July 9, 2013

The Honorable Fred Upton
Chairman
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Upton:

On behalf of the Board of Directors of the American Medical Group Association (AMGA), I am writing today to commend you for your continued leadership to address the flawed Medicare physician sustainable growth rate (SGR) formula. We greatly appreciate your recognition of this problem, as well as the time and energy your staff is dedicating to this important health care issue. We sincerely appreciate the opportunity to provide comments in response to the questions for interested stakeholders attached to your June 28 advanced legislative framework to repeal the SGR and replace it with a fair and stable system that rewards quality over quantity.

AMGA represents multi-specialty medical groups and other organized systems of care, including some of the nation's largest, most prestigious integrated health care delivery systems. Specifically, the Association represents 430 medical groups that employ nearly 130,000 physicians who annually treat more than 130 million patients in 49 states. A sizable number of these patients are Medicare beneficiaries. We therefore have a strong interest in the development and implementation of a Medicare payment structure that provides long-term stability for their patient populations, their physicians, and movement toward a value-based payment system.

With respect to tying measurement to payment, we believe that what AMGA has defined as a "high-performing health system" should be considered as a separate category, bucket, or update within any transitional model or alternative payment model once the SGR has been repealed. Rather than provide rewards to individual physicians, this new category would reward multi-specialty medical groups or other organized systems of care that have demonstrated success managing the per capita cost of health care, improving the overall patient experience, and improving the health of their respective population or population cohorts. As in our previous comments, we have attached our definition of a high-performing health system for the Committee to review. Rewarding high-performing health systems will steer Medicare toward a durable physician payment system that will preserve access to the highest quality health care for Medicare beneficiaries.

The draft that you have put forth places an emphasis on provider and public feedback in all aspects of the establishment of a new Medicare payment model. The majority of our members are particularly interested in the process by which the Committee plans to define the quality measures for the competency measure sets and the clinical improvement activities. Specifically,

we believe the Committee should give provider organizations and other relevant stakeholders three years, at the minimum, in order to identify, develop, and submit quality measures. We also believe that quality measures and clinical improvement activities are inextricably linked and go hand-in-hand with improved patient outcomes. Systematic quality measurement and improvement activities are essential for a patient-centered, value-based approach to health care delivery. Together these include an emphasis on preventive care and wellness, plus chronic disease management programs and ongoing patient outreach activities to improve the health of the populations served. High-performing health systems participate in continuous learning and conduct benchmarking on utilization rates and patient outcomes. They also report on clinical outcomes at the group level and track care team performance internally.

The activities of high-performing health systems are well aligned with the core competency categories defined in the National Quality Strategy, cited in your draft legislation. However, there is currently a lack of endorsed quality measures for all of the components of the National Quality Strategy. We would recommend additional funding to research, evaluate, and test measures that would address the existing gaps.

The Committee asks whether efficiency measures should be considered in future clinical practice improvement activities. AMGA's definition of high-performing health systems asks such systems to manage the total cost of care, and promotes preventive care and longitudinal care coordination which both contribute to efficiency. Efficiency is exceedingly difficult to measure at an individual level, however. We therefore recommend that efficiency measurement would best be undertaken at a physician group level, be a voluntary activity, and that ample time to test and evaluate efficiency measures be provided, due to the technical issues involved in measuring the total costs of care.

The attachment to the draft legislation, Attachment A, proposes two methods to determine the fee schedule provider update. In our view, number one, the "Threshold" or "Benchmark" Update Incentive Payment Model would be preferable to number two, the Percentile Update Incentive Payment Model. Number one contemplates developing the model based on specialty society input and would publish the benchmark, or threshold, prior to the performance period, and therefore would provide medical groups with a greater sense of what they should be working toward during the performance period. The legislation should provide the Secretary of Health and Human Services with the discretion to develop the best methodology to produce a statistically reliable and accurate composite quality score, however, since there are many complex variables to consider. In addition, for year one, there should be some flexibility provided for setting benchmarks, since the previous year's performance data may not be available.

And while transparently reporting performance is a key attribute of any new alternative payment model, AMGA believes that an appeals system is required to assure fairness and accuracy of reporting so that a system can request a re-determination related to the evaluation of certain performance and quality measures. This appeals process should not be unduly burdensome or costly as are certain federal review processes presently in use, like those connected to the Recovery Audit Contractor and the Administrative Law Judge processes. After all, most existing appeal processes require groups or individual physicians to re-validate hundreds of medical

records and locate any errors that are then submitted to the appropriate governing body. A bright line – meaning clear, defined, and unambiguous technical specifications for performance measurement standards, which leaves little or no room for varying interpretation – is necessary. In the best interest of all parties, the bright line would need to be established early on – at the very beginning of the performance measurement and reporting program. The goal of the bright line would be to produce fair and accurate measurement and reporting results, which would ultimately reduce the number of appeals and simultaneously reduce the potential increased burden on practicing physicians. For that reason, it is incredibly important for those being measured to be actively involved in the development of a quality and improvement system.

AMGA finds some of the criteria included in the document entitled, "Patient Charter for Physician Performance Measurement, Reporting and Tiering Programs: Ensuring Transparency, Fairness, and Independent Review"[1] to be valuable, particularly when it comes to medical professionals accessing and appealing performance rankings. This document calls for the active participation of those being measured. Specifically, the paper outlines the following general principles:

- Physicians and physician organizations should be solicited to provide input on the program;
- Physicians should be given reasonable prior notice before their individual performance information is publicly released;
- Establishment of a clearly defined process for physicians to request review of their own performance results and the opportunity to present information that supports what they believe to be inaccurate results (within a reasonable time frame) must be a component; and
- Results that are subsequently determined to be inaccurate after the reconsideration process should be corrected.

We are also encouraged that the draft recognizes the importance of reducing the reporting burden on provider organizations, a goal which the Committee has expressed throughout this process. The Group Practice Reporting Option web-based tool utilized in the Physician Quality Reporting System has become unduly burdensome on not just our members, but organizations across the country. It requires medical group staff to perform extensive manual chart abstraction and confirmation of much of the data, often necessitating the hiring of additional staff to complete. This problem could be eliminated by moving to electronic measures (eMeasures), which can promote greater consistency and confidence in measure development and in comparing performance results.

AMGA believes that the federal government should ultimately move toward the development of eMeasures that can be reported directly from a medical group's Electronic Health Record (EHR). We recognize that a Centers for Medicare and Medicaid Services pilot program is underway to test this process, and we applaud such efforts. However, this reporting option must be

[1] Consumer-Purchaser Disclosure Project: Improving Health Care Quality through Public Reporting of Performance. "Patient Charter for Physician Performance Measurement, Reporting and Tiering Programs: Ensuring Transparency, Fairness and Independent Review. April 1, 2008. www.healthcaredisclosure.org

disseminated more widely throughout the health care delivery system in order to spur necessary improvements in efficiency. High-performing health systems are more likely to have made investments in the systems necessary for reporting directly from their EHR, and we believe that the entire health care delivery system should be moving in this direction.

Reducing financial and regulatory burdens on health systems, wherever possible, should be a pivotal part of changes to the current fee-for-service system as well as the transition to alternative payment models. An example of such a burden that could be mitigated is the premium tax included in the Affordable Care Act. A number of AMGA member groups have provider-sponsored health plans that will have to contend with this looming tax. This tax could undermine their ability to provide care to patients and continue the structural and behavioral changes necessary to become a high-performing health system. While we deeply appreciate the Committee's focus on Medicare payment reform, we would strongly encourage you to examine the potential negative impact this upcoming premium tax will have on provider-sponsored health plans.

We believe that Congress can use our attached definition of a high-performing health system as a means to reward existing systems and incentivize structural and behavioral changes in others, as our health care landscape continues to evolve toward rewarding for quality. Developing this definition was not easy, and although not all AMGA members currently meet these criteria, we believe that all should aspire to make these goals a reality. It is our hope that the definition can be used in both the legislative and regulatory arenas, and will ultimately prove foundational to providing high-performing health systems with greater financial and regulatory predictability.

Thank you again for your efforts to address the flawed SGR formula and for your careful consideration of my comments. Attached for your review, is a copy of the definition of high-performing health systems. As always, AMGA members and I stand ready to work with you on reform of the nation's Medicare program, especially those dealing with physician reimbursement issues.

Sincerely,

Donald W. Fisher, Ph.D.
President and CEO