



May 16, 2009

**Comments of  
The Association of American Medical Colleges (AAMC)  
to the  
Senate Finance Committee**

**“Transforming the Health Care Delivery System: Proposals to Improve Patient  
Care and Reduce Health Care Costs”**

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**Introduction**

The Association of American Medical Colleges (AAMC) thanks the Senate Finance Committee (SFC) for the opportunity to comment on its April 29, 2009 description of policy options, “Transforming the Health Care Delivery System: Proposals to Improve Patient Care and Reduce Health Care Costs.”

The AAMC is a not-for-profit association representing all 130 accredited U.S. and 17 accredited Canadian medical schools; nearly 400 major teaching hospitals and health systems, including 68 Department of Veterans Affairs medical centers; and nearly 90 academic and scientific societies. Through these institutions and organizations, the AAMC represents 125,000 faculty members, 75,000 medical students, and 106,000 resident physicians. The AAMC and its members are committed to improving the nation's health through medical education, research, and high-quality patient care. Together, our members provide approximately one-fifth of all clinical care in the country and over forty percent of hospital charity care.

The nation's teaching hospitals and medical schools applaud the SFC for its efforts to craft comprehensive health care reform legislation to improve the nation's health. We are pleased to see that the SFC's health reform objectives align closely with those of the AAMC, namely:

- Ensuring that affordable, transportable, and continuous health care coverage is available to all;
- Rethinking the delivery system to facilitate health promotion and disease prevention while providing high-quality, cost-effective care;
- Creating financing mechanisms that are sustainable, equitable, explicit, and accountable while promoting quality;

- Preserving the safety net for vulnerable populations until new alternatives are proven to be superior;
- Ensuring an adequate supply of health care practitioners that reflect the nation and its health care needs; and
- Continuing to advance discovery and innovation to support research and a “learning” health care system.

The AAMC hopes the SFC will incorporate the following comments as it moves forward in drafting specific policy proposals. Our comments reflect perspectives from our broad membership of physicians, hospitals, medical researchers, and the educators of the next generation of health professionals. We look forward to working with the SFC and other policymakers to ensure the best policies to achieve better health for the nation are enacted.

### **Establishment of a Hospital Value-Based Program (VBP)**

The AAMC has consistently partnered with others in the hospital community to improve the quality and safety of patient care. This includes collaborating with the American Hospital Association, Federation of American Hospitals and other hospital associations to establish a set of principles for the development and implementation of any type of performance-based payment system, which we have shared previously with the SFC. We continue to endorse the principles and believe they should be incorporated into any program proposal.

The AAMC supports the concept of aligning payment with the delivery of high-quality patient care, but given the complexity and magnitude such an approach, we encourage the SFC to continue moving forward cautiously, thoughtfully, and deliberately. The AAMC is pleased that the options paper proposes an incremental implementation of the program, and that it rewards both quality improvement and quality attainment.

The AAMC also is pleased that the SFC proposes to fund VBP initiatives through adjustments to the base MS-DRG amount and to exclude indirect medical education (IME) add-on payments, which are a vital source of support for the unique missions of teaching hospitals. Additionally, the AAMC believes that the withhold pool should affect only the payments for MS-DRGs that are related to quality measures and not all MS-DRGs.

The AAMC recommends that no more than 1% of hospital payments be used to reward performance, particularly since the proposed approach is untested and unproven (The Medicare Payment Advisory Commission (MedPAC) has made a similar recommendation). Given the successful experience of the hospital quality reporting program, we believe that a 1% maximum level is sufficient to incentivize hospitals. Similarly, since this is a new program it should be implemented in a budget neutral manner. Program savings should be returned to hospitals to support ongoing quality improvement efforts to achieve improved health outcomes.

All hospitals should be eligible and have equal opportunities to receive incentive payments beyond the portion of money withheld to fund the program. Likewise, the formula to determine the incentive payments should be based on actual, not relative, performance; similar to what was in the HHS report on VBP submitted to Congress. Relative performance could potentially disadvantage many hospitals as well as make it more difficult for hospitals to be able to determine their incentive potential.

In addition, as stated in the hospital community's principles, the AAMC believes that any VBP program should align incentives across all provider groups in a way that encourages broad and unified efforts to improve patient care. The program must account for the differences in patient populations served by hospitals and ensure no bias or disadvantage. It should utilize evidence-based, NQF-endorsed and HQA-approved measures that are developed in an open and transparent process. Measure selection should be in consultation with key stakeholders, including the Hospital Quality Alliance.

### **Physician Quality Reporting Initiative (PQRI) Improvements and Requirement**

The AAMC supports the efforts of the American Board of Medical Specialties to make the certification process more robust through Maintenance of Certification (MOC). We expect this effort to yield positive results over time; however, the process requires more study and evaluation. It is important to seek an alignment of the MOC practice assessment process and physician quality reporting so that the process is seamless and not overly burdensome to physicians. The Secretary should also explore criteria for physicians who are not engaged in MOC activities (e.g., the American Medical Association's Performance Improvement-CME process).

The AAMC strongly supports the establishment of a PQRI appeals process and the provision of "feedback reports" in a timelier manner. Currently, feedback reports are published more than six months after the most recent date of services and include services up to 18 months prior to the report date. Improving the timeliness of feedback will accelerate meaningful performance improvement as well as participation rates of physicians in PQRI.

While the AAMC believes PQRI reporting incentives should be extended, we also believe it is premature to impose penalties for non-reporting physicians. Rather, CMS should evaluate program participation to understand why certain professionals are not reporting, and work to remove possible barriers to participation. The AAMC believes that no penalties should be imposed if fewer than 85% of eligible professionals participate. The PQRI program is still relatively new; in the program's first year (2007), only 16% of qualified professionals actually submitted data. The 2008 PQRI participation rates have not yet been published, though it seems unlikely that the rates will approach the 85% mentioned in the options paper, or that such participation levels would be achieved in the next few years.

## **Transparency and Evidence-Based Decision-Making for Imaging Services**

The AAMC supports the SFC's goal of providing transparency to patients. We ask that a study be conducted to determine the effect that this disclosure requirement has on self-referrals for these imaging services, with a focus on whether services are reduced and cost savings ensue.

## **Hospital Readmissions and Payment Bundling**

In general, the AAMC agrees that the current payment system lacks incentives for coordinating services across the continuum of care. As stated in the AAMC health reform principles, an "improved delivery system should help enable professionals to provide coordinated patient-centered care—including medical homes ...." While we believe such coordination is crucial to providing high quality, efficient care, it remains unclear as to how the readmissions and bundling proposals contribute to such a goal. The AAMC strongly urges the SFC to permit the health care community to conduct careful analyses and modeling of these proposals before moving forward. Such analyses will require access to additional CMS data. For example, at this time it is essentially impossible to obtain the Medicare data needed to calculate hospital readmission rates.

### ***Readmissions***

Hospital readmissions are complex, system-wide occurrences that involve multiple caregivers. We agree that to the extent a readmission policy is implemented, it should be a temporary solution; additional deliberation of coordinated policies is still needed to achieve high value care. Given that the readmissions policy option currently affects only hospitals, we believe consideration should be given to examining whether 7 day readmission rates would be more appropriate. The greater the length of time between the initial discharge and the readmission, the more likely it is that issues beyond the control of the hospital are responsible for the readmission.

Public policies seeking to reduce readmissions should focus exclusively on certain types of unplanned readmissions that are related to the initial admission; and where there are evidence-based approaches or actions that hospitals can take to prevent the occurrence of the readmission.

The AAMC commends the SFC for acknowledging that certain conditions should be excluded. These conditions should be identified using currently available administrative data. In addition to cancer, burn and trauma care, and scheduled surgeries, which the SFC option paper identified as not "potentially preventable", there are other readmissions that should explicitly be excluded from a readmission policy, including those associated with psychoses and other mental illnesses, maternity and neonatal admissions, and those related to end-stage renal disease.

Our data analyses, using a subset of our teaching hospital members, show significant differences in readmission rates depending on severity levels: more severe cases have higher readmission rates. Accurately measuring severity levels is critical to understanding

readmission rates and ensuring that hospitals treating a higher proportion of complex cases (e.g., teaching hospitals) are not unfairly disadvantaged.

The AAMC also believes strongly that the readmission rates should, in some manner, account for the socio-economic status of patients, and/or whether they are dually eligible for Medicare and Medicaid. Failing to recognize the higher readmission rates for such patients (as identified by MedPAC and others) unfairly penalizes teaching hospitals and other safety net institutions that serve disproportionately large numbers of low-income patients.

While there is agreement that more can be done to reduce readmissions, it also is important to ensure that the financial penalty does not provide an incentive for hospitals and practitioners to delay needed readmissions or produce other unintended consequences for the most vulnerable patients in our communities.

### ***Bundling***

Conceptually, payment bundling has the potential to improve care coordination. However the concept must be more fully tested (e.g., voluntary demonstration projects) and defined before being fully implemented. The current Acute Care Episode Demonstration Project is too limited to provide the necessary information to ensure the success of such a program. Moreover, it is important that any payment bundling encompass all aspects of care provided during the episode and that equitable payments are made to the various providers (e.g., physicians) whose services comprise the bundle.

We also have concerns that the proposed option states that the “bundled payment amount would be adjusted to capture savings from the expected efficiencies gained from improving patient care and provider coordination.” While we believe that ultimately savings may be possible, it is unclear, and unlikely, that such savings can be achieved immediately. If bundling were to be implemented, it would be a sea-change from the current system with many potential unintended consequences. Initially, the focus should be on patients and ensuring that this change improves their care.

We also urge Congressional action to release the Medicare claims data and other relevant information necessary for hospitals and others to analyze bundled care. Such efforts will provide the information needed to develop a greater understanding of the services and costs related to care episodes, and will support efforts to improve health care delivery.

Finally, the AAMC supports the SFC’s proposal to address existing legal and regulatory barriers that hospitals, physicians, and other providers face when attempting to better coordinate care.

### **Medicare’s Sustainable Growth Rate (SGR) for Physician Payments**

The AAMC supports a full repeal of the SGR. We encourage Congress to replace the SGR with an update methodology that links physician updates to the Medicare Economic

Index (MEI) or another inflationary index that accurately reflects the cost of providing care to Medicare beneficiaries.

While the AAMC appreciates that the SFC policy options include 1% positive update for Calendar Years (CYs) 2010 and 2011, we are very concerned that this option does not provide a long-term, stable, predictable, and sustainable solution to the problematic SGR methodology. Clinical revenues generated by medical school faculty group practices (including Medicare payments) account for 38% of total medical school funding, and are therefore vital sources of support for the educational, research, and patient care activities at medical schools. As the nation faces a growing physician shortage, stable and predictable funding for medical schools is more vital than ever to ensuring an adequate supply of physicians for Medicare beneficiaries.

The AAMC supports a gradual transition to new physician payment models that could improve efficiency, care coordination, and high quality care. The models need to be thoroughly tested and evaluated in a variety of settings, including academic medical centers.

### **Medicare Shared Savings Program (i.e. Accountable Care Organizations)**

The AAMC believes that Accountable Care Organizations (ACOs) have the potential to both improve patient care and achieve efficiencies. Currently, however, this idea remains largely conceptual. We believe widespread testing of this concept is needed. If structured appropriately, academic medical centers (which include teaching hospitals and large multi-specialty physician practices) could serve as the core of an ACO.

A key issue meriting further exploration is whether focusing on Medicare beneficiaries alone is enough to trigger the transformational changes necessary to truly align incentives and improve synergies across the health care system. Also, a robust health information technology system is critical to the success of the ACO concept.

As with bundling, while we believe that savings can ultimately be achieved with a corresponding increase in patient quality, it is unclear whether savings can be achieved immediately. We believe there may be a need for additional funding, or at least level funding, at the start of this program for planning and implementation purposes.

### **Health IT**

#### ***Encouraging Health Information Technology Use and Adoption in Support of Delivery System Reform Goals***

The AAMC supports expanding the eligibility for electronic health record (EHR) incentives to nurse practitioners and physician assistants who practice in settings outside a physician office. The Association also supports providing additional health IT incentives to other health care providers to support care coordination and quality improvement goals.

### ***Improving Quality Measurement***

The AAMC supports the SFC proposal for improving quality measurement. The proposal provides necessary funding to support, enhance, and preserve the current quality measurement framework.

### **Comparative Effectiveness Research**

The AAMC applauds the SFC's interest in Comparative Effectiveness Research (CER) and its recognition of the importance of input from a broad range of stakeholders relevant to setting priorities for this research. The problems of cost and quality that beset our health care delivery system do not lend themselves to easy solutions. The AAMC believes that sustained new investments in comparative effectiveness and health services research will be key to discovering the solutions to the nation's health care crisis.

The AAMC strongly supports further research to inform clinical care delivery and the development of delivery system reforms. Physicians and others must treat patients on a daily basis for whom no relevant clinical trials exist that fully capture the conditions and preferences of single individuals. Further investment in clinical information useful to clinician and patient decision-making must be developed alongside the research which will inform the systems and processes which facilitate high quality patient-centered care. In addition to CER, research on knowledge translation, patient engagement, and health system transformation are key to converting biomedical discoveries into effective new approaches to the diagnosis, treatment, and prevention of human illnesses.

The AAMC also sees the further development of research methods in CER as an important national priority. Another high priority is expanded research training in the disciplines relevant to CER. Such investments are greatly needed to enhance the skill, supply and diversity of the research workforce. AAMC also sees the further development of the national research infrastructure for CER as important to the success of this initiative.

The AAMC strongly supports developing and using CER through means that are synergistic with continued discovery of clinical innovations through biomedical science. In this exciting era of burgeoning discoveries in the health sciences (such as genomic medicine) it is essential to advancing the health of the public that we continue to apply the discoveries in biomedical science to enhance patient care. Simplistic applications of CER could stifle new discoveries and limit the benefits from ongoing US investments in biomedical science. A robust culture of discovery spanning all the health care sciences, including biomedical, translational, comparative effectiveness, and health services, will be needed to create a sustainable system that can advance the health of all Americans

### **Transparency: Physician Payment Sunshine**

The AAMC supports the SFC's policy option regarding greater transparency in the relationships between physicians and manufacturers of drugs, devices, biologicals, and medical supplies. As recommended by MedPAC, the SFC's policy option distinguishes

between industry payments made directly to physicians, versus payments made to hospitals, medical schools, and universities for sponsored research (including clinical trials).

### **Physician-Owned Hospitals**

The AAMC supports the SFC policy option to ban physician self-referrals to limited-service hospitals, with limited exceptions for existing facilities that meet strict investment and disclosure rules.

### **Workforce**

We applaud the SFC's recognition that the health care workforce must be expanded to address current physician shortages, particularly if coverage is expanded to currently uninsured Americans. The proposed redistribution of unused Medicare-supported Graduate Medical Education (GME) training slots represents a small first step in increasing physician supply. However, the proposed redistribution is unlikely to produce more than a few hundred additional physicians annually, and falls short of what is needed to address a projected shortage of over 100,000 physicians in multiple specialties.

The AAMC strongly urges the SFC to include in any health reform legislation the language included in the AAMC-supported "Resident Physician Shortage Reduction Act" (S. 973/H.R. 2251). Introduced by Sens. Nelson (D-FL), Schumer (D-NY), and Majority Leader Reid (D-NV), the bill makes a more comprehensive and significant investment in physician training by adding 15% more Medicare-funded GME positions. Since the Balanced Budget Act of 1997, Medicare has been severely restricted in the level of support it can provide for physician training and the unique clinical training environment maintained by teaching hospitals. This, in no small part, has contributed to physician shortages across the nation, particularly in primary care.

The AAMC applauds the SFC's recognition of, and proposals to address, the many regulatory barriers to placing residents in non-hospital locations for portions of their training. Provisions in S. 973/H.R. 2241 similarly address these issues.

With regard to proposals for a workforce commission, the AAMC agrees that the nation must do more to develop an effective workforce strategy that identifies and accounts for future health care needs. We strongly urge continued and expanded support for current programs and entities authorized under Title VII, which collect and analyze data, identify priority workforce needs, disseminate this data and information widely and encourage effective workforce development. These programs have been unfunded or underfunded for nearly a decade. It is particularly important to provide adequate resources to the Health Resources and Services Administration (HRSA) which is already responsible for the identification of workforce needs, as well as workforce development programs such as Titles VII and VIII and the National Health Service Corps.

## **Provider Screening**

The AAMC is concerned about the following proposals regarding provider screening:

- It is unclear how the Secretary will be able to establish a timely and equitable system to assess the risk of a provider's noncompliance with statutory and programmatic requirements, while at the same time avoiding unreasonable delays in the granting of billing privileges.
- Providers may not be aware that they had previous affiliations with enrolled entities that have uncollected Medicare and Medicaid debt, so they should not be required to report this information; or alternatively, they should not be penalized for failure to report the information if it would not be reasonable for the provider to know about it.
- Enhanced oversight—such as prepayment review and payment limitations for 6-12 months imposes an extraordinary burden to which new providers should not be subjected. Enhanced oversight should only be targeted at providers for whom there is a reason to believe that it is warranted. Consideration should be given to whether enhanced oversight could be acceptable if it is targeted at re-enrolling providers for whom there is evidence that such oversight is justified. To select new providers without cause may result in fewer providers being willing to participate in Medicare and Medicaid.
- HHS should not have the blanket authority to impose a moratorium on the enrollment of new providers as determined to be necessary to prevent or combat fraud. Any moratoria should be targeted at providers, or classes of providers, where there is ample evidence to suggest that they may be engaged in fraudulent activity.

## **Data Base Creation and Data Matching**

As envisioned in this proposal, the “One PI” database would contain an extraordinary amount of information that could prove helpful, and having it in one place may be very useful. However, CMS already is charged with an enormous number of challenging tasks and may well be responsible for even more as health care reform is enacted. The AAMC is concerned that CMS may not be the best agency to establish and maintain the database. HRSA already maintains the Healthcare Integrity and Protection Data Bank and National Practitioner Data Bank, and thus may be better positioned for this task.

## **Provider Compliance and Penalties**

The AAMC opposes requiring compliance programs as a condition of participation. When the Office of Inspector General (OIG) published the first compliance guidance in 1998, it was careful to state that this was part of its effort to “promote voluntarily developed and implemented compliance programs.” In the years since, teaching hospitals, faculty practice plans, and other providers have embraced the notion that they must have robust compliance plans, and that implementing them is, as the OIG stated, “designed to establish a culture.” The OIG also emphasized that there is “no single ‘best’ hospital compliance program, given the diversity within the industry.” Without evidence

that allowing voluntary adoption of compliance plans has resulted in a widespread failure, plans should not now be mandated for all providers. If certain sectors of the health care industry have not embraced compliance, then it may be reasonable to target this type of requirement to them. Additionally, to make compliance plans a condition of participation could have the effect of reducing the flexibility that each entity has in instituting a plan that works best for it.

The AAMC also objects to the notion that payments could be suspended during an investigation. This suggests that an entity or individual under investigation is assumed to be guilty even before the investigation is completed.

Finally, the AAMC is unclear about why there is a need to increase the penalties for violations of EMTALA. Absent evidence that EMTALA violations are increasing, or are becoming more egregious, the current penalties are sufficient.

The AAMC appreciates the commitment of the SFC to improving health and health care and appreciates the opportunity to share these comments as the nation works towards thoughtful, effective policies that minimize unintended consequences. We look forward to working with you to ensure that meaningful health care legislation is enacted this year.

A handwritten signature in black ink, appearing to read 'Atul Grover', with a stylized flourish at the end.

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