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November 12, 2013

The Honorable Max Baucus
Chairman
Committee on Finance
U.S. Senate
Washington, DC 20510

The Honorable Dave Camp
Chairman
Committee on Ways and Means
U.S. House of Representatives
Washington, DC 20515

The Honorable Orrin Hatch
Ranking Member
Committee on Finance
U.S. Senate
Washington, DC 20510

The Honorable Sander Levin
Ranking Member
Committee on Ways and Means
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Baucus, Chairman Camp, Ranking Member Hatch, and Ranking Member Levin:

The Association of American Medical Colleges (AAMC) applauds your bipartisan efforts to reform the Medicare physician payment system. We appreciate the serious challenges involved in replacing the current system and have submitted comments throughout this process. The Committees' thoughtful proposal represents progress toward establishing sustainable funding for Medicare physician payments and moving toward a payment system that rewards quality while preserving access for Medicare beneficiaries. We urge you to continue this bipartisan approach and to find a permanent solution.

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. Physicians at academic centers are organized into faculty practice plans and while the structure of these plans varies enormously, many are large multispecialty group practices. Therefore, our comments focus on how the proposals in the discussion draft would affect such practices.

While the discussion draft contains many concepts that will help move the health care system to one that rewards quality and efficiency, the proposed timelines may not be realistic and workable for many providers and many of the proposed thresholds may be too high for most providers to meet in the near future. In addition, the current quality and reporting programs upon which this proposal is built need additional refinements. With these overarching concerns in mind, our major recommendations are:

- Value-Based Purchasing (VBP) payments should be phased-in in a way that appropriately and accurately reflects the current state of quality and cost reporting.

- The legislation must require the Secretary to implement a group performance option for the VBP Payment Program.
- Any resource measures and outcome measures need robust risk-adjustments that take into account socioeconomic status and demographic factors. At a minimum, the resource measures should include the protections that exist in the current physician value-based payment modifier program.
- Participation in alternative payment models (APM) will be constrained by the number of existing APMs. To be effective in incenting providers, the APM participation bonus should consider a phased-in approach with lower thresholds and multiple opportunities for participation.

In addition to the repeal of the sustainable growth rate (SGR), we also ask the Committees to consider addressing the impending workforce issues, in particular the looming physician shortage.

Section I: SGR Repeal and Updates

The discussion draft proposes a 10-year freeze for physician payment, with a 1 or 2 percent update after 2023. Committee staff have been clear that a freeze is necessary because of the current fiscal environment; however, physician groups still face increased costs to provide health care to Medicare beneficiaries. Without the promise of a positive update for physicians, it is essential that practices that deliver quality health care are able to have a realistic opportunity to achieve a bonus from either the VBP Payment Program or the Alternative Payment Model participation. The next two sections outline our concerns with the feasibility of the proposals and suggestions on how to refine these options.

Section II: Value-Based Purchasing Payment Program

The AAMC commends the Committees for the innovative concept of replacing the potential penalties from three disparate reporting and performance programs-- Physician Quality Reporting System (PQRS), Medicare Electronic Health Record (EHR) Incentive Program, and the Value-based Payment Modifier Program (VBPM)--into a single consolidated, coordinated VBP Payment Program in which physician groups can achieve a bonus for excellent performance. The AAMC's concerns about this proposal reside in the ability to effectively and accurately capture performance in the mandated time period, particularly given the current state of quality and resource reporting. Because the amount at risk is so large (starting at 8 percent in 2017) and successful participation in the VBP Payment Program is the one way all physicians can compete for a positive update, it is particularly important to ensure that the program is feasible and fair.

Timing of the VBP Payment Program Is Too Aggressive to Capture True Performance Differences

The discussion draft notes the VBP payment adjustments would begin in 2017 based on a professionals' performance in a prior period. Since the Center for Medicare and Medicaid Services (CMS) has consistently chosen performance periods 2 years prior to the imposition of a payment adjustment, it is reasonable to anticipate that the quality, cost and EHR performance period would be calendar year 2015. While the AAMC supports transition to VBP as soon as possible, we do not believe it is possible to have this program operational in just one year and have reliable results. Two commentaries in the November 6, 2013, New England Journal of Medicine discussed the issues still outstanding on the current physician-based Value-based Payment Modifier program. One noted that "CMS …cannot accurately measure any physician's overall value, now or in the foreseeable future" and that "policy overreach could undermine

the quest for higher-value health care."[1] The second noted the challenges with not enough physicians engaged in public reporting, and issues related to attribution and accountability.[2]

There are two major reasons that the rapid timeline for a performance-based program could provide poor measurement and unintended outcomes:

- **The relative immaturity of resource measures**. For the past several years, CMS has been working on resource measures, and the Agency continues to refine them. The current Total Per Capita measure was recently reviewed by the National Quality Forum, yet was not recommended for endorsement. In addition, that measure is currently designed for physician group practices, not individual clinicians. There is not yet a reliable measure for calculating performance at the individual physician level, indicating that a broader roll-out of resource measures would be premature. Episodic measures are still in their testing phase. Finally, CMS is still modifying the benchmark comparisons to determine what appropriate adjustments need to be made.

- **The lack of standardized reporting by physicians**. If the 2014 physician fee schedule (PFS) proposals are finalized, 2014 will introduce a number of changes to quality reporting: the number of measures professionals must report for PQRS will increase dramatically; there are new PQRS reporting options, such as the qualified clinical data registry; professionals have to report new quality metrics for Stage 2 of the EHR Incentive Program; and group quality reporting for the EHR incentive program and PQRS are scheduled to be aligned. There are a significant number of unanswered questions about how these changes will work and if they will affect performance rates. As the VBP payment is based on performance, it is essential that providers have some period of stable quality reporting before moving to a performance-based payment program.

Because of these reporting and methodology concerns, if the VBP program were to be implemented with a 2015 performance year, it would be difficult to ensure that physicians and group practices are measured in a fair and equitable way. The AAMC suggests the following changes to the VBP Payment Section:

- **Resource use should be limited to no more than 15 percent of the total composite score** (and perhaps even less) until there is a stable and valid measure.
- **For a limited time, allow physicians to be given credit for part of the composite score by successfully reporting quality information.** This transition phase will allow physicians and group practices to understand their resource performance as well as their different quality reporting options.
- **Limit the amount at risk in 2017/2018.** Instead of starting the VBP program at 8 percent for 2017 and ramping up to 10 percent for 2019, start at a lower amount (such as 5 or 6 percent) for 2017 and ramp up to 10 percent later, after measures have stabilized and CMS can identify true performance differences.
- **Limit the total amount at risk to 10 percent.** The discussion draft does not put a limit on the total amount at risk, leaving the possibility that in the future the amount could exceed 10 percent. This should be changed to a cap of 10 percent at risk.

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[1] Berenson RA, Kaye DR. "Grading a Physician's Value - The Misapplication of Performance Measurement." N Engl J Med. 2013 Nov 6.
[2] Chien AT, Rosenthal MB. "Medicare's Physician Value-Based Payment Modifier - Will the Tectonic Shift Create Waves?" N Engl J Med. 2013 Nov 6.

Group Reporting Option Should Be a Legislative Requirement

Another consideration for the VBP Payment is the unit of measure for the composite score. Currently, the EHR Incentive Program is measured at the individual eligible professional (EP) level, the VBPM is measured at the group practice level, and PQRS has the option of either individual or group reporting.

The AAMC believes it is essential to have a group reporting option that evaluates care at the group or system level. This encourages care coordination and communication across the system. While the legislation that created the EHR Incentive Program provides the authority to implement a group reporting option, CMS has not exercised that option. As a result, academic practices, which often have hundreds, and at times well over a thousand physicians, are subjected to the administrative burden of tracking performance at the individual clinician level. This is particularly challenging when physicians work for multiple groups (and their performance data needs to be consolidated) or when new physicians join the practice (and their prior performance needs to be tracked). To prevent these challenges in the VBP Payment Program, the legislation should include an explicit requirement that the Secretary develop a group performance option.

Resource Use Data Collection

The discussion document notes that for resource measurement, professionals would indicate their role in treating a beneficiary (primary care or specialty care) and the type of treatment (acute or chronic) on the claim form, rather than using a formula to make this determination. The AAMC appreciates that this data collection is intended to improve attribution methodology; however, resource measurement is very complicated and it is unclear if this type of data collection could be a) accurately done at the time of claims submission and b) accurately incorporated into a resource measure formula. The AAMC recommends the legislation direct the Secretary to consult with stakeholders to evaluate such claims-based reporting options rather than requiring a detailed data collection.

Feedback for Performance Improvement

Group practices, and individual physicians, need feedback data to improve performance. If resource measures will be a significant portion of the composite score, then Medicare has an obligation to provide timely data to clinicians on resource measures. At a minimum, the feedback data should include patient-level information, as well as information about where the costs for that patient occurred.

Need for Appropriate Risk Adjustment

The AAMC strongly encourages the Committees to ensure the new legislation continues the requirement to have resource and outcome measures properly risk adjusted. At a minimum the risk adjustment needs the protections that are currently in the VBPM, which require resource measures to consider patient characteristics such as socioeconomic status.

Section III: Encouraging Alternative Payment Model (APM) Participation

The AAMC supports the concept of incentivizing providers to move into advanced APMs in which the providers bear two-sided risk and are accountable for quality. The Association is concerned, however, about the feasibility of the current proposal.

Lack of Existing APMs Are a Barrier to Participation

There are currently very few APMs in the Medicare program; there are even fewer that require two-sided risk. For example, the Medicare Shared Savings Program (MSSP), a signature program of the Affordable Care Act (ACA), offers one-sided risk as a model, and would thus not meet the criteria as described. As a facilitator-convener in the CMS Innovation Center's (CMMI's) Bundled Payments for Care Improvement (BPCI) initiative, the AAMC has experienced firsthand the challenges associated with designing and implementing a new payment model. BPCI has taken over two years to move from the Request for Applications to participant go-live. CMS and CMMI would need to implement a wide range of APMs on an extremely aggressive timeline in order to provide options for participation by 2016. The AAMC appreciates that the discussion draft encourages the Secretary to test APMs relevant to specialist physicians and those that align with private and state-based payer initiatives, but remains skeptical about the timeline. Finally, it must be taken into account that physicians and/or physician groups are often not the sole contracting entity bearing risk with CMS. Therefore, physician groups could be actively engaged in APMs while not in a two-sided risk contract with Medicare.

Practices Actively Engaged in APMs May not Meet Proposed Thresholds

Beyond the dearth of programs that meet the APM definition, the AAMC believes the thresholds as stated are not achievable. Most existing programs, while rigorous to implement, impact only a small proportion of a provider's revenue, particularly when aggregated to the group level. The ACO models, for example, use primarily primary care attribution, so much of a group's specialty revenue might not be covered by participation in an ACO. The issue of "Medicare revenue" must also be clarified so as to specify if "revenue" is, for example, clinical revenue, fee-for-service revenue, or all Medicare revenue, as well as the relationship of this proposal to participation in Medicare Advantage, which has spending and quality targets for providers and could be considered an APM. Furthermore, APMs are very new models and providers are still assessing their options and beginning the transition. If a physician group has applied for the MSSP to start in January 2014, by January 2016 the group will still be in its first performance contract and will only have one full year of results and reconciliation against benchmarks. This group would have changed its business structure and be providing care in the type of value-based model desired, but would likely not meet the advanced APM criteria or the revenue thresholds as proposed.

APM Recommendations

The AAMC believes the proposal is thoughtful and aims to move providers and our health care system in the right direction. In order to achieve the greatest participation and success, however, there needs to be a more phased-in approach to accommodate providers at all levels of APM readiness and implementation. A phased-in approach would also recognize the reality that most existing APMs are yet "advanced APMs." The Association recommends the following changes to the APM Participation:

- **Establish multiple options for groups and physicians to participate in APMs.** For example, groups could receive a smaller bonus for participating in a 1-sided APM, or in an APM that does not meet the 25 percent Medicare revenue threshold. The maximum bonus could go to those groups with the fullest participation in a given APM (i.e., all eligible physicians in a group are participating and the APM is two-sided risk).
- **Include language that gives APM credit to group practices and physicians even if they are not the contracting entity in an APM.** In Bundled Payments for Care Improvement (BPCI), for example, several physician practices are working with their hospital partners to redesign care around certain hospitalizations. While the hospital signs the bundling risk-bearing contract with CMS, the participating groups should receive credit for their efforts.

- **Provide a positive update for 2022 and 2023.** The proposal provides a five percent bonus for six years (2016-2021) for groups that participate in APMs. Starting in 2024, groups can receive a 2 percent update, but there is a two-year gap with no bonus payments or positive update in 2022 and 2023. We urge the Committee to allow some positive incentive during those two years. One possibility is to start the APM bonus a year or two later and/or then scale back the 5 percent bonus and spread the amount over 2022 and 2023.

Section IV: Encouraging Care Coordination for Individuals with Complex Chronic Care Needs

The AAMC supports the continued effort to improve care coordination particularly for complex care patients; however, the Association questions the need to legislate this proposal as a similar policy is currently moving through the regulatory process.

Section V: Ensuring Accurate Valuation of Services

The AAMC appreciates the need for accurate cost information for the PFS. We are concerned about the relative burden associated with reporting and the associated 10 percent reduction for not reporting. The AAMC supports a revision that compensates physicians for their burden and that requires the Secretary to meet with stakeholders to determine the most cost-effective data collection option.

Section VII: Expanding the Use of Medicare Data for Performance Improvement

The AAMC is very concerned about the appropriateness of selling information to employers and insurance companies without ensuring that providers can see that information first and without limitations on how insurers and employers use the data. Without an understanding about why it is necessary to include this provision in the legislation, we ask that it be removed.

Section VIII: Transparency of Physician Medicare Data

The AAMC supports the use of increased transparency, but would requests that the legislation include some protective language ensuring that only useful and accurate data are displayed.

Opportunity to Address Physician Workforce in Physician Payment Reform

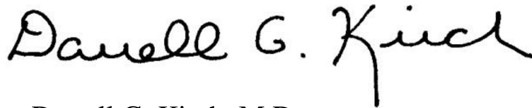
One critical component that is not addressed in the current framework is the need to ensure there are enough physicians to meet the needs of the growing number of Medicare beneficiaries. The AAMC estimates that by 2020 the United States will face a shortage of 91,500 physicians, equally distributed between 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 fact that the number of federally-supported residency slots has remained stagnant since 1997. In fact, the total number of applicants to medical school for 2013 grew by 6.1 percent to 48,014 and the number of students enrolled in their first year of medical school exceeded 20,000 for the first time, a 2.8 percent increase over 2012. Despite this, without an increase in Medicare support for Graduate Medical Education (GME), we face a shortfall of physicians across dozens of specialties. We urge you to use this opportunity to address the physician shortage by increasing Medicare support for GME. Incorporating GME expansion provisions, such as those included in “The Resident Physician Shortage Reduction Act of 2013” (S. 577), will guarantee provider access to Medicare beneficiaries and all patients.

Paying for SGR Repeal

One major barrier that is not addressed in the discussion draft, is how to pay 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 impact on beneficiaries and on the teaching hospitals and teaching physicians that care for 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. We urge you to avoid any cuts that jeopardize the nation's teaching hospitals and the ability of their physicians to provide Medicare beneficiaries with timely access to care.

The AAMC appreciates and supports your efforts to address the challenging issues associated with repealing and reforming the SGR. We look 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 comments in greater detail, please contact Leonard Marquez, AAMC Director of Government Relations, at lmarquez@aamc.org or 202-862-6281.

Sincerely,



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