



AMERICAN OSTEOPATHIC ASSOCIATION

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November 12, 2013

The Honorable Dave Camp  
Chairman  
Ways & Means Committee  
United States House of Representatives  
Washington, DC 20515

The Honorable Sandy Levin  
Ranking Member  
Ways & Means Committee  
United States House of Representatives  
Washington, DC 20515

The Honorable Max Baucus  
Chairman  
Finance Committee  
United States Senate  
Washington, DC 20510

The Honorable Orrin Hatch  
Ranking Member  
Finance Committee  
United States Senate  
Washington, DC 20510

Dear Chairmen Camp & Baucus and Ranking Members Levin & Hatch:

On behalf of the American Osteopathic Association (AOA) and the more than 104,000 osteopathic physicians and osteopathic medical students we represent, thank you for the opportunity to submit comments on your Committee's work to reform the physician payment system and to permanently repeal the Sustainable Growth Rate (SGR) formula for physicians participating in the Medicare program. We are very encouraged by the bicameral, bipartisan agreement that this issue should be addressed, and the policy framework presented in your proposal. Your work provides a solid foundation to permanently repeal the SGR and advance physician payment reform this year.

The AOA appreciates your work greatly as we understand this is a very complex issue, and is one that we all hope to find the best solution to for both physicians and their patients. We further recognize the fiscal environment we are in, and that not all expectations of physicians will be met with any single piece of legislation. With that said, the AOA stands committed to work with you to further refine your proposal to improve and stabilize the Medicare program. We provide the following comments in an effort to clarify and further improve the future physician payment system this proposal would advance.

## **AOA Comments on House Ways & Means and Senate Finance Committee SGR Repeal and Medicare Physician Payment Reform Discussion Draft**

### **I. SGR Repeal & Annual Updates**

The AOA agrees and has long advocated that the SGR be repealed. We appreciate the Committees' commitment to doing so in this proposal. The cost of annual patches to prevent cuts over the last decade totaling \$145 billion has now exceeded the full current cost of SGR repeal at \$139 billion. The Committees have rightfully recognized the necessity to not just freeze rates at current levels over the next ten years, but to provide opportunities for positive payment opportunities that do not exist in current law.

While the AOA agrees with the proposal's provision of these opportunities for potential payment bonuses, we continue to believe that not only is stability in payment rates of great importance, but that predictable positive annual updates are a necessity. Positive updates provide physicians with much needed capital to invest in practice transformations which physicians have not had access to for over a decade due to stagnant payment rates. The AOA, however, recognizes the fiscal constraints we are under, which are not paled by those of the physicians we represent. We suggest that if there is not an ability to provide all physicians with positive annual updates over the next ten years, that at minimum the Secretary be charged with monitoring inflation, patient access, and participation rates of physicians in Medicare. This will ensure that if patients' access to Medicare physicians and/or participation by physicians in the program drops, or if inflation rises at an unprecedented rate, changes to the baseline payment rate can be adjusted to account for these situations.

It remains unclear from the current proposal as to whether the current Primary Care Incentive Payment (PCIP) program in Medicare which expires in 2015 will be extended. The AOA strongly advocates that this important incentive bonus for primary care services be made permanent. Absent that, primary care physicians will effectively take a 10 percent cut to their payment levels in 2016 under this proposal. It is important to recognize that primary care physicians are disproportionately disadvantaged in adopting practice transformations due to their limited capital, and the current incentive payment program serves to assist in alleviating some of this burden.

Beginning in 2024 the Committees propose a positive payment update for all physicians. The AOA supports this provision and encourages the Committees to consider a higher differential update for those physicians providing primary care services. We strongly believe that our commitment to primary care as a strong foundation to improved quality in the Medicare program is vital and should be sustained through incentives.

## **II. Value-Based Performance (VBP) Payment Program**

The AOA supports the alignment and harmonization of the current quality reporting programs as proposed in the draft language. Additionally, the administrative burden on physicians should be reduced in this alignment. We also believe this should be utilized as an opportunity to improve upon and refine each of the individual programs to better reflect the work of a physician in providing quality care for patients. We are unclear from the proposal as to whether this will occur and/or if the Secretary will be directed to work with stakeholders in doing so. It is our strong belief that this would be a missed opportunity if that is not the case. Simply combining the three programs in name only would not appropriately reflect the input from the physician community to date toward improving the programs. As well, we would urge the Committees to consider hardship exemptions for those physicians with significant extenuating circumstances.

As we have stated before, an immediate transition away from the programs would undermine the investments that have already been made in these important programs, such as the costly purchases of EHR systems. Only after a period of smooth transition from the distinct programs to a VBP reflecting improvement across each of the previously separate programs, physicians should no longer be held to penalties under the old model and should be fully transitioned into the new improved system.

We are uncertain from the draft as to whether the VBP ends at the end of 2023. The AOA would like to see that be the case for those physicians practicing in alternative payment models (APMs) as they will continue to be paid according to the selected model. On the other hand, those physicians who do not transition should continue to be subject to the requirements of the VBP in order to receive the one percent payment update written into the proposal.

### Terminating Current Law Incentive Payment Reductions

The AOA agrees with the proposal's sunset of incentive payment reductions required under current law at the close of 2016. However, it is unclear if this means that payments under the VBP beginning in 2017 are truly based on previous year. Regardless, we appreciate the Committees' decision to keep what would have been penalty payments in the payment pool rather than that money going to Treasury.

### Professionals Eligible for the VBP Program

The AOA supports the inclusion of non-physician providers currently paid under Medicare. We do not agree with the proposal beginning those providers in the program in 2018 as opposed to 2017 along with physicians. If they are to be held to the same requirements as physicians as we understand from the proposal, they should also have the same start date. Further, performance should be measured based upon the specific service provided, rather than who is providing the service. Payment, however, should continue to be based upon the providers' level of training and extent of their license. We agree with the Committees' assessment that non-physician providers should be held to equally high standards for providing the same quality care as physicians. These other providers should be measured based upon their performance rather than competency, consistent with the proposed physician performance program. The program must also ensure the services to be provided and measured are within the non-physician provider's respective scope-of-practice.

In addition, we support the Committees' choice to exempt those physicians receiving a significant portion of their revenue from an APM as well as those who treat a limited number of Medicare patients.

### Assessment Categories

The AOA supports the VBP's cumulative score of four categories - quality, resource use, clinical practice improvement activities and EHR meaningful use. We continue to believe that it is most effective to employ the "crawl-walk-run" approach to assessment. Focus should first be placed on achieving meaningful use, then quality, then resource utilization, with clinical practice improvement activities being employed throughout the entire process.

### **Quality Measures**

The AOA supports requiring the Secretary to annually solicit measures for inclusion. It is unclear where these measures will be solicited from; however, the AOA hopes the Secretary will be required to solicit from physician organizations and multi-stakeholder entities. Additionally, we suggest development funding be provided to those same organizations and entities for their work. We also support the proposal's recognition that physicians who report their quality measures through a certified EHR system would be deemed to meet the meaningful use clinical quality requirement. Here we recommend substantial improvements be made to the PQRS program consistent with those recommendations that have been made to date prior to 2016.

While we support physicians being given credit for attainment and achievement, with higher overall weight given to outcomes measures, we stress the importance of risk adjustment because determinants of the outcomes of patients are not entirely under the control of the physician. The attribution of results to the physician could be at the least unfair and potentially damaging for those physicians that serve disadvantaged communities. Our own analysis of factors affecting glucose control in diabetic patients in the AOA-Clinical Assessment Program (CAP) showed a large amount of variation attributable to factors not under the physician's control. Our findings suggest that system factors (such as insurance type and level of coverage) and patient factors (such as compliance) have large effects on the level of control at the patient level. The prevalence of these factors in any sample a physician provides for PQRS can markedly influence the rate of control. Indeed, if we are reporting all-payer data to CMS, a physician who sees a larger portion of uninsured individuals (self-pay) would have markedly lower performance without risk-adjustment. The same example may be applied to patient compliance rates.

## Resource Use

The AOA is pleased that the process involves physicians in furthering the measurement of resource utilization. In many cases the science has not yet caught up and accurate measures do not yet exist. With that said, we continue to believe that physicians are the best source of data to aid in this endeavor.

Efficiency measures and methodologies that are most appropriate for a range of practice types and patient populations must be carefully evaluated before widespread implementation. Risk-adjustment and attribution methodologies are still woefully unrefined and resource-use feedback reports distributed to physicians to date have not yet yielded significant value. These issues must be addressed before cost data can be used to influence payment decisions. We believe that soliciting physician organizations on development of efficiency measures is an important step to refining the necessary methodology to appropriately gauge the efficient use of health care resources.

We urge the Committees to build on the significant work that has already been done by private payers in developing episode groupers to define episodes of care. By harmonizing and building on these different efforts, Medicare providers will be able to have a better understanding of the impacts of their treatment decisions and resource utilization, without the confusion that comes from conflicting methodologies. Regardless of grouper methodology used, proper attribution is the key to ensuring accurate and fair resource use. However, we must ensure that the requirement under the Committees' proposal for a physician to indicate their specific role in treating the patient not be onerous. It is unclear how much the payment would be reduced if that information were not provided; however, we suggest that it be kept to a minimum, at least initially, and potentially gradually increased.

Ultimately, the AOA is concerned that penalizing physicians for providing care that is viewed as less than optimally efficient could inadvertently lead to under-treatment. More importantly, in measuring efficiency we believe that it is important that the barriers between Medicare silos be terminated. There are many scenarios in which a physician's treatment decisions could easily save resources in other parts of Medicare—for example, additional office visits with a particularly complex patient, while costing more in Part B, could decrease hospital readmissions and emergency room visits in Part A. Similarly, additional time spent counseling a patient during an office visit (Part B) could result in Part D savings due to better medication adherence and management. The flow of health care dollars should not be limited to individual segments of the program.

Efforts to encourage efficient use of resources should complement and enhance the delivery of appropriate, evidence-based, patient-centered health care. Furthermore, the program(s) should not adversely impact the physician-patient relationship or unduly intrude upon the physician's medical judgment. Additionally, increased volume of certain physician services should be viewed in the context of impact on the entire program.

Specifically, the AOA believes the value-based modifier (VBM) can only be useful if it is simple to understand for both patients and physicians, easy to incorporate into a busy practice, and straightforward for CMS to administer. Complicated formulas could become an administrative nightmare for physician practices and CMS alike, and will likely be frustrating and unworkable. The AOA supports and highly suggests an evolved VBM that is based upon timely data, episode-based cost measures, alternative attribution methods that accurately assess how a physician affects costs, and physicians receiving credit under Part B for savings they achieve in Part A. Under the VBM's current construct, rewarding or crediting physicians and physician practices for efforts to reduce admissions, readmissions, and hospital lengths of stay are not possible. This concept is consistent with the ACO model.

We believe that appropriate data adjustments should be made to account for differences in the demographic characteristics and health status of individuals so as not to penalize those physicians serving less healthy individuals who may require more intensive interventions. Statute requires the quality of care measures to be

risk adjusted as determined appropriate by the Secretary. According to CMS in the CY 2012 Medicare Physician Fee Schedule Rule, “In establishing the quality of care measures for the value modifier, our interest is to move toward a core set of measures so that we can assess and benchmark physician performance.” The AOA is concerned that CMS has to date not specified details for risk adjustment and attribution models.

### **Clinical Practice Improvement Activities**

The AOA believes that clinical practice improvement activities are vital toward practice transformation and should be appropriately incentivized. The Committees’ approach to utilizing a collaborative process of stakeholders in establishing these activities is appreciated. In addition, we support providing special consideration for physicians practicing in rural and Health Professional Shortage Areas (HPSA). We suggest also including small practices of one to five physicians in all areas of the country for these considerations.

The five defined sub-categories of activities in the proposal are quite reasonable. We fully support certified medical homes receiving the highest possible score for this category, and APMs receiving half of the highest possible score. This clearly reflects a commitment of the Committees to encourage movement into medical homes and APMs, which the AOA has advocated for throughout this process.

The AOA also believes that specialty board-sponsored quality improvement initiatives can serve as excellent Clinical Improvement Activities. Most of these programs, including all 18 of the AOA’s Specialty Certifying Boards, now require (or are in the process of requiring) that professionals engage in systematic practice performance measurement and demonstrate improvements in patient care as part of maintaining continuous certification - Osteopathic Continuous Certification (OCC). We suggest those physicians participating in OCC or Maintenance of Certification (MOC) be eligible for the highest possible score in this category as well.

These programs require professionals to continuously monitor performance feedback, to compare their performance to clinical guidelines and similar peers in their field, to identify improvement goals, and to demonstrate actions to improve upon practice and to assess the impact of such improvements. Since these programs are developed with the input of relevant clinical experts, they are often less onerous and more meaningful than federal or externally imposed programs. Professionals often can select from a range of educational interventions and practice improvements designed for sustained improvement in patient care, and personal practice performance is measured against national standards among similar peers within the specialty with similar patient populations. At the same time, these programs are developed and monitored under distinct and independent authorities that ensure high quality standards.

### **EHR Meaningful Use**

The AOA continues to support physicians moving to EHR meaningful use; however, we also believe this presents an opportunity to refine the program based upon physician experiences in the program to date. We must be very cautious to recommending physicians meet Meaningful Use Stage III requirements when we have not yet seen what exactly they will be, and how they will impact and/or improve practices. Significant issues remain that must first be resolved in the Stage II Meaningful Use program before we can begin to move physicians to Stage III.

Similar to certified medical home participating physicians receiving the highest possible score in the clinical practice improvement activities, we also believe they should achieve the highest score for the EHR meaningful use category. True advanced medical homes are already incorporating this component into their practices today.

### **Performance Assessment**

The AOA is concerned that the new combined quality programs will create one pool of physicians and other practitioners that would be in essence pitted against one another to achieve the highest composite score by meeting the same requirements under a budget neutral environment. Even amongst physicians, the concern

remains that physicians would be disincentivized to share best practices in order to score above their peers. We believe the sharing of best practices should be promoted and not potentially stifled.

To that end, the AOA supports appropriately risk-adjusted and equitable benchmarking of physicians relative to their peers. The data should not be used to penalize physicians; rather, it should be used to encourage improved efficiency and adoption of evidence-based practice guidelines and/or health information technology into a physician's practice. This comparison encourages physicians to look toward innovative ways to improve their practice and the efficiency of services provided to their patients. The introspective look at how a fee-for-service physician is performing relative to a physician in an innovative payment model, can serve as incentive to undertake the structural and behavioral changes that are necessary to effectively move into a new payment model such as the PCMH or ACO.

The AOA supports the ability of a physician to determine whether their quality performance be assessed at the individual or group level. We also appreciate the Committees' inclusion of virtual groups for practices of ten or fewer professionals. Regardless of the design or assignment, a "virtual group" should be permitted to validate its own members before it is used for performance assessments. There also should be an interactive process that allows correction, additions, and deletions to the group makeup over time. The need to involve physicians in the process of defining methods for physician grouping is critical.

The proposal also suggests allowing the Secretary to potentially allow hospital or facility-based professionals to have their quality assessment determined by their affiliated hospital or facility. We are concerned that this option might unfairly disadvantage those in solo or small practices who are not equipped with the same resources to improve quality as those in hospitals or other facilities. The AOA recommends the Secretary consider creating two separate performance pools, one for practices of ten or fewer and another for hospital and facility-based professionals choosing to have their performance be determined by their affiliated entity. This could ensure a more level playing field, with providers who engage in similar activities to improve quality being compared against each other.

#### Weights for Performance Categories

The AOA agrees with the Committees' decision to divide the performance categories into four and assign weights to each. We support the phase-in of quality and resource use weights for the first two years until they eventually balance in 2019. We reiterate our belief that quality should be the initial focus with a heavier weight assigned it and resource utilization being secondary.

We suggest the Committees consider reversing the weights of the four categories with clinical practice improvement activities and EHR meaningful use totaling 60 percent, while quality and resource use would total 40 percent of the composite score. It is our belief that the effective employment of electronic health records and clinical improvement activities will lead to improved quality and resource use, and should therefore be the focus.

We also suggest that once EHR adoption reaches 75 percent, the difference between the drop and remaining percentage, 10 percent in the current proposal, be reallocated to the clinical practice improvement activities' category. This will again serve to further improve the quality and value offerings of the Medicare program.

#### Performance Pool Funding

The AOA recognizes the need for the performance pool to be budget neutral in the current fiscal environment; however, we are concerned with the lack of true predictability that will occur within this performance pool construct. Physicians will not know what their potential payment bonus or payment cut will be from year to year even if attaining the highest performance score due to the unpredictability of the distribution of others in the pool. This does not help with practice transformation investments and the ability to make improvements to maintain or achieve a higher composite score.

We appreciate the gradual increase in the size of the pool from 2017-2019, and the inability for the Secretary to decrease the pool in subsequent years. We do, however, recommend requiring that the Secretary not increase the pool by greater than 1 percent from the previous year. We hope this will help move toward some predictability under the VBP.

#### Assistance to Small Practices

The AOA strongly supports assistance being provided to small practices located in HPSAs or rural areas. We encourage the addition of fully independent practices of one to five physicians in all areas of the country for this assistance. In addition, we do not believe the proposed \$10 million dollars per year for each of the five years will be adequate to appropriately support small practices. We recommend at minimum \$20 million be allocated per year.

#### Feedback for Performance Improvement

The AOA appreciates the Committees' recognition of the importance of timely feedback. One of the most challenging and frustrating aspects of the current set of federal quality programs has been the lack of timely, understandable feedback. We, therefore, recommend physicians be provided with access to timely and meaningful data from CMS on *at minimum* a quarterly basis (not "such as quarterly" as written in the current discussion draft). Since the goal is improvement and education, physicians should be given the opportunity to make care adjustments along the way before they risk being penalized for performance.

### **III. Encouraging Alternative Payment Model Participation**

The AOA supports the encouragement of alternative payment model adoption by physicians as offered under this proposal. We appreciate the 5 percent incentive bonus payment for those physicians demonstrating a significant stake in a PCMH or APM. We also support the gradual increase in the percentage threshold required.

However, we believe a percentage threshold of patient mix as opposed to revenue would more accurately reflect this participation. We are concerned that an unintended consequence of revenue versus total patients might, for example, inadvertently encourage the under treatment of a provider's patients outside of the APM in order to achieve the necessary revenue percentiles. As well, in subsequent years as costs reduce in the APM due to the nature of the model, it will likely become more difficult for providers to continue to qualify based on the proportion of their Medicare revenue in the APM.

We again commend the Committees for recognizing the valuable role the PCMH has played by allowing professionals in a qualifying PCMH to receive the 5 percent annual bonus in the years 2016-2021. In order to ensure the program's success, we recommend the following in regards to this provision:

- The 5 percent annual bonus for qualifying PCMH and other APMs ends in 2021, yet according to the proposal, the transition to across-the-board 2 percent updates for all providers in APMs and 1 percent updates for all other providers remaining in fee-for-service, do not begin until 2024. This leaves a two-year gap where it is unclear what payment adjustments, if any, providers will be eligible for. If none, then it would essentially force providers to transition to the VBP Program for those two years if they want to receive any bonuses, only to have to switch back to an APM in 2024 to receive the higher 2 percent payment. In order to avoid such a disruptive and counter-productive scenario, we strongly urge the Committees to continue the 5 percent annual bonus for qualifying PCMHs and APMs through 2023.
- The revenue thresholds necessary to qualify for the PCMH bonus are determined at the end of the year, yet a provider must know at the beginning of the year whether or not she will need to engage in the administrative work and reporting needed to comply with the VBP Program. Since participation in a qualifying PCMH or APM exempts providers from the VBP Program requirements, we

recommend that revenue determination is based on the previous year's revenue. This will give providers the certainty they need to fully engage in either the VBP Program, or their PCMH.

- While qualifying PCMH bonuses begin in 2016, the existing penalties under PQRS, EHR MU, and the VBM do not sunset until the end of that year. We recommend that early adopters who qualify for the PCMH bonus in 2016 be exempt from reporting requirements for that year. The AOA also recommends consideration of one-sided risk APMs that meet the same requirements of PCMHs.

#### **IV. Encouraging Care Coordination for Individuals with Complex Care Needs**

The AOA fully supports the establishment of payment for one or more complex chronic care management codes. Additionally, we agree that physicians practicing in a PCMH or comparable practice as certified by an organization should qualify. Pathways outside of traditional medical home certification should also be considered. We also recommend that the Committees direct the Secretary to work with physician organizations to develop additional codes for care coordination for individuals with complex care needs that are less narrow than those currently available, and will be more indicative of practice transformation. Finally, while we understand that only one professional or group practice could receive payment for these services for any given individual, we question whether it will create an environment where a race to the billing office will determine payment.

#### **V. Ensuring Accurate Valuation of Services Under the Physician Fee Schedule**

The AOA remains certain that the physician is the best data source in providing input on the amount of work, time, and intensity involved in performing physician services. We are concerned that this provision would have potential long-term impacts on the payment baseline if the 1 percent target or any portion thereof is not met in any of the three years. With that said, we recognize the need for a carrot-stick model to be applied unlike the Energy and Commerce approved legislation having a similar target, but lacking any penalty associated if the 1 percent annual target was not met. It is important to consider the fact that reaching the 1 percent target in year one might be easier due to low-hanging fruit that may have been overlooked in previous years by the RUC. However, reaching the target in subsequent years will potentially prove more difficult because less high-volume and/or high-cost procedures would be left that are misvalued.

We recommend the 1 percent or portion thereof in any given year be reallocated to those same E/M codes used to establish eligibility for the PCIP, in order to ensure office-based primary care services are prioritized. Additionally, rather than cutting all services across the board if any portion of the target is not met in any year or combination thereof, we support holding harmless these same E/M services. It is not clear from the draft proposal how many professionals will be solicited for information by the Secretary. We believe that all professionals who submit information be compensated for doing so, and as the Committees suggest should be exempt from submission if called upon the subsequent year.

The proposed ten percent payment penalty for those physicians who do not submit data when selected is sizable. Since the proposal provides little information on the scope of data submission that physicians will be called on to provide, it is difficult to say whether or not it is an appropriately balanced penalty. The more burdensome this data submission will be to physicians, the less appropriate such a significant payment penalty becomes.

Most importantly, regardless of any inability to reach the 1 percent target of misvalued codes any of the three years, the AOA strongly recommends that the baseline must be reset back to 100 percent in 2024. Otherwise, the proposed 1 and 2 percent updates could be reduced or even only serve to bring the payment level back to the original baseline, thus negating scheduled positive payment updates beginning in 2024.

## **VI. Recognizing Appropriate Use Criteria**

The AOA supports the Committees' proposal to implement a program requiring consultation of appropriate use criteria. However, this should be done in a manner that does not increase administrative burden on physicians. As we understand, the ordering physician would be required to attest to consulting appropriate use criteria, such as clinical decision support, and would still be able to determine within their best judgement whether the criteria is appropriate for the patient. This should not inhibit physician judgment of necessary and timely treatment, nor would it interfere with the physician-patient relationship if implemented properly.

The proposal grants the Secretary authority to expand the use of appropriate use criteria to services beyond those outlined. Are there parameters for how the Secretary determines expansion? We hope the parameters center around those services found to have the highest cost variation. We further believe any expansion of services under this provision should be gradually phased in.

## **VII. Expanding the Use of Medicare Data for Performance Improvement**

The AOA appreciates the requirement for the Secretary to provide data to qualified clinical data registries. We are concerned that qualified entities that currently receive data for public reporting purposes would have the option to sell this data to physicians rather than only have the option to provide them at no cost. Physicians need this type of data to transform and improve their practices, and it should not come at an additional expense to the physician.

## **VIII. Transparency of Physician Medicare Data**

While the AOA recognizes the value of involving consumers in their care, we urge caution on how public disclosure of physician performance information (as included in the draft proposal) is structured. We urge incorporating safeguards so that the sharing of data does not intrude into the patient-physician relationship or exacerbate the practice of defensive medicine to the ultimate detriment to patients. Public reporting of physician performance should:

1. be complete and continuously updated,
2. only compare physicians by measures that are evidence-based,
3. allow physicians an opportunity to see and explain the information before it is disseminated,
4. only compare physicians who practice in the same areas of expertise and geographic regions, and
5. most importantly, be risk-adjusted.

The standard established by CMS for the Hospital Compare website is to report risk-adjusted outcomes when publicly reporting outcomes. We stress the importance of risk adjustment because determinants of the outcomes of patients are not entirely under the control of the physician. The attribution of results to the physician could be at the least unfair and potentially damaging for those physicians that serve disadvantaged communities.

Our own analysis of factors affecting glucose control in diabetic patients in the AOA-Clinical Assessment Program (CAP) showed a large amount of variation attributable to factors not under the physician's control. Our findings suggest that system factors (such as insurance type and level of coverage) and patient factors (such as compliance) have large effects on the level of control at the patient level. The prevalence of these factors in any sample a physician provides for PQRS can markedly influence the rate of control. Indeed, if we are reporting all payer data to CMS a physician who sees a larger portion of uninsured individuals (self-pay) would have markedly lower performance without risk-adjustment. This would be a disservice to the physician and actually in a 'market' sense may punish them by driving patients with insurance from the practice. The same example may be applied to patient compliance rates. Until issues around risk-adjustment

are solved, we are unable to endorse public release of physician specific outcome data as it would be inaccurate and potentially harmful to the public.

The AOA and our members appreciate the opportunity to share these thoughts, views, and recommendations with the Committee, and encourage you to continue seeking physician community input as you progress. Again, we applaud your work toward addressing this critical issue and stand ready to work with you, collectively, to identify and implement new delivery and payment models that promote quality and efficient care for all patients.

Sincerely,

A handwritten signature in black ink, appearing to read "Norman Vinn D.O.", written in a cursive style.

Norman Vinn, DO  
AOA President

C: Members of the House Ways & Means Committee  
Members of the Senate Finance Committee