May 25, 2012

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

Dear Chairman Camp:

On behalf of the nation’s medical schools, teaching hospitals, and clinical faculty, I write to express our appreciation for your seeking input regarding how Congress might reform the Medicare physician payment system. The Association of American Medical Colleges (AAMC) is a not-for-profit association representing all 137 accredited U.S. medical schools; nearly 400 major teaching hospitals and health systems, including 59 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.

Medicare’s physician payment system needs to be replaced by a permanent, sustainable solution; however, the optimal approach has yet to be determined. Your letter sought feedback on rewarding physicians for cost and efficiency and alternative payment models. You also asked how best to engage patients and address regulatory relief. The AAMC notes that many of the new demonstrations and payment models currently are testing these concepts. In particular, the AAMC supports the efforts of the Medicare Shared Savings Program and Center for Medicare and Medicaid Innovation (CMMI) to test delivery models that enhance quality and efficiency, increase care coordination, lower health care costs, and improve our nation’s health. AAMC members actively are participating in new payment models including the Pioneer Accountable Care Organizations (ACO), the Medicare Shared Savings Program, and the Bundling Payments for Care Improvement initiative. In addition, academic medical centers received half of the HHS Health Care Innovation grants that were awarded. Each of these programs is in its infancy and should be given time to develop and be evaluated before Congress considers changes based on the concepts that they are testing. The goal should be the creation of a payment system that adequately compensates physicians based on such factors as the services provided, complexity of the patients served, and geographic area where the physician practices, while accounting for increased costs due to inflation.

In addition to testing new payment models, the Centers for Medicare and Medicaid Services (CMS) is implementing several pay-for-performance programs to increase the “value” of Medicare spending in the traditional Medicare fee-for-service payments. While the AAMC supports measuring the cost and quality of services provided, we are concerned that several technical issues related to the physician value modifier have yet to be resolved. Many private payers have implemented successfully pay-for-performance programs, but they do not work under the same constraints as CMS. For example, they are able to provide timely feedback reports, something that does not appear possible with CMS’s current data infrastructure. Additionally, these payers do not need to work within the budget neutrality constraints of the physician value modifier, and can provide “upside only” models that allow practices to be incentivized to meet certain cost and quality targets.
In contrast, the CMS physician value modifier is based on relative performance, which leaves open the possibility that a financial penalty can be imposed despite improved performance of a physician or group practice. This is particularly concerning for faculty physicians who care for sicker, more complex patients referred from other physicians in the community. Payment policies must not create incentives to abandon these medically vulnerable patients.

The AAMC and physician community have been working with CMS and our members to understand the current feedback reports that CMS has provided, yet the effect of different patient attribution, cost measurement, and benchmarks on performance results remains unclear. The current plan is for CMS to base the 2015 value-modifier on performance in calendar year 2013. We believe this performance period is premature, given the current methodology concerns. The AAMC urges Congress to take into account the numerous challenges related to this value modifier as it considers alternatives to the SGR update.

We also request that Congress address the many impediments that CMS must face to be able to implement changes successfully, including the fraud and abuse laws and anti-trust concerns. HHS, the Department of Justice, and the Federal Trade Commission have provided relief in both of these areas for participants in the Medicare shared savings program. Much of this relief was contingent on extensive monitoring and evaluation of patient care and transparency. Congress should consider ways to make such relief widely available.

Again, thank you for your leadership in attempting to address the long-standing problem of replacing Medicare’s physician payment system with a sustainable solution. The AAMC looks forward to working with you and Congressional leaders to find a way to provide physicians with a rational and predictable payment system that promotes efficiency, quality, and population health.

Sincerely,

Atul Grover, MD, PhD
Chief Public Policy Officer

cc: House Ways and Means Committee Members