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President and Chief Executive Officer

August 26, 2009

Ms. Charlene Frizzera  
Acting Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Room 445-G, Hubert H. Humphrey Building  
200 Independence Avenue, SW  
Washington, DC 20201

Submitted electronically at: <http://www.regulations.gov>

**Re: CMS-1431-P, *Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2010; Proposed Rule; 74 Fed. Reg. 33520 (July 13, 2009).***

Dear Ms. Frizzera,

The Association of American Medical Colleges (AAMC) is a not-for-profit association representing all 131 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 128,000 faculty members, 75,000 medical students, and 110,000 resident physicians. The Association appreciates the opportunity to comment on The Center for Medicare and Medicaid Service's (CMS's) proposed physician fee schedule for 2010 and other issues raised in the proposed rule.

The rule contains many proposals, but our comments focus on the issues most relevant to academic medicine:

- Payment changes for teaching anesthesiologists and certified registered nurse anesthetists (CRNAs);
- The elimination of consultation codes; and
- Group report requirements for the Physician Quality Reporting Initiative (PQRI) and E-prescribing incentive programs.

## **Sustainable Growth Rate**

AAMC applauds CMS for using its administrative authority to remove physician-administered drugs from the definition of physician services for purposes of the SGR update. This is a change that the AAMC and physician community have long supported.

The AAMC remains concerned with the projected negative 21.5% 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.

## **Payment for Teaching Anesthesiologists and CRNAs**

The AAMC strongly opposes CMS's proposal regarding payment when a teaching anesthesiologist is involved in two concurrent resident cases. Finalizing the rule as proposed will be contrary to the statutory intent as it will impose an impediment to allowing teaching anesthesiologists to be paid 100% of the fee schedule amount for two concurrent cases in which a resident is involved.

Under the CMS proposal, a teaching anesthesiologist must be present during all of the key or critical portions of the procedure, though another teaching anesthesiologist with whom the teaching anesthesiologist has an arrangement could be immediately available to furnish service during a non-critical or non-key portion of the procedure. The agency supports this choice by saying that it is "the most logical reading of the statute and would be consistent with the way the teaching surgeon payment policy is applied for overlapping surgical cases."

Voicing concerns about quality (though acknowledging that there are no data to support these concerns), CMS has rejected the notion of allowing multiple handoffs among teaching anesthesiologists during a case involving a resident. A 1982 article by Jeffrey Cooper, et al, that is still cited today, *Critical Incidents Associated with Intraoperative Exchanges of Anesthesia Personnel* (*Anesthesiology*, 56:456-461) examined the effects of hand-offs among anesthesiologists. While acknowledging some limitations of the data, the authors concluded that "overall, relieving anesthesiologists do more good than harm even setting aside the other potential benefits of relief on vigilance and morale." For example, one of the benefits of hand-offs is "the 'second opinion' offered from the perspective of a fresh anesthesiologist."

While the proposal provides parity between teaching surgeons and teaching anesthesiologists, it does not acknowledge that physicians in these two specialties practice medicine differently. As CMS notes, "[t]he ASA has informed us that teaching anesthesiologists who work in the same anesthesia group sometimes provide different part of the key or critical portions of a single anesthesia procedure." In fact, this is a

common practice among anesthesiologists, and it is critical that anesthesia residents learn the optimal way in which these hand-offs occur. **Therefore, the AAMC strongly urges CMS to finalize the second option that was considered. This option would permit different anesthesiologists in the same anesthesia group to be considered “the teaching physician” for purposes of being present at the key or critical portions of the anesthesia case. This option not only provides a logical reading of the statute, but also acknowledges the way in which teaching anesthesiologists routinely practice medicine.**

### **Consultations**

CMS has proposed that consultation codes (except for telehealth) be eliminated and replaced with an office visit or initial hospital and facility visit codes and that the work RVUs for the visit codes will be increased. As will be discussed in detail below, the AAMC strongly opposes this proposal because:

1. It fails to adequately compensate physicians for consultations, a service that is widely recognized, and has a particular meaning in the medical community that is separate from other evaluation and management services.
2. It will be administratively burdensome to implement.

In 2006 AAMC and 50 other societies and organizations wrote to CMS requesting revisions to the consultation and transfer of care policy and suggesting language that we believed would clarify the areas of confusion. The agency never responded. Two years later, a second letter was sent to CMS that asked the agency to instruct all contractors to refrain from audits of visits that were billed as consults due to the continuing confusion about the correct billing of these services. Rather than respond to either of these letters, the Agency concluded in the current proposed revisions to the fee schedule that “[r]egardless of all of our efforts to educate physicians on Medicare guidance or documentation, transfer of care, and consultation policy, disagreement in the physician community prevails.” The AAMC asks that rather than eliminating consultation codes, CMS respond to the issues identified in the letter.

#### *Consultations are not equivalent to other evaluation and management (E/M) services*

According to CMS, physician work associated with both inpatient consultation and office/outpatient consultation is “clinically similar” to the corresponding visit codes, with the difference being the additional documentation requirements for consultations. Consultations, especially those at level 4 and 5, require medically complex decision-making and are requested when the primary physician needs an additional opinion and/or specialized knowledge and expertise. Unlike other E/M services, a consult involves not only physician-to-patient communication, but also communication from the consultant to

the referring physician. It also requires the physician to digest a large amount of information, possibly including records from multiple physicians and results from multiple tests, and may involve the ordering of additional tests and analysis of the results. CMS contends that because the requirements for documenting consults have been eased, the effort of preparing a report to the referring physician requires little or no additional work than is required for the documentation of other E/M services. CMS does not have objective data to determine whether consults and visits are clinically similar, nor does it acknowledge the additional complexities of effectively communicating with other physicians.

The data in Table 1 show that academic physicians provide proportionately more level 5 Medicare inpatient and outpatient consultations than Medicare physicians overall. Academic physicians often receive requests for consults for complex cases because they have expertise in areas in which few other physicians are knowledgeable. The data show that on the outpatient side, 25% of consultations done by academic physicians are at level 5, compared to 17% for all of Medicare. Similarly, approximately 29% of initial inpatient consults billed by faculty practices are level 5 compared to 24% for all Medicare physicians. These data in this table may understate the differences in consults between academic and non-academic physicians because academic physicians are included in the total Medicare numbers.

**Table 1: Distribution of Selected Consultation Codes in Medicare Part B FFS Overall Rates versus Academic medicine**

	All Medicare Part B FFS	Academic Medicine Professionals Billing Medicare Part B FFS
<b><i>Outpatient Consults</i></b>		
99243	38%	29%
99244	46%	38%
99245	17%	25%
Total number of allowed services	13,424,117	1,063,448
<b><i>Inpatient Consults</i></b>		
99253	27%	31%
99254	49%	40%
99255	24%	29%
Total number of allowed services	11,954,296	604,722

Source: Part B Physician/Supplier Nation Data – CY 2007; Top 200 Level 1 Current Procedural Terminology (HCPCS/CPT) Codes; <http://www.cms.hhs.gov/MedicareFeeforSvcPartsAB/Downloads/Level1SERV07.pdf>; AAMC analysis of UHC-AAMC Faculty Practice Solutions Center 12 months of data from 2007-2008. Data restricted to most commonly reported consultation codes (levels 3-5).

Academic medical centers provide a disproportionate share of the specialty and subspecialty professionals for the community. Eliminating the current, separately recognized payment for consultation services will have a disproportionate impact on these institutions. Academic medical centers often are safety net providers for the under- and uninsured. Asking them to bear the additional costs inherent in consultation services without appropriate reimbursement will further stretch this critical community resource.

### *Implementation Issues*

As long as consultation codes remain in the CPT manual and are used by other payers to describe this type of service, Medicare's elimination of consultation codes will be extremely difficult to implement. For example, coordinating payments with non-Medicare payers where one payer recognizes consultation codes and the other does not will become more complex. If the effect of the Medicare rule is that physicians always need to bill for the lower-cost visit code, even when Medicare is not the primary payer, then the financial impacts effectively extend beyond the Medicare fee schedule. At a time when the US is trying to improve administrative efficiencies, CMS should not adopt a policy that not only diminishes payment, but hampers coordination across different payers.

CMS recognizes that a patient may require more than one consult. On the inpatient side, CMS addresses the issue of multiple inpatient consults by proposing the admitting physician to use a modifier; however, the mechanism of using code-modifiers is cumbersome and prone to error. It may result in either the attending physician or the consultant losing reimbursement for their services, or having to spend administrative time to appeal erroneous decisions.

Eliminating consults in the outpatient side will cause other unintended coding inaccuracies. In a faculty practice, it is common for physicians in the same department to have very different areas of expertise. Therefore, it would not be unusual for two or more physicians who ostensibly share the same specialty to provide a patient with a consultation within a short period of time. Currently the rule is that if a patient has been seen by another member of a group within the last three years, a visit to a practitioner in the same group would have to be coded using a return patient code. Given current E/M guidance, if outpatient consultation codes are eliminated, then an interventional cardiologist in the same group as the general cardiologist would have to bill for an established patient visit, thus receiving inadequate compensation for work that is at the same level as an initial patient consult. At a national level, 2009 total RVUs for a level 5 office consult at a non-facility setting is 6.08, while it is only 3.46 total RVUs for an established patient visit. Even when the visit codes are adjusted for budget neutrality, the consulting physician will not receive the appropriate payment for the work provided.

The agency states that “documentation requirements are now similar across all E/M services.” If CMS adopts the proposal to eliminate consultation codes, will the agency eliminate other requirements for consultations (e.g., a request for consultation, render opinion, written report)? If the answer is yes, this could inadvertently reduce communication between physicians and potentially impact the quality of care if the referring physician does not receive information about the consultation. If CMS adopts its proposal, it is essential that the agency promptly provide clear guidance on these types of issues. Without such guidance, physicians may be subject to confusion when they are audited, including being subjected to requests for repayments because the initial hospital care or new patient care billing did not support “consultation.”

Although CMS may have concluded that the term “consultation” does not fit well into the fee schedule billing construct, it remains a term-of-art in the medical community and will continue to be used and have a specific meaning. In the most basic terms, it describes what happens when one physician (or other provider) asks another physician (or other provider) to see a patient and render an opinion and/or recommendation because the referring physician did not have the necessary expertise to do so. The use of new or established visit codes does not adequately describe the essence of a consultation service. The problem is not, as characterized by CMS, that “the physician community disagrees with Medicare interpretation and guidance for documentation of transfer of care and consultation.” The problem is that the guidance and interpretations do not reflect the way in which consultations are performed. **A solution that is preferable to pushing consultations into an ill-fitting box—and one that will not adequately compensate physicians for the services they provide to Medicare beneficiaries—is to revise the RVUs for consultation codes through a consensus-driven process and then work with the provider community, as has been requested over the past several years, to develop clear guidance about when and how to use these codes.** In the meantime, the AAMC again requests that CMS instruct its contractors not to audit consultation services, as the way in which these codes should be used and documented remains unclear.

### **Practice Expense RVU proposals**

The AAMC agrees with CMS that all RVUs should be calculated based on the best and most recent data available. At the same time, the Association appreciates that this may mean that some specialties will have to absorb sometimes sharp payment decreases during a difficult economic time.

#### *Utilization rate for equipment costing more than \$1,000,000*

The AAMC is concerned about the proposal to change the utilization rate assumption for equipment costing more than one million dollars from 50 percent to 90 percent. To

support this proposal, CMS references work done by the Medicare Payment Advisory Commission (MedPAC), which analyzed CT/MRI utilization in six markets, but fails to note that in its March Report to Congress MedPAC acknowledged that the study is not nationally representative. While MedPAC recommended changing the utilization rate for “expensive imaging equipment,” it also stated that Section 4605 of the BBA, requires the Secretary to “use actual data on equipment utilization and other key assumptions...” The AAMC feels that by proposing this change without using actual data on equipment utilization and other key assumptions, CMS may have exceeded its statutory authority.

Even if CMS believes that the studies cited by MedPAC are sufficient to fulfill the statutory requirement, the agency has nonetheless made a proposal that is far broader than is merited by the MedPAC recommendation. MedPAC focused on expensive imaging equipment; however, CMS has expanded the MedPAC findings and applied them to all equipment costing more than \$1 million. **If CMS adopts a higher usage rate for equipment costing over \$1million, it should be limited to the equipment studied by MedPAC until such time as CMS provides data supporting the application of this assumption to equipment that was not covered by the MedPAC study.**

### **Malpractice RVU proposals**

The AAMC commends CMS for its detailed review of malpractice RVUs. In particular, the Association supports the CMS proposal to use the risk factor of the dominant specialty for rarely billed Medicare services.

### **Physician Quality Reporting Initiative (PQRI)**

In general, the AAMC supports having the most flexible reporting process possible for PQRI. The AAMC is pleased that the 2010 PQRI program will include a group reporting option and data submissions from EHRs (should the testing be completed in time). We encourage CMS to continue to offer and refine these options in future years and would be pleased to work with you to make improvements. Our concerns with specific proposals are described below.

#### *Electronic Health Records (EHR)*

The AAMC is pleased that if testing concludes positively, PQRI reporting will be expanded to include EHR data submission. We believe CMS should continue this work and make every effort to align future PQRI EHR data submission with the definition of “meaningful use” that will be used to determine whether eligible providers qualify for an incentive for EHR adoption, as per the American Recovery and Reinvestment Act (ARRA). To help professionals assess whether or not the EHR option would be available to them, CMS should publish as soon as possible the results from the current testing. This

is especially critical, as CMS is proposing to only accept EHR reporting for 12-month reporting period that would start January 1, 2010.

*Transitioning from claims-based reporting*

The AAMC agrees that PQRI should eventually transition from claims-based to other reporting mechanisms, particularly as ARRA HIT incentives encourage adoption of electronic health records. We also understand the difficulties that claims-based submissions pose for the Agency; however, at this time CMS should be making every effort to encourage PQRI participation by as many providers as possible. **The AAMC believes that claims-based reporting continues to be an important reporting mechanism and that it is premature to consider transitioning away from claims based reporting after 2010.**

CMS stated that limiting the claims-based reporting options after 2010 is contingent upon the availability of an adequate number of registries and/or EHR reporting options. While the number of qualified registries more than doubled from 2008 to 2009, not all registries report all measures. In addition, some registries are not open to all eligible professionals or require a participation fee. EHR data submission is currently being tested. Even if EHR vendors are able to successfully complete testing for 2009, EHR data submission would only be available for a limited number of measures. In addition, it is not certain that all clients of the EHR vendor would be able to submit data, particularly if a practice needs to make modifications to its EHR implementation (such as adopting new code sets.)

Claims-based reporting has limitations, but it is available to all practices. It also must be recognized that the early participants in PQRI have invested in workflow changes to enable claims-based reporting. They will need sufficient time to transition to other reporting mechanisms. The AAMC urges CMS to continue to monitor the types of reporting mechanisms that are used, and to work with the provider community to determine the best timing and optimal approach for moving away from claims-based reporting.

*Measures groups and minimum patient reporting size*

The AAMC strongly supports CMS's proposal to simplify the reporting requirements for measures group reporting by removing the consecutive patient requirement. The AAMC also agrees that it is reasonable to require a minimum sample size of 15 patients for at least one measure during a twelve-month reporting period (or a minimum of 8 patients for a 6-month reporting period, when reporting through alternative measures such as measure groups or registry reporting.) The sample sizes will help ensure that professionals report often enough to be accurately measured.

To maintain reporting integrity, CMS should routinely analyze data at the end of the reporting period. It is important to ensure that the new reporting criteria for measures group reporting do not inadvertently provide incentives for physicians to cherry pick the patients on whom they report.

### *Group reporting*

The AAMC is pleased to see the group reporting option, as required by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), included in the 2010 PQRI. Group reporting has many benefits, including providing groups with incentives to invest in systems that focus on high-cost diseases (diabetes, congestive heart failure, and coronary artery disease) as well as preventive care measures.

CMS has taken the logical step of initially basing the group reporting process on the Physician Group Practice (PGP) and Medicare Care Management Performance (MCMP) demonstrations. We believe restricting groups to 200 professionals simplifies the modifications for PQRI reporting, but we ask CMS to consider whether in the future smaller group sizes should also be allowed to participate in this option.

The AAMC is disappointed that CMS has not used its proposal to address limitations in the patient assignment methodology that have been identified by these demonstrations. Correct patient assignment is a key to implementing a system that measures physician quality performance. While there is no easy way to accurately assign patients, methods other than the one proposed by CMS may be preferable. We urge CMS to consider revisions to the proposal regarding patient assignment before the group reporting option is finalized.

The current methodology, based on plurality of E/M allowed charges, results in a number of inaccurate assignments. While CMS has attempted to account for these inaccuracies by oversampling the patients from which 411 are selected, it would be preferable to employ a more precise methodology. Work by Dr. Pham, et al, illustrates that Medicare patients see a variety of physicians in different practices and describe problems attributing care based on claims data.

(N Engl J Med 2007;356:1130-9) According to the article “[t]ypically, beneficiaries see many physicians, and no more than half their visits are with physicians or practices to which they would be assigned under current pay-for-performance models.” This may occur more frequently for academic medical centers, because many are referral centers for complex patients needing specialized care.

The AAMC has contacted participants in the current PGP demonstration who mentioned many errors in patient attribution, especially when patients have co-morbidities that

would put them in one of the disease categories. Patient assignment should be based on the assumption that if a patient is assigned to a physician then that physician and his/her organization will have primary responsibility for the care of that patient. This would avoid a situation where, for example, a patient being treated for cancer might become part of the diabetes cohort because of a secondary diagnosis. One possibility is to refine the patient attribution methodology to limit the E/M visits to primary care physicians and selected other specialists, such as endocrinologists and cardiologists, who frequently provide and coordinate care for Medicare beneficiaries. CMS should analyze possible refinements to the patient attribution methodology and implement them as soon as possible.

We support using the data collection reporting tool that has been tested through PGP and want to ensure the patient selection is done correctly. Currently, PGP demonstrations wait several months for their pre-populated database. CMS is proposing to have the pre-populated results to the group practices by the year end, just two months after the patient selection period (January 1- October 29, 2010) has ended. The Association applauds this quick turnaround, but is concerned about whether CMS can meet its own deadline and still maintain data accuracy.

Due to the concerns about the new group reporting option, the AAMC suggests that CMS allow groups the flexibility to decide, at any stage in the process, whether they want to continue with the group reporting process. Because it may not be possible for a group to make this decision until relatively late in the reporting year, individual eligible professionals within the group should be allowed to concurrently continue individual reporting. We recognize that double payment cannot be allowed, so that eligible professionals within a group practice that receives a PQRI incentive payment cannot receive separate individual incentives. However, if a group decides not to participate or is unable to complete the group submission, individual eligible professionals should remain eligible to receive an individual incentive payment.

*Public reporting of performance data as a condition for group reporting*

**The AAMC requests that CMS withdraw its proposal for public reporting of group practices' PQRI performance rates.** When Congress established a quality reporting program for hospitals and ambulatory surgery centers (ASCs) under the Tax Relief and Healthcare Act of 2006 (TRHCA), it specifically granted the Secretary of HHS the authority to “establish procedures for making data submitted under [the quality reporting program] available to the public.” We appreciate CMS’s desire “to move toward [the] goals of making information on physician performance publicly available”(74 Fed. Reg. 33589), but Congress has not provided such authority for the PQRI. MIPPA requires reporting of the names of the eligible professionals (or group practices) “who satisfactorily submitted data on quality measures under this subsection” and of those

individuals and groups “who are successful electronic prescribers.” We believe that requiring the reporting of performance rates—as opposed to reporting of those who satisfactorily submitted data—far exceeds the authority that was granted by MIPPA. Even if CMS does not withdraw its proposal, the AAMC believes that implementing it at a time when the group reporting option is in its infancy is premature and will serve to discourage groups from using that option.

CMS acknowledges in the proposed rule that an important aspect of a quality reporting program is that physicians (and other eligible professionals) have the opportunity to review their data on reporting rates on PQRI quality measures. We strongly agree. The agency must allow groups to review data—both their individual data and comparative benchmarks—before it 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.

If done correctly, public reporting has the potential to help provide appropriate and accurate information to patients. There remain, however, several critical issues that must be resolved before public reporting provisions can be implemented. There must be a method for ensuring that any publicly reported information is: (i) correctly attributed to those involved in the care; (ii) appropriately risk-adjusted; and (iii) accurate, user-friendly, relevant and helpful to the consumer/patient. CMS must educate consumers/patients about the publicly reported performance measures and corresponding benchmarks. Only in this way will it be possible to evaluate the information in a meaningful way.

The public reporting issues identified by CMS in its Issue Paper: *Development of a Plan to Transition to a Medicare Value-Based Purchasing Program for Physician and Other Professional Services* should be addressed in a thoughtful manner before any public reporting occurs. Finally, after CMS addresses these issues, public reporting should be applied to all participants of PQRI, not just those who want to participate in group reporting.

The public reporting proposal may create a barrier to group practices’ willingness to participate in the group reporting option. Practices will be concerned that data are inaccurately portrayed and may not be correctly understood. **Given the concerns described above, the AAMC recommends that as authorized by MIPAA, public reporting at this time should be limited to the names of those individuals and groups that have satisfactorily submitted data on quality measures.**

## **E-prescribing**

The AAMC is pleased with the proposal to simplify e-prescribing. A preliminary analysis of 2009 e-prescribing participation in the UHC-AAMC Faculty Practice Solutions Center (FPSC), a database jointly sponsored by the AAMC and the University HealthSystem Consortium (UHC) with billing data from over 80 faculty practices, shows that over half of the G-codes submitted for e-prescribing in calendar year 2009 documented that e-prescribing did not occur (either because no prescription was written or because at least one prescription was not e-prescribed due to specified reasons). This proposal will decrease that reporting burden.

The AAMC also concurs with the proposal to set the reporting threshold for most prescribing professionals at a minimum of 25 encounters. However, we suggest that CMS use current claims data to evaluate the number and specialties of eligible professionals who use an e-prescribing system but do not meet the 25 count requirement due to state or federal law or regulations that require certain prescriptions (e.g., prescriptions for narcotics or other controlled substances) to be filed by phone or to be in writing. CMS should consider whether it is possible to provide an alternative to accommodate these physicians.

The AAMC supports both the proposal to expand the e-prescribing reporting to allow for registry and EHR data submission (if the EHR proposal for PQRI is finalized) and the proposal to use the EHRs and registries that are qualified under PQRI.

The Association agrees with CMS's assumptions and proposals for group reporting that "as many as half" of the eligible professionals in an average practice "do not furnish the services represented by the electronic prescribing measure's denominator codes." (74 FedReg 33599). Therefore, it is reasonable to set criteria for successful group e-prescribing using the assumption that the group (which has at least 200 professionals) submits data on 2,500 encounters (100 professionals reporting on e-prescribing at least 25 times).

The AAMC is concerned that the proposed method for calculating the 10% charge threshold for groups will prevent most, if not all, large multi-specialty group practices from being able to use the group reporting option and, in effect, thwart Congressional intent. MIPPA legislation states that the e-prescribing incentive is not permitted if the allowed charges for the e-prescribing codes "are less than 10% of the total of the allowed charges under this part for all such covered professional services furnished by the eligible professional (or group, as applicable)." The current proposal would calculate the 10% exclusion threshold based on all claims submitted by all professionals in the group, including professionals who may not provide the services listed in the e-prescribing denominator.

The AAMC asks that CMS consider an alternative method for determining which services are included as “all such covered professional services” for the purpose of the 10% calculation and corresponding incentive payment. When a group practice submits the list of their eligible professionals’ NPIs to CMS, the practice should have the opportunity to indicate which, if any, eligible professionals should be excluded from the e-prescribing calculation. This exclusion should be targeted toward eligible professionals who are unlikely to provide the services described in the e-prescribing denominator. The allowed charges associated with those NPIs could then be removed from both the 10% threshold calculation, as well as from the charges used to calculate the 2% incentive. This method might reduce the incentive available to a group, but it would make e-prescribing group reporting more widely available. At a time when CMS and others are trying to encourage integration in the health care system it is important to encourage the delivery of care through a large, multispecialty group practice, something that can be done through the group reporting option.

### **Resource Use Reports (RURs)**

The AAMC commends CMS for its thoughtful resource use of the RUR pilot. The addition of quality measures and diabetes care in the Phase II of the pilot are useful. As CMS continues to expand resource use reporting, we would like to recommend the changes described below to ensure that physicians receive a report that is useful and likely to influence their behavior.

#### *Patient attribution and reports*

Understanding and managing the patient population is essential to a successful resource use program that aims to change physician behavior and improve care. Reports that detail patient level information– starting with patient identification and resource use associated that with patient – would improve the reports. Ideally, at the start of the process, physicians would be given a list of patients and provided with an opportunity to review it for accuracy. Admittedly, it is difficult in a fee for service system to proactively identify a patient population. One possibility is to select the potential patient pool from previous episodes of care. For example, the COPD patients that a physician or practice would be measured on in 2010 would be based on the COPD episodes assigned to that physician during the previous year. Patients also should be informed that while they are free to see any physician they choose, solely for purposes of the RUR they will be considered to be the patient of Dr. Jones. If this is not acceptable to the patient, then the patient will not be assigned to that physician for RUR purposes.

### *Benchmark*

AAMC understands that any benchmark methodology needs to find the balance between precision and sample size; however, we are concerned the current specialty benchmarks are not discrete enough to compare different sub-specialists. The FPSC has sufficient data to allow some benchmark comparisons within the academic clinical community. We look forward to meeting with the CMS staff to discuss our concerns and suggestions for moving forward.

### *Risk adjustment/exclusions*

Any resource use reporting system must contain risk adjustments to account for patients with complex illness and co-morbidities, admittedly a challenging undertaking. It is very possible that during an episode of illness these patients will see one or more physicians who are treating them for conditions unrelated to that particular episode of care. To avoid overstating resource use, it is critical to avoid attribution of such unrelated costs to the physician treating the patient for the episode of illness. The AAMC suggests that CMS also should explore methodologies that would allow physicians to appropriately exclude noncompliant patients from resource use measurement. Lack of compliance can be caused by many reasons that are outside the physician's control, such as substance abuse, mental health problems, and psychosocial disorders, and should not be allowed to lead to a poor report.

### **Value-based purchasing (VBP)**

We believe that any VBP program should consider the particular circumstances of academic clinical faculty. While providing patient care, many clinical faculty at academic centers simultaneously train medical students and residents and conduct research. Academic medical centers also receive complex referral patients, and often provide specialized services such as transplant surgeries and burn and trauma care. Many are safety net providers, treating poor patients who often come to them when they are very ill and require extensive services. CMS must ensure that the costs associated with caring for these patients, and providing services that may not be available elsewhere, are accounted for in any program that relies on a payment system based on comparative results of quality and resource measures. The AAMC looks forward to working with CMS staff to identify items that might be unique to academic medicine.

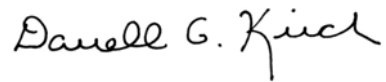
### **Electronic Signatures**

After discussing CMS's clarification regarding the rules for signatures for orders and requisition with members, it is apparent that the distinction between an "order" and a

“requisition” remain unclear. We request that CMS work with the provider community to develop definitions that are consistent with current clinical practice. The AAMC also requests that CMS indicate whether electronic signatures are sufficient for electronic orders.

If you have questions, please contact either Ivy Baer ([ibaer@aamc.org](mailto:ibaer@aamc.org)) or Mary Patton ([mpatton@aamc.org](mailto:mpatton@aamc.org)) of my staff, both of whom may be reached at 202-828-0490.

Sincerely,

A handwritten signature in black ink that reads "Darrell G. Kirch". The signature is written in a cursive style with a large, prominent "K".

Darrell G. Kirch, M.D.  
President and CEO