



November 12, 2013

The Honorable Max Baucus
Chairman
Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Orrin G. Hatch
Ranking Member
Senate Committee on Finance
104 Hart Senate Office Building
Washington, DC 20510

The Honorable Dave Camp
Chairman
Committee on Ways and Means
1102 Longworth House Office Building
Washington, DC 20515

The Honorable Sandy Levin
Ranking Member
Committee on Ways and Means
1236 Longworth House Office Building
Washington, DC 20515

Re: SGR Repeal and Medicare Physician Payment Reform Discussion Draft

Dear Chairmen Baucus and Camp:

I am writing today on behalf of the American Medical Group Association (AMGA) to commend you for the work the Committees have undertaken in drafting the "SGR Repeal and Medicare Physician Payment Reform" Discussion Draft (SGR Discussion Draft or Draft). 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. More specifically, AMGA represents over 430 medical groups that employ more than 130,000 physicians who annually treat more than 120 million patients. A sizable number of these patients are Medicare beneficiaries.

Our members have a strong interest in providing high-quality medical services to their patients, and many of them have been trailblazers in the use of electronic medical records and the redesign of care processes in order to treat their patients more efficiently and effectively. We therefore have a strong interest in the development and implementation of a Medicare payment structure that will provide long-term stability in physician payments and supports a value-based payment system. We sincerely appreciate the SGR Discussion Draft's focus on these areas.

As you may know, AMGA believes that High-Performing Health Systems™ (HPHS) are distinguished by certain attributes that contribute to the delivery of high-quality, patient-centered, efficient care. AMGA has developed a definition for HPHS's and we believe physicians meeting the definition of an HPHS should qualify as an Alternative Payment Model (APM) and be eligible for the increased APM payments as described in the Draft. A HPHS is defined by these core requirements:

Organized System of Care

A HPHS is an “organized system of care” that provides the continuum of care for patient populations; is an integrated system, either internally, or through partnerships with other care sites; and includes physicians as the principal leaders of all clinical programs. An organized system of care will also assume accountability for coordination across transitions of care. Unless the delivery system itself is considered, the health care delivery system will continue to promote fragmented care.

Quality Measurement and Improvement Activities

AMGA believes that quality measurement and improvement activities are essential to the provision of a patient-centered, value-based approach to health care delivery as outlined in the SGR Discussion Draft. Further, AMGA envisions that such activities would include preventive care and chronic disease management programs for targeted groups of patients; ongoing patient outreach programs to improve the health of those populations; participation in continuous learning, such as collaboratives where medical groups can learn from one another; benchmarking activities; use of research such as applied data analytics to validate clinical processes and outcomes data to determine effectiveness; external reporting and transparent internal reporting on clinical outcomes, variability, and timely performance improvements; and the conduct of patient experience surveys.

The SGR Discussion Draft proposes to adjust Medicare payments to professionals based on performance in the Value-Based Performance (VBP) Payment Program. AMGA believes that quality reporting is a cornerstone of a true value-based purchasing health care model, however, the wide variation in current quality reporting measures, both in Medicare and in the private sector, precludes an accurate analysis of the care that high-performing health systems provide. Cost-effective care requires a system approach, with a team of providers and significant investments in infrastructure so that quality can be measured at the system level.

We ask the Committees to consider the development of a measurement system that is suited to address High-Performing Health Systems™, with such systems closely involved in the development of the quality measures. High-Performing Health Systems™ utilize a team-based approach and have devoted significant resources to developing a team culture within their system. Requiring high-performing health systems to report separately on every physician specialty measure creates quality silos that work against the team-based culture in High-Performing Health Systems™. We are encouraged that your draft includes the ability for “group-level quality-reporting credit for groups reporting to a qualified clinical data registry,” but respectfully request that the Committees include language allowing for the development of medical group specific measures based on expert clinical input from the medical group community.

Care Coordination

The High-Performing Health System™ will utilize a team-based approach that supports collaboration and communication among the patient, physician, and the licensed or certified medical professionals who are working at the top of their license to improve their patients’ well-being. This would entail a single plan of care across health care settings and across health care providers who furnish care to the patient. Another important feature is shared decision-making,

which is a true collaboration between the patient and the health care provider that empowers the patient in the decision-making process and provides the patient with objective information concerning (1) the risk or seriousness of their disease or condition to be prevented or treated; (2) available treatment alternatives; and (3) the costs and benefits of available treatment alternatives.

Use of Information Technology and Evidence-Based Medicine

A High-Performing Health System™ will meaningfully use interoperable information technology, scientific evidence where it exists, and comparative analytics to aid in clinical decision-making and improve patient safety; help monitor patients and track preventive services; and aid in the prescribing of prescription drugs in order to improve safety. Health information technology provides the foundation for other delivery system improvements.

Compensation Practices That Promote the Above-Listed Objectives

The High-Performing Health System™ will use compensation structures that provide incentives to physicians and licensed and certified medical professionals to improve the health and outcomes of patient populations. Such practices could include patient experience surveys; and quality metrics such as chronic disease measures and compliance with prevention strategies within a patient population. We are gratified that the SGR Discussion Draft includes compensation practices that will allow health care practitioners to earn performance-based incentive payments.

Accountability

Ultimately, HPHSs will assume shared financial and regulatory responsibility and accountability for successfully managing the per-capita cost of health care, improving the overall patient experience, and improving the health of their respective populations.

We ask you to consider the elements found in our definition of High-Performing Health Systems™ as you seek to reform the outdated Medicare payment system. Medical groups that meet this definition are the foundation of a health care delivery system that rewards value over volume of services provided, and should qualify as an APM as defined in the SGR Discussion Draft.

Value-Based Performance Payment Program (VBP)

Under the SGR Discussion Draft being contemplated, Medicare payments to professionals would be adjusted based on performance on a single budget-neutral incentive payment program and calculated on physician performance in a previous period. The composite score for determining the payment incentive includes quality, resource use, and use of electronic health records, which we applaud. However, we believe that the proposed legislation should include requirements to assure effective attribution methods. Medical group experience with alternative payment models have shown that up to 40 percent of patients attributed to a medical group actually receive some, most or all of their care outside the system. Physicians are willing to be held accountable under new payment models but to redesign care processes for patient populations requires an understanding of whom those patients are. A 40 percent attribution error rate is a significant obstacle to population health management. New methods of attribution could include requiring Medicare patients to prospectively choose a primary care physician (PCP) who is responsible for their care. We believe patient accountability should be

paired with provider accountability to achieve the full benefits of a value-based payment system.

Value-based payment systems also require robust data sharing between health care providers and health plans, whether federal or private payor, and is particularly important for larger group practices and health care systems. We appreciate that the SGR Discussion Draft highlights the need for timely feedback on performance in quality and resource use on a regular basis. However, the importance of timely data cannot be overemphasized, and we believe that quarterly feedback is not timely enough. The provision of feedback on a monthly basis, or as close to real-time as possible would be preferable so that physicians and medical groups can monitor their progress and make appropriate adjustments to care processes. Requiring Medicare to share this information, in a standardized and easy to understand format, is an essential step toward accountability for patient care. Such sharing of data entails a true partnership between payor and health care provider.

The SGR Discussion Draft requires physicians to accept risk by 2016 in order to fall under the definition of an APM. While it is generally accepted that all providers will eventually accept risk, a longer transition period is needed. Most medical groups and physicians have operated under a fee-for-service payment model for decades. Accepting risk requires significant clinical re-design, as well as financial, information technology, legal, and cultural changes. Groups may opt-out of enrolling in an APM given the ambitious risk timeline. We believe a five year transition period (2019) allows medical groups and physicians the necessary time to better understand how to accept risk and will ensure greater participation in APMs which is the goal of the SGR Discussion Draft.

Rural Health Clinics

We would also urge you to consider the inclusion of Rural Health Clinics (RHCs) in the VBP Payment Program, and since this program does not take effect until 2016, we are also asking for your support of any legislative proposals that would permit RHCs to be eligible for electronic health record (EHR) incentive payments through the Medicare program in 2014. Currently, RHCs are ineligible for EHR incentive payments through the Medicare program simply due to the claim form they use - not for a lack of data, performance, or merit. The last year that an eligible provider can start participation in the Medicare EHR incentive program is 2014. Therefore, we respectfully request Congress to level the playing field for RHCs, since they form a critically important part of the nation's primary care fabric.

The benefits of health information technology are especially important to patients and physicians in RHCs. RHCs use a team-based approach that includes physicians and other health care professionals working together to provide high-quality health care services to their patient populations. RHCs benefit greatly from the use of health information technology, which allows them to share clinical data with hospitals and physicians that may be located many miles away. Given the financial challenges of the health care landscape in our country, many RHCs are unable to make the initial investment in health information technology without financial support, and can therefore benefit from the ability to earn incentives through the Medicare EHR Incentive Program.

We note, and appreciate, the special emphasis the SGR Discussion Draft places on clinical practice improvement activities for those practicing in rural areas and Health Professional Shortage Areas, and would like to ensure that RHCs are not left out of these opportunities.

Terminating Current Law Incentive Payment Reductions

AMGA supports the more streamlined approach found in the SGR Discussion Draft creating the VBP Payment Program, and the sunset of penalties under the Physician Quality Reporting System, the Value-Based Modifier, and the Medicare Electronic Health Record Incentive Program, beginning in 2016. We believe that this approach represents important progress toward minimizing administrative burdens for medical groups, in addition to the Centers for Medicare and Medicaid Services, while appropriately rewarding for quality health care delivery, respectful use of resources, and the use of electronic health records.

Premium Tax on Provider-Sponsored Health Plans

Lastly, as we have written you earlier in the year, we would urge reducing the financial and regulatory burdens on health systems, as part of any changes to the current fee-for-service system, inclusive of the transition to APMs. An example of such a burden that should be mitigated, either via repeal or delay, is the premium tax included in the Affordable Care Act. A number of AMGA member groups have provider-sponsored health plans that will be struggling to contend with this looming burden. This tax will undoubtedly diminish their ability to provide care to patients and continue the structural and cultural changes necessary to become high-performing health systems. While we deeply appreciate the Committees' focus on Medicare payment reform, we would strongly encourage you and your colleagues to examine the potential negative impact this upcoming premium tax will have on provider-sponsored health plans.

Thank you for your continued efforts to address our country's health care issues. We believe the SGR Discussion Draft outlines a thoughtful and comprehensive approach to transitioning our health care delivery system from one that rewards the quantity of health care services delivered to one that rewards quality. We ask for your careful consideration of our comments concerning how the elements of High-Performing Health Systems™ could be utilized in this effort. As always, AMGA members and I stand ready to work with and assist your Committees on these issues. If you have any questions, please do not hesitate to contact Chet Speed of my staff at cspeed@amga.org.

Sincerely,



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