of successful payment alternatives for physician services. This letter does not attempt to address all the questions, but highlights specific issues that are of particular interest to academic faculty 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.

Option to "Election for Application at Group Practice Level"

The updated proposal outlines an "update incentive program" under which a portion of the physician payment is at risk based on quality performance. On page 6, the Committee asks whether there should be an explicit provision to elect payment application at the group level or individual level. The AAMC strongly believes the legislation must require that the Secretary develop an option for group level measurement and payment. Academic medical centers have hundreds, and in some cases, thousands of

individual clinicians. Tracking the pricing, quality, and reporting data for individual physicians can be administratively burdensome. When these practices negotiate with private payers, they contract as a group and not by the individual physician. Medicare should also allow the same option.

The legislation for another physician-level program, the Electronic Health Record (EHR) Incentive Program, gives the Secretary the option to apply the program at the individual or group level; however, the Centers for Medicare and Medicaid Services (CMS) has not been successful in implementing a group level option that meets all of the legislative requirements. As a result, practices have spent considerable staff time attempting to monitor information at the clinician level which is especially challenging for physicians that work in multiple practices and/or physicians that come into or leave the practice. Incorporating a well-thought out group-level proposal would avoid repeating some of the same issues.

Having measurement and payment at the group level has additional benefits including promoting systems of care and accountability for teams of clinicians. Group measurement also minimizes some methodological issues such as sufficient sample size for reliable results. Quality measurement, even at the group level, has a series of methodological considerations that must be resolved, including the following:

- What is the definition of a group?
- Are all groups comparable?
- What types of measures should be reported and on what set of patients?

Many of these issues can be addressed through the regulatory process, although key framework considerations should be included in the legislation. The AAMC welcomes the opportunity to work with Committee staff to incorporate a group option into the next version of its SGR proposal.

Quality Improvement Should Be Rewarded

The Affordable Care Act contains several hospital and physician performance programs, including the Hospital Value-Based Purchasing Program (VBP), the Physician Value-Based Payment Modifier (VBPM), the Readmissions Reduction Program, and the Healthcare-Acquired Conditions (HAC) Reduction Program. Two of these programs are budget neutral (VBP and VBPM) and two are penalty only programs (Readmissions and HAC). Of these programs, only one, the Hospital VBP, recognizes providers for improving their quality performance. However, because the program is budget neutral, if the hospital's improvement is less relative to the improvement of others, it is possible for an improved score to nonetheless incur a penalty. The AAMC encourages the Committee to avoid this type of result when it drafts the legislation.

Adjustments to Existing Reporting Programs

Congress has prescribed a variety of quality reporting and performance programs, including the Physician Quality Reporting System program (PQRS), the EHR Incentive Program, the E-prescribing Incentive Program, and the VBPM. Each program has separate requirements that make it difficult for individual providers (and group practices) to understand and meet all statutory requirements to avoid penalties. Because the VBPM also incorporates cost and quality performance of physicians, the Committee should explore how the update incentive program will interact with the VPBM and whether any modifications are needed. We encourage the Committee to consider ways to reduce the administrative burden of

coordinating the numerous quality reporting programs and also streamline the EHR Incentive Program so that it can be easily adapted to group-level reporting.

Paying for SGR Repeal

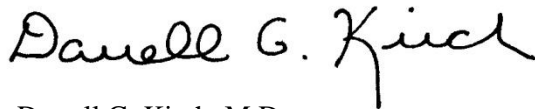
The AAMC remains concerned that Congress will look exclusively to the Medicare program to find the required savings necessary to pay for the SGR proposal. This approach would have an adverse effect on beneficiaries and on the teaching hospitals and teaching physicians that provide care to them. Using 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.**

Need for Expanded GME Support

One critical component that often is overlooked in the Medicare payment reform discussion is the need to ensure there are enough physicians to meet the needs of the 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. Our nation's medical schools and teaching hospitals have increased their capacity to train new doctors despite the number of federally-supported residency slots remaining stagnant since 1997. It is critical that any effort to reform Medicare physician payment also increases Medicare support for Graduate Medical Education (GME). I urge you to take this opportunity to address the physician shortage and guarantee provider access to Medicare beneficiaries and all patients by 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), as a key component of any reform legislation.

Thank you again for your work to address this important issue. The AAMC appreciates and supports your efforts to address important issues associated with repealing and reforming the SGR. The AAMC 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, and pays physicians and all providers fairly. If you would like to discuss any of these suggestions in greater detail, please contact Leonard Marquez, AAMC Director of Government Relations, at lm Marquez@aamc.org or 202-862-6281.

Sincerely,



Darrell G. Kirch, M.D.

Cc: Atul Grover
Leonard Marquez
Ivy Baer
Mary Wheatley