August 30, 2011

Donald Berwick, M.D., M.P.P.
Administrator
Centers for Medicare & Medicaid Services
7500 Security Blvd.
Baltimore, MD  21244-8013


Dear Dr. Berwick:

The Association of American Medical Colleges (AAMC or the Association) welcomes this opportunity to comment on the Centers for Medicare and Medicaid Services’ (CMS’ or the Agency’s) Proposed Rule entitled Medicare Program: Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2012. 76 Fed. Reg. 42772 (July 19, 2011). The AAMC represents all 135 accredited U.S. medical schools, nearly 400 major teaching hospitals and health systems, and nearly 90 academic and scientific societies. Through these institutions and organizations, the AAMC represents over 100,000 clinical faculty members, 75,000 medical students, and 110,000 resident physicians.

The proposed rule outlines several modifications to the Medicare programs that measure quality and value for clinicians and group practices. The AAMC supports a robust and transparent reporting process, yet is concerned that implementation will be difficult to achieve, particularly by the performance periods that CMS proposes to use for the 2015 value modifier and the Physician Quality Reporting System (PQRS) penalty. While CMS has made great strides in aligning the different reporting programs, more needs to be done. The AAMC is also concerned that all of these programs (and associated penalties) are being implemented while the threat of severe payment cuts is looming from the sustainable growth rate (SGR). The following sections further explain the AAMC’s positions.

ALTERNATIVE DEFINITIONS OF GROUP PRACTICE FOR QUALITY REPORTING

CMS currently recognizes groups for the PQRS by taxpayer identification number (TIN). In the proposed rule, CMS notes that the Agency is considering modifying the definition of group practice to include multiple TINs and seeks comments on parameters that will ensure that the multiple TINs represent a single integrated practice.
The AAMC believes that a single TIN is one viable definition of “group” but has long supported an alternative group definition that would enable broader participation in group reporting. Due to a variety of business reasons unrelated to quality reporting, some faculty practice plans have multiple TINs. In these practice plans, the departments share common services, consider themselves to be part of the same physician practice, and are viewed by the public as being part of the same physician practice. The AAMC urges CMS to adopt a voluntary process whereby such groups are able to nominate themselves to be considered as a single group for quality and resource reporting purposes.

To determine the characteristics that connect the individual TINs at academic faculty practices, the AAMC conducted interviews with several faculty practice plans that operate under multiple TINs. Among the characteristics that indicate the TINs function as a group are:

- **Shared systems**, which could include designated faculty appointments (or common employment agreement for non-academic institutions), a single source for clinician paychecks, shared funds flows, combined financial statements, shared policies, shared technologies, or shared management structures; and
- **Public perception of a group**, which could include common logos, signage and/or uniforms; combined billing statements for physician services; or having a single address for remitting payments.

It is important to note that no faculty practice could document ALL of the examples listed above; however, each organization could document that it meets at least some of these criteria.

The AAMC recommends that CMS adopt a multi-TIN group definition that incorporates the two concepts of “shared systems” and “public perception,” but allows organizations the flexibility regarding the criteria to qualify as a group. The AAMC does not believe there should be a limitation on the number of TINs that can be included in a group, as long as the “group” is willing to accept accountability for all TINs that form the group. This type of definition will reduce regulatory burden and accommodate the variety of health care models that currently exist. A flexible definition would also accommodate new health care models. The AAMC would be happy to work with CMS to further refine parameters for establishing a multi-TIN group practice.

**PHYSICIAN FEEDBACK REPORTS AND VALUE MODIFIER**

The Affordable Care Act (ACA) requires CMS to establish a value-based modifier (VM) that will pay physicians or physician groups differentially based on quality and cost measurement. The VM must apply to certain physician and physician groups by 2015 and to all physician and physician groups by 2017. In the proposed rule, CMS notes that the value modifier will be based on the Physician Feedback Program reports. CMS also proposes the quality and cost measures for the 2015 VM and to use calendar year 2013 to measure performance.
The AAMC supports the movement to a payment system that rewards quality, efficiency, and patient-centered care, provided that it can be accomplished in a methodologically sound and transparent way. The Association also believes that programs that adjust payment based on performance must meet stringent methodological requirements, and that sufficient time must be provided so that measure results are reviewed and validated by physicians prior to implementing payment adjustments. If not done properly, the VM program could make physicians reluctant to treat Medicare patients, especially the high-cost, complex patients often cared for by physicians in faculty practice plans.

**Resource Measurement and Physician Feedback Reports**

CMS first attempted physician resource measurement in 2009 with Phase 1 of the Physician Feedback Program. Those reports focused on per-capita and episode-based resource measurement for a limited number of physicians. Due to issues with using those measures in the elderly Medicare population, Phase 2 reports eliminated episode-based measures; however, the Phase 2 reports expanded to include measurement for physician group practices and incorporated claims-based quality measures. For Phase 3, the Agency will focus on individual physician measurement in four states (Iowa, Kansas, Missouri, and Nebraska) and will include PQRS reporting results where available. For group reporting, CMS will analyze the performance data for the large group practices that participated in the 2010 PQRS Group Practice Reporting Option (GPRO). CMS also is developing episode grouper software which can evaluate episodes for the Medicare population. CMS plans to select a prototype by January 1, 2012, and may incorporate those measures in future reports.

The AAMC believes resource measures that include Part A hospital payments must exclude the indirect medical education (IME), direct graduate medical education (DGME), and disproportionate share hospital (DSH) payments. This standard has been applied in other payment programs, such as the proposed Medicare spending per beneficiary measure for the inpatient value-based purchasing (VBP) program. The AAMC asks that CMS be consistent and apply the same exclusions to any physician resource use measures that incorporate Part A hospital payments. Further, the AAMC requests that the description of the Agency’s methodology explicitly state that IME, DGME, and DSH are excluded.

The AAMC also applauds CMS’ efforts to find the most accurate and appropriate methodologies for resource measurement, but remains concerned about the numerous issues the Agency is encountering and the lack of consensus about resource measures. A recent GAO report highlighted that almost 82 percent of the physicians in Phase 2 were ineligible to receive a report after CMS applied the attribution and sample size criteria. In addition, there are no endorsed industry standards regarding resource measurement. The National Quality Forum (NQF) is traditionally the organization that endorses measures. While NQF is in the process of reviewing resource use measures, to-date no measures have been formally endorsed. Even when measures are endorsed, changes to the patient attribution, risk-adjustment, and/or benchmarks can alter the relative performance of a clinician or a group of clinicians.
Further complicating resource measurement is the lack of readily available information for additional analysis. For Phases 1 and 2 of the Physician Feedback Program, CMS published template reports that included detailed methodologies. However, with the exception of the GAO report, there has not been a summary report that highlights the current findings and issues, such as the variance in results both within and across different benchmark groups. There also is no readily available data set stripped of personal health information that policy makers could use to understand the impact of changing attribution, risk adjustment, and benchmarks. **The AAMC encourages CMS to publish an annual report of these high-level findings and to consider making such data sets available.**

**Risk Adjustment**

The AAMC is pleased that the ACA requires that the quality and cost measures in the VM be appropriately risk-adjusted. The legislation also mandates that the risk adjustment for the cost measures should consider factors such as socio-economic status (SES) and demographic characteristics, including ethnicity and health status of the assigned beneficiaries. Unfortunately, the risk adjustment model that CMS uses for Medicare Advantage and for the resource use measures, the CMS-HCC model, does not incorporate SES and ethnicity. The AAMC recognizes that developing risk adjustment methodologies is a difficult undertaking and we appreciate the efforts made to date, yet we feel more must be done. The AAMC urges CMS to convene national experts to discuss risk adjustment and develop mechanisms to implement the legislative requirements.

**Benchmarking**

In defining comparison groups, CMS is considering moving from benchmarks based on specialty to stratifying physicians by both specialty and the conditions of the patients they treat. The AAMC believes this adjustment will be an improvement over using only Medicare specialty, but would prefer that the benchmark include the types of services provided. Even within a single specialty, there is much practice variation. This is especially true at academic medical centers, where many academic clinicians provide unique specialty services that are not performed by others within their specialty. UHC (University HealthSystem Consortium) and AAMC have partnered to develop productivity benchmarks for academic physicians through UHC-AAMC Faculty Practice Solutions Center®. While the FPSC benchmarking application differs from resource reporting benchmarking, we believe that some valuable lessons can be shared. The AAMC and UHC are willing to meet with CMS staff to discuss ways to improve the benchmarking process.

**GPRO Feedback Reports**

The AAMC is pleased that CMS is developing feedback reports for the 2010 GPRO participants. Similar to the practices in the Physician Group Practice Demonstration, the 2010 GPRO practices are large (greater than 200 physicians) and reported on the same quality metrics.
Although 2010 GPRO participants immediately knew their own performance rate on the quality metrics, they did not have data on the other participants. The AAMC believes that such confidential reports with benchmarking data will be a valuable resource to the participants. Because CMS has a relationship with these group practices, the AAMC hopes the Agency will seek feedback from participants regarding issues in the data collection and reporting. Any relevant findings should be included in an annual summary report.

2015 Value Modifier

Proposed Quality and Cost Measures

For the 2015 VM, CMS indicates that the Agency will use the following to assess quality measurement: PQRS core measures, clinical quality measures (CQM) from the Medicare and Medicaid Electronic Health Records (EHR) Incentive Program, and measures from the 2012 PQRS GPRO. For cost measurement, CMS is proposing per-capita costs and costs for patients with specific conditions.

For value-based purchasing programs, the AAMC supports using only measures that have been NQF-endorsed, because the NQF endorsement process ensures that measures meet rigorous standards. A handful of measures in the quality measures set do not currently have NQF endorsement. The AAMC requests that all measures in the PQRS or VM programs receive NQF endorsement.

The AAMC also recommends that physicians and group practices be given the opportunity to review quality and cost results for at least one year prior to their inclusion in the VM program. This time period is critical to ensuring that issues with data collection, validity, and reporting are resolved prior to inclusion in the VM program. This time delay is consistent with the VBP requirement that measures only be eligible for inclusion after they have been publicly reported on Hospital Compare for at least one year. Clinicians need to have real-world experience with a measure prior to its incorporation into a value program, and the AAMC believes this is only achievable if the providers have the ability to review the results before facing financial consequences based on the results.

2013 Performance Period

The AAMC does not agree with the Agency’s proposal to use CY 2013 as the performance period for the 2015 value modifier. CMS has indicated that the Agency will begin “implementing the value modifier through the rulemaking process in 2013” 76 Fed. Reg. at 42913. If the details of the VM are finalized during 2013, then physicians and physician groups will not know how they will be measured until they are in the middle of the performance period, at which point it may be impossible for them to implement systems to monitor and improve performance. The performance period should begin after the measurement details are finalized.
2015 Implementation Deadline

CMS faces the difficult task of determining which providers or provider groups should be included in the 2015 modifier. The AAMC believes cohorts should not be based on employment relationships or organizational characteristics. The AAMC urges CMS to actively engage with stakeholders and organizations that represent them to ensure that all possible options are considered and that the final decision is one that will be seen as a reasonable method for moving toward the adoption of a value modifier.

The AAMC recognizes that the health care system is going through a transformative period that will include transitioning to a payment system that rewards quality, efficiency, and patient-centered care. However, this must be accomplished in a methodologically sound and transparent way that does not reduce beneficiaries’ access to care through inappropriate measurement. While Congress has imposed deadlines of 2015 and 2017 for implementing value-based purchasing, the AAMC is concerned that it will be difficult, if not impossible, to establish a payment system that meets the necessary methodological rigor in that time period. The AAMC urges CMS to monitor its progress implementing the VM and to provide regular updates to Congress. If necessary, CMS should consider requesting Congressional relief from the current deadlines.

PHYSICIAN QUALITY REPORTING SYSTEM

PQRS-Medicare EHR Incentive Pilot

The ACA requires CMS to align the reporting requirements for PQRS and the Medicare EHR Incentive program. To comply with this requirement, CMS is proposing a new pilot, the PQRS-Medicare EHR Incentive Pilot, whereby eligible professionals (EPs) can use a single set of metrics to meet the quality reporting requirements for 2012 PQRS as well as to meet the clinical quality measure (CQM) requirement for the Medicare EHR Incentive program (also referred to as “meaningful use”). The pilot would have the same requirements as the current Medicare EHR Incentive Program with the following exceptions:

- EPs must use a PQRS-qualified EHR to submit data directly from the EHR or through a data vendor;
- EPs must report for Medicare Part B patients only; and
- EPs must report data for the entire calendar year.

The AAMC supports CMS’ efforts to streamline the reporting requirements between PQRS and the Medicare EHR Incentive program; however we believe more alignment is possible. First, CMS should coordinate the certification requirements between the two programs so that EPs can participate in the pilot if they have purchased certified EHR technology. There should not be a
separate process to be qualified for PQRS submission. In addition, CMS should ensure that certified EHRs are able to report on all approved PQRS measures.

Second, the program reporting dates should be aligned for professionals who are in the first year of achieving meaningful use. For the first year of the EHR Incentive Program, EPs only need to report data for 90 days, yet the PQRS-Medicare EHR Pilot project requires a full year of performance data. The AAMC recommends a 90-day reporting option for the pilot to accommodate EPs who are in the first year of meaningful use.

The AAMC also asks that CMS clarify the data submission processes for the Medicare EHR Incentive program and PQRS. The AAMC supports having a single data submission the meets both program requirements.

**GPRO Measures**

CMS proposes to retire 3 measures from the 2011 GPRO 1 reporting measure set and proposes to add 18 new measures. Unlike other PQRS reporting options, groups must report all of the GPRO measures. The AAMC is concerned that a few of the proposed measures are not currently endorsed by the NQF and asks CMS to restrict the GPRO measures to those that are NQF-endorsed.

Several GPRO measures look at whether a patient is above or below an absolute clinical threshold. The AAMC acknowledges that these measures can provide useful information but cautions that without proper exclusions or risk adjustment, the results could provide an inaccurate picture of a provider’s performance. Ideally, this data should be considered within the context of an individual patient’s history and co-morbidities.

**Proposed Performance Period for 2015 PQRS Penalty**

The AAMC objects to the CMS proposal to use CY 2013 data to determine which professionals may be subject to the 1.5 percent PQRS penalty in 2015. EPs should be able to demonstrate participation through CY 2015. Currently, professionals are balancing the needs to report to PQRS as well as adopt electronic health records. The AAMC suggests that CMS consider additional reporting periods for EPs to avoid the potential 2015 PQRS penalty, and that the Agency be willing to apply penalties retroactively.

**PHYSICIAN COMPARE**

CMS is proposing to report the performance results from the 2012 PQRS GPRO participants on the Physician Compare Web site starting in 2013. CMS asserts that because the GPRO Web reporting tool provides performance results to group practices, the GPRO participants will have had the opportunity to review their data prior to publication.
The AAMC does not believe that the proposed review of data for Physician Compare is sufficient. Groups should have the opportunity to review not only their individual data, but also their comparative benchmarks, before the information is publicly reported. Sometimes it is only through review of data compared to a peer cohort that it is possible to detect problems with one’s own data. At a minimum, a process should be established that allows for prior review and comment before data are made public. As with Hospital Compare, providers should have the right to suppress any data that are inaccurate.

**E-PRESCRIBING INCENTIVE PROGRAM**

In the proposed rule, CMS outlined the requirements for providers to earn a potential 1.0 percent incentive in 2012 and a 0.5 percent incentive in 2013 for successfully reporting to E-prescribing (eRx) Incentive Program. The rule also outlines the criteria for EPs and group practices to avoid a potential 1.5 percent reduction in 2013 and 2.0 percent reduction in 2014.

**Reporting Periods to Avoid eRx Penalties**

CMS offers two time periods during which eligible professionals can report e-prescribing events and potentially avoid the 2013 penalty. EPs who are successful e-prescribers in 2011 (by reporting 25 e-prescribing events) will be exempt from the 2013 penalty. In addition, for those EPs who do not meet the 2011 criteria, CMS is providing a six-month reporting period in 2012 to report 10 e-prescribing events and avoid a penalty. The requirements for 2014 penalty are similar, using a twelve-month reporting period in 2012 and a six-month reporting period in 2013.

The AAMC asks CMS to clarify that if an EP does not meet the reporting requirement during the 12-month period, but meets one of the exception criteria, then the EP will not be subject to the penalty. For example, if an EP does not report 25 eRx events in 2011, but less than 10 percent of the EP’s charges in the 2011 are from the codes in the eRx denominator, then the EP is automatically exempt from the 2013 penalty.

The AAMC also believes that CMS should provide EPs additional time to comply with the eRx requirements. At a minimum, for the 2013 and 2014 penalties, CMS should provide a reporting period that occurs during each penalty year. The AAMC acknowledges that this would require a retroactive payment adjustment, but believes that the logistical difficulties of that process are preferable to penalizing EPs who become successful e-prescribers during 2013 or 2014.

**Denominator Specification**

The eRx measure requires physicians to report e-prescribing events that occur with one of the services in the denominator. CMS is proposing to modify the reporting requirements for the six-month reporting period. During that period only, EPs would be able to report e-prescribing associated with any covered service, not just services in the measure denominator. The AAMC appreciates CMS’ desire to create more reporting opportunities during the six-month reporting
period, but having two different measure specifications for the two reporting periods could lead to additional confusion about the e-prescribing program. Instead, the AAMC encourages CMS to adopt the proposed standard of reporting eRx events associated with any service for all eRx reporting periods.

**Hardship Exceptions**

In May 2011, CMS released a proposed rule that included four new hardship exception categories for the 2012 eRx penalty. If the proposals are finalized, CMS will have a total of six hardship exceptions for 2012. For 2013 and 2014 penalties, CMS is proposing to retain four of the six hardship exceptions while removing the following two:

- EPs achieving meaningful use through the EHR Incentive Program; and
- EPs unable to report e-prescribing due to the limitations in the measure denominator.

**The AAMC strongly encourages CMS to retain these hardship exceptions to avoid the 2013 and 2014 eRx penalties.**

While CMS has made modifications to simplify eRx reporting for EPs who are implementing EHRs, the Medicare and Medicaid EHR Incentive Programs already require EPs to measure e-prescribing use. The AAMC believes it is a poor use of resources for EPs who have achieved meaningful use in the EHR Incentive Programs to report separately to the eRx program simply to avoid a penalty.

Similarly, the CMS proposal to modify the denominator criteria for reporting eRx events will provide more opportunities for EPs to report. However, the new measure will not count e-prescribing that occurs outside of a billable service. The AAMC believes it is reasonable to retain the exception on the denominator limitations as well.

**REVISION OF THE TELEHEALTH STANDARD**

The AAMC supports CMS’ proposal to modify the standard for approving telehealth services that are not similar to currently covered services (called category 2 services). In the new standard, requestors will need to demonstrate clinical benefit rather than meeting the stricter requirement that the telehealth service be comparable to an in-person service. The AAMC believes this new standard will support appropriate expansions in the coverage of telehealth services.

**SUSTAINABLE GROWTH RATE**

Unless there is congressional action, physician fees will decrease 29.5 percent on January 1, 2012. The AAMC remains concerned with the projected negative update and supports a full
repeal of the SGR. We encourage CMS to work with Congress to revise the physician payment formula so that physicians will no longer face an annual negative update.

If you have any questions concerning these comments, please feel free to contact Mary Wheatley, Senior Specialist, at mwheatley@aamc.org or 202-862-6297 or Ivy Baer, Director and Regulatory Counsel, at ibaer@aamc.org or at 202-828-0499.

Sincerely,

Joanne Conroy, M.D.
Chief Health Care Officer

cc: Mary Patton Wheatley, AAMC
    Ivy Baer, AAMC