Association of American Medical Colleges
2450 N Street, N.W., Washington, D.C. 20037-1127
T 202 828 0400 **F** 202 828 1125
www.aamc.org

December 16, 2008

Thomas Valuck, M.D.
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850
Mail Stop C5-15-02
Attn: Physician VBP Comment

VIA E-mail: PhysicianVBP@cms.hhs.gov

Dear Dr. Valuck:

The Association of American Medical Colleges (AAMC) appreciates the opportunity to comment on the Development of a Plan to Transition to a Medicare Value-Based Purchasing (VBP) Program for Physician and Other Professional Services Issues Paper. The AAMC is a not-for-profit association representing all 130 accredited U.S. medical schools; nearly 400 major teaching hospitals and health systems; and 90 academic and scientific societies. Through these institutions and organizations, the AAMC represents 125,000 faculty members, 70,000 medical students, and 104,000 resident physicians. We are supportive of CMS' desire to improve the quality and value of the Medicare program. Our members are committed to providing high-quality care. Many faculty physicians have been leaders in developing measures within their own specialty societies. In addition, we have members participating in the Physician Group Practice (PGP) Demonstration and the Physician Quality Reporting Initiative (PQRI).

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.

We would like to thank CMS for compiling the comprehensive document that outlines the many issues associated with VBP. In the following sections we will address the questions raised in the paper.

Overarching Questions

CMS requests comments on the objectives, assumptions and design principles of the physician VBP program. We suggest that the following issues should be considered when designing the program:

- The cost of individual services should be only one factor used to measure value. CMS also should review such factors as the types of services that are provided, the health status of patients served, and whether teaching and research also are being conducted.

- Measures and benchmarks should be evaluated and, where appropriate, adjusted for resident training and/or for complex, hard-to-manage patients.

- A successful VBP program requires hospitals and physicians to work together. Therefore, to the extent possible, the physician and hospital VBP programs should be aligned to ensure that all providers are working in tandem to achieve the same goals.

- Offering multiple approaches towards VBP is a wise design principle. It allows CMS the flexibility to test innovative health care delivery and payment models, while also offering other models that can be applied to different types of practitioners.

- The design principle to “avoid creating additional health disparities” and “to reduce existing disparities” is essential to a fair and equitable VBP program. Physicians should be rewarded--not penalized--for managing complex and difficult patients. To help ensure that outcome, we suggest that the quality and resource use indicators should, at a minimum, be adjusted for health and socio-economic status. It also is essential that programs address impact of patient compliance, as this is a factor over which physicians have little to no control.

- The evaluation program, as described in the options paper, should ensure that payments are made in a fair manner in addition to monitoring for any unintended consequences.

- Special payments to teaching hospitals should be excluded from all VBP measurement and payment calculations.

Measures

Quality Measure Selection
Quality measures are a key part of any VBP program. CMS has proposed clinical-effectiveness process measures, outcome measures, structural measures, and patient satisfaction measures. The AAMC urges CMS to select measures which are evidence-based, endorsed by the National Quality Forum (NQF), appropriately tested for validity and reliability, and are actionable. In addition, the measures must be regularly reviewed and updated to reflect current science and any outcome measures must have a robust risk adjustment methodology that adjusts not only for health status, but for patient compliance and other socio-economic factors as well.

Risk Adjustment/Patient Exclusion
Many risk adjustment methodologies use claims data to estimate a patient’s health. Claims data, however, do not contain a patient’s entire clinical history, nor consider other factors, such as patient choice and

compliance. It is vital that CMS take whatever steps are necessary to ensure that accurate and complete data are used, as it will be difficult for physicians and others to adopt a system that they believe is based on incomplete information. As CMS considers long-term planning for VBP, the agency should invest in methods to better assess and adjust for patient complexity. CMS also should consider options for exception reporting which would appropriately exclude certain patients from measurement.

Accountable Entities
CMS should allow providers the flexibility to determine the appropriate accountable entity, either at the individual physician, the group practice, or possibly the health system level. This methodology is consistent with the design principle of offering multiple approaches to accommodate multiple practice arrangements and care settings. PQRI will provide an example of how this accountability option could work. Currently, PQRI is reported at the individual physician level, but starting in 2010, it will offer a group practice reporting option.

Resource Use
Prior to finalizing any resource use requirements in the VBP plan, CMS should review the results from the current Resource Use Reports (RUR) pilot. In particular, CMS should consider issues of sample size and attribution, as well as methodology differences between per-capita measures and episodes of care measures. In measuring resource use, CMS should analyze not just the cost of services, but the utilization of services and variance of those services across episodes. Resource use should also be considered with quality metrics to ensure that appropriate care is being delivered. Additionally, the results should be adequately risk adjusted for patient compliance, patient demand for services, as well as for health and socio-economic factors.

Physicians practicing at teaching hospitals, by their very nature, may have higher resource use. CMS should evaluate the potential impact of resident training and research activities in both the benchmark selection and in the attribution methodologies to ensure these physicians are not penalized for training our future physicians and health care professionals or for doing important research. The AAMC looks forward to working with CMS to evaluate options for measuring resource use. We will be submitting further comments on the Resource Use Reports as part of our response to the 2009 Medicare Physician Fee Schedule Final Rule and we will ensure that you receive a copy of those comments.

Incentive Structure

When determining the amount of the incentive payments, CMS should consider the costs associated with data collection and work flow interruptions. Many faculty practice plans chose to participate in PQRI for reasons other than the financial incentives. In many cases, the 1.5 percent incentive payment did not cover the practice plan costs for data collection and reporting.

The AAMC does not believe that incentive payments should be based on a relative thresholds or percentile rankings. Relative thresholds prohibit participants from knowing in advance what their target goal should be. Instead, participants should receive incentives for performance improvement and attainment, subject to a minimum, similar to the hospital VBP plan. This type of system would reward both high achievers that continue to perform well as well as incent low-performers to improve their

performance. The AAMC also supports a system with an option to reward systems or individuals that manage patients across a continuum of care.

Regardless of how the incentives are calculated, professionals should have the opportunity to appeal any payment determination. An appeal process will help ensure the integrity of the reporting and payment system.

Data Strategy and Infrastructure

Infrastructure
When the Tax Relief and Health Care Act of 2006 was enacted in December of 2006, CMS had approximately six months to establish the infrastructure for PQRI before the first reporting period started on July 1, 2007. We applaud CMS for meeting this statutory deadline, but recognize that initially the PQRI program experienced some operational and technical difficulties, such as claims splitting. The hospital quality reporting programs also have experienced operational and technical difficulties. These experiences illustrate the need for CMS to ensure the appropriate infrastructure is in place to support the VBP program prior to widespread implementation of the program. The infrastructure should be able to manage the increasing number of providers submitting data and accommodate the multiple methods for data submission.

Data Collection
We appreciate CMS' plan to minimize the burden of data collection. We recommend that CMS offer options in addition to claims-based reporting to facilitate more efficient and complete data collection. Such options could include registries, electronic health records, or submitting data through a standardized file format.

Feedback Reports
In order for a VBP plan to be successful, professionals need to receive data in a timely fashion, and have useful and actionable information. We recommend the following:

- **Report the data as soon as possible.** Physicians will not be able to modify their practices until they receive information.

- **Provide enough information to make the data actionable.** For example, professionals may want to see results at the patient level. CMS should also provide educational materials so that professionals understand the reports they receive.

- **Provide data in a format that can be aggregated and disaggregated easily.** For the 2007 PQRI reports, many faculty practices received PDF files in excess of 1000 pages. The data had to be extracted and reformatted so that department as well as physician-level reports could be generated and distributed. This task would have been simpler if the information was available through an Access database or similar electronic format.

- **Give administrative staff access to reports.** Particularly in large practices, administrative staff can ensure that physicians receive the reports, and can help physicians interpret the reports.

Public Reporting

CMS indicated that the public reporting would build upon the agency's current "Compare" websites, such as Hospital Compare. Because the AAMC was actively involved in the development of the Hospital Compare website, we gained some insights from that experience that should be of value as CMS designs a site for Medicare physicians and other professionals.

- CMS should not report the names of those who satisfactorily submitted quality data until the data submission process and reporting results have been verified. This ensures the data on the website is accurate and avoids the potential of unfairly penalizing providers due to technical or operational problems.

- CMS should establish a multi-stakeholder workgroup, similar to the former Hospital Information Workgroup, to provide input and feedback to CMS on the development of the website. The Workgroup also would be able to identify potential problem areas. It should include representatives from the providers, consumers, and purchasers.

- CMS must devote ample staff and computing resources to create a user-friendly website.

- In addition to the multi-stakeholder workgroup, CMS should ensure through other sources that the architecture, navigation, display and language are thoroughly tested with consumers.

- For the public reporting of data, physician groups should have the option to have their results reported at the group level.

- Physicians (or physician groups) should have the chance to review, and, as appropriate, either appeal or amend the data prior to the public display.

Thank you for this opportunity to comment. If you have any questions or concerns about these comments, please contact me, or Mary Patton (mpatton@aamc.org) of my staff. We both may be reached at 202-828-0490.

Sincerely,

Joanne Conroy, M.D.
Chief Health Care Officer

Cc: Mary Patton, AAMC
Ivy Baer, AAMC
Jennifer Faerberg, AAMC