



**AMERICAN ACADEMY OF
OTOLARYNGOLOGY–
HEAD AND NECK SURGERY**

May 29, 2013

The Honorable Max Baucus
United States Senate
Chairman, Committee on Finance
Washington, DC 20510

The Honorable Orrin G. Hatch
United States Senate
Ranking Member, Committee on Finance
Washington, DC 20510

Dear Chairman Baucus and Ranking Member Hatch:

Thank you for the opportunity to provide comments and assist in the U.S. Senate Committee on Finance's (the Committee) efforts to permanently repeal the flawed Sustainable Growth Rate (SGR) formula and develop a new payment system under the Medicare program. The American Academy of Otolaryngology–Head and Neck Surgery (AAO-HNS), with approximately 12,000 members nationwide, is the national medical association of physicians dedicated to the care of patients with disorders of the ears, nose, throat (ENT), and related structures of the head and neck. We look forward to working with Congress to resolve the many details that must be considered in creating a system which is fair, equitable, and most importantly, rewards the provision of high quality care.

The existing Medicare physician payment system, driven by the SGR formula, is broken beyond repair. For years, physicians have struggled in a system that fails to differentiate by provider or specialty, continues to reward volume, and lacks the tools necessary for recognizing quality outcomes and/or efficiency in regards to the delivery of care. The strict budgetary focus and inherent instability of the current payment system have resulted in annual threats of significant reduced payment to physicians that impede providers' willingness and ability to care for beneficiaries. In addition, it has become increasingly difficult for physicians to make fiscally responsible, and necessary, practice management decisions. **We support full repeal of the current SGR formula.**

Following repeal of the SGR formula, a period of stable payments will be necessary while physicians adapt and adjust to any new payment mechanism. In addition, it is important to ensure that physician payments keep up with the costs of providing services and inflation during this transition period. The ability to offset physician costs is necessary to implement the new system, and failure to do so will limit access to care.

We appreciate the opportunity to provide comments, concerns, and observations on your questions regarding the Medicare physician fee schedule and Fee-For-Service (FFS) system. While we support the repeal of the SGR formula and the development of new payment models, the current FFS system will still need to remain the standard in the short-term as the transition takes place over the course of several years, and for certain physician practices for the longer term as well. This is particularly important for small practices made up of one to three physicians, which currently represents a large number of otolaryngology private practices, as well as for highly sub-specialized surgeons.

The AAO-HNS agrees appropriate changes to the FFS system could be made, but there must be a phased approach to this endeavor. We urge Congress to use appropriate caution if it moves forward with its efforts to concurrently overhaul the FFS while also moving forward with the implementation of entirely new payment models. We believe

2012-2013 ACADEMY BOARD OF DIRECTORS

OFFICERS

James L. Netterville, MD
President
Nashville, TN

Richard W. Waguespack, MD
President-Elect
Birmingham, AL

Gavin Setzen, MD
Secretary/Treasurer
Albany, NY

David R. Nielsen, MD
Executive Vice President and CEO
Alexandria, VA

IMMEDIATE PAST PRESIDENT

Rodney P. Lusk, MD
Omaha, NE

AT-LARGE DIRECTORS

Paul T. Fass, MD
Aventura, FL

Bradley F. Marple, MD
Dallas, TX

Jerry M. Schreiberstein, MD
Springfield, MA

James A. Stankiewicz, MD
Maywood, IL

Michael G. Stewart, MD, MPH
New York, NY

J. Pablo Stolovitzky, MD
Atlanta, GA

Duane J. Taylor, MD
Bethesda, MD

Kathleen L. Yaremchuk, MD
Detroit, MI

BOARD OF GOVERNORS

Denis C. Lafreniere, MD
Chair
Farmington, CT

Peter Abramson, MD
Chair-Elect
Atlanta, GA

Sujana S. Chandrasekhar, MD
Immediate Past Chair
New York, NY

SPECIALTY SOCIETY ADVISORY COUNCIL

Albert L. Merati, MD
Chair
Seattle, WA

Sukgi S. Choi, MD
Chair-Elect
Washington, DC

COORDINATORS

Michael Setzen, MD
Practice Affairs
Great Neck, NY

James C. Denny III, MD
Socioeconomic Affairs
Columbia, MO

Jane T. Dillion, MD
Coordinator-Elect, Practice Affairs
Hinsdale, IL

time for physicians to transition to any new payment mechanism is necessary and while we agree that changes could be made to the FFS system, we urge Congress to consider the effects that a transition will take on the healthcare system as a whole, and caution the overhaul of both the FFS and transition to alternative payment systems concurrently.

We also believe federal resources must be allocated to ease the transition to payment models that not only improve efficiency, but also improve quality, so that in the long term, a revised FFS system complements the transition into a performance-based payment system. The importance of this was emphasized in our recent response to the U.S. House of Representatives Ways & Means and Energy & Commerce Committees following their request for comment on their framework for moving beyond the current Medicare physician payment model.

Finally, we urge you, your Committee, and other members of the United States Senate to continue to foster bipartisan collaboration and communication with House members to finally resolve this long-standing conundrum. We continue to be encouraged by both chambers' outreach to various stakeholders, as input from physician groups will be necessary to appropriately take into account the complexity, intensity, and associated risk in valuing services provided to patients.

Again, thank you and your staff for the opportunity to participate in this critical process, and please accept the following more specific comments on the three questions posed in your letter dated May 10, 2013.

.....

1. MedPAC and others have suggested changes they believe would improve the accuracy of fee schedule payment amounts and the validity of resource inputs used to establish payments for services under the fee schedule. What specific reforms should be made to the physician fee schedule to ensure that physician services are valued appropriately?

In October 2011, MedPAC recommended abandoning the Sustainable Growth Rate (SGR) and replacing it with a 10-year path of statutory fee-schedule updates. This path would be comprised of a freeze in current payment levels for primary care. All other services would be subject to annual payment reductions, followed by a freeze. MedPAC once again reaffirmed this recommendation in their March 2013 report. Below are comments and concerns related to these recommendations, along with some specific proposed reforms that could be made to the current system and implemented in the short-term.

- MedPAC recommendation 1: The Congress should repeal the sustainable growth rate (SGR) system and replace it with a 10-year path of statutory fee-schedule updates. This path is comprised of a freeze in current payment levels for primary care and, for all other services, annual payment reductions of 5.9% for three years, followed by a freeze. The Commission is offering a list of options for the Congress to consider if it decides to offset the cost of repealing the SGR system within the Medicare program.

As you know, the current Medicare FFS system is based on the Resource Based Relative Value Scale developed at Harvard University. This system assigns procedures performed by a physician or other healthcare provider a relative value unit (RVU), which is adjusted by geographic region (so a procedure in New York City is valued at more than a procedure in Tulsa). This value is then multiplied by a fixed conversion factor, which changes annually, to determine the amount of payment. RBRVS determines prices based on three separate factors: physician work (52%), practice expense (44%), and malpractice expense (4%).

The AAO-HNS does not agree with MedPAC's recommendation as described above. We strongly oppose this recommendation and do not believe this proposed approach will provide the stability needed during the transition to a performance-based payment system. The Harvard RBRVS study supported no differentials between specialties. The playing field was supposed to be "level." In addition, several of the non-primary care specialties, including otolaryngology-head and neck surgery, deal with a large number of primary care issues. There have been estimates that 45-55 percent of the office visits in otolaryngology are for primary care issues – earache, cerumen removal, otitis

externa or media, pharyngitis (sore throats), allergic rhinitis, acute and chronic sinusitis, nose bleeds, etc. The conversion factor should not be different for different physician specialties. This will only lead to continued “silos of care” and will hinder increased coordination, which will be a core long-term goal of a new performance-based system.

- MedPAC recommendation 2: The Congress should direct the Secretary to regularly collect data—including service volume and work time—to establish more accurate work and practice expense values. To help assess whether Medicare’s fees are adequate for efficient care delivery, the data should be collected from a cohort of efficient practices rather than a sample of all practices. The initial round of data collection should be completed within three years.

The AAO-HNS believes the AMA RUC process is a sound and reliable process for evaluating and valuing physician services to Medicare beneficiaries and the process should be maintained in some form as physician payment reforms are implemented and alternative payment models are developed. Notably, the AMA RUC process ensures relativity across services and allows for physician involvement and expertise to play a role in valuing the medical services they provide on a daily basis. The process currently includes screening of services that reach certain levels of utilization and identifies misvalued codes, but there should be the option to raise, as well as, to lower RVUs. This is especially true as the population ages and the work involved to care for some patients becomes more complex.

We encourage the continued use of the AMA RUC as the primary method of validating physician work RVUs time for physician services, with physician input as an essential piece of this process. We are supportive of other methods to obtain data from outside databases to help validate times, number of visits, supplies actually used, etc. However, we urge any new process or methodology be conducted in an open and transparent manner to keep specialty societies informed on the process and methodology that will be used to validate the RVUs for these services.

Further, we do not agree with MedPAC’s recommendation to collect data only from a cohort of efficient practices rather than a sample of all practices. This is problematic since there is a bell-shaped curve for RVUs across all practices, so gathering data only from the most efficient practices would skew what realistically occurs across all specialty practices. **We believe the average (mean) or median value—which is the current method employed by the RUC – is the fairest measurement for all specialties.** We encourage CMS to be open about any new proposed methodology for use in addition to the current AMA RUC process and to include input from practicing physicians who are knowledgeable about the specific services being reviewed.

We do believe there could be reforms made to the current system. One proposed change we support is some process to place more limitations on the costs of drugs and equipment. This could include a thorough review of practice expense values through the AMA’s Practice Expense Review Committee. We would welcome the opportunity to work with the Committee, CMS, and the AMA, to develop further specifics for this proposal. While we believe the RUC is still the best way to determine RVUs, we believe the RUC should use data points other than time to deal with RVUs, such as the use of magnitude estimation. Extant databases should be evaluated and their use encouraged by the RUC when they appear to be accurate.

- MedPAC recommendation 3: The Congress should direct the Secretary to identify overpriced fee-schedule services and reduce their RVUs accordingly. To fulfill this requirement, the Secretary could use the data collected under the process in recommendation 2. These reductions should be budget neutral within the fee schedule. Starting in 2015, the Congress should specify that the RVU reductions achieve an annual numeric goal—for each of five consecutive years—of at least 1.0 percent of fee-schedule spending.

We believe it is inappropriate to reduce RVUs of at least 1.0 percent annually for each of five years. Again, the demographics would suggest that the work with the elderly may be greater not less. Also, as new technology arrives that contributes to improvements for patients over traditional practice, this may be more complex and expensive.

2. Physician services are critical to the ongoing health of Medicare beneficiaries. Appropriate utilization of physician services can lessen disease burden and reduce avoidable emergency department visits and hospitalizations. However, inappropriate or excessive utilization of physician-related services can negatively impact beneficiary health and drive up Medicare spending. Volume control mechanisms are not an inherent component of a FFS system. The SGR was intended to address excessive volume, but its mechanism is fatally flawed. What specific policies should be implemented that could co-exist with the current FFS physician payment system and would identify and reduce unnecessary utilization to improve health and reduce Medicare spending growth?

While we believe that value should be emphasized, the issue is how do we arrive at value? This could be accomplished with the development, implementation, and dissemination of clinical practice guidelines. However, guideline development is resource intensive. There must be a funding mechanism which assists medical societies with the expenses associated with guideline and performance measure development. This is an investment that would pay dividends in the long run.

The AAO-HNS has been at the forefront of quality improvement activities in otolaryngology for over a decade, and for a small specialty, we believe we have developed significant programs and initiatives that serve to improve clinical practice and performance and could be integrated into future payment models. Outlined below are highlights of some of these activities:

- ✓ **Clinical Knowledge Products:** <http://www.entnet.org/Practice/clinicalPracticeguidelines.cfm>. To date, ten guidelines and three clinical consensus statements have been published by the AAO-HNS; two additional guidelines are in press and will be published this year. Of note, the AAO-HNS development process was recognized as a “best practice” by the AHRQ and cited in the Institute of Medicine’s 2011 report on the development of trustworthy guidelines. We are now moving into adopting technical solutions to allow for implementation of guidelines into practice at the bedside.
- ✓ **Choosing Wisely list released in February 2013:** <http://www.entnet.org/choosingwiselyUPDATE.cfm> We became the first surgical specialty to join the ABIM Foundation’s *Choosing Wisely*® campaign. Many AAO-HNS guidelines were used to develop our list of five tests and/or procedures that should be questioned by physicians in the care setting. We have already been notified that the State of Washington is promoting the AAO-HNS list to physicians within the state, so we are confident use will continue to expand and strongly expect this list of tests and/or procedures could be used in future payment models.
- ✓ **Database and survey studies undertaken by the AAO-HNS Patient Safety Quality Improvement (PSQI) Committee resulting in published journal articles accessible to members on topics such as:** Errors with Concentrated Epinephrine in Otolaryngology; Errors in Otolaryngology (2004 and currently being updated); Wrong Site Sinus Surgery; Surveillance and Management in Tracheotomy Patients); and Morbidity and Mortality after Tonsillectomy: Etiologic Factors and Strategies for Prevention (in press).
- ✓ **Patient Safety Event Web Portal:** The PSQI Committee developed an online web-based portal for the collection of patient safety event data from members. The Committee will analyze the data to identify potential areas of risk to guide future research and quality improvement efforts.

In addition, physicians should be rewarded for reducing unnecessary cost by transitioning more services to the office or outpatient setting. Medicare should reward physicians for utilizing less intensive settings, when appropriate, for outpatient imaging, laboratory, and other services; thereby reducing reimbursement rates to the non-facility rate. We believe such reforms would reduce costs immediately, and in a meaningful way. However, the practice costs incurred must be covered as an incentive to make this transition. As work is shifted to the outpatient or office setting, funding to cover the services could shift from Part A to Part B. As length of stay is reduced, some of these cost savings could then be incorporated into Part B.

It is our understanding that the Committee is looking for specific proposals that could be developed by the U.S. Health and Human Services Secretary (HHS), and implemented by the Centers for Medicare & Medicaid Services (CMS), in a short-term setting. **We are supportive of a proposal for the Secretary to request that physicians submit clinical practice improvement activities as part of the new framework. We agree with including the following list of activities as part of the new program, and welcome the opportunity to provide assistance with further development of this proposal, including the fact that these activities are not meant to be mutually exclusive.**

- Provision of care consistent with specialty-specific evidence-based guidelines or application of decision support tools;
- Improved care organization or coordination and delivery;
- Targeted utilization of patient registries;
- Enhanced access to comprehensive and timely care that is delivered in the least intensive and most appropriate setting based on patient needs;
- Reporting and collection of clinical data to optimally manage care and prevent unnecessary hospitalizations and emergency department visits; and
- Collection of feedback from beneficiaries on their care experience.

Further, the AAO-HNS continues to engage our members and promote their participation in current CMS initiatives such as Physician Quality Reporting System (PQRS) and the Electronic Health Record (EHR) incentive program. Indeed, the AAO-HNS has worked with a vendor to develop a CMS qualified registry for the purposes of PQRS reporting. Through participation in this database, AAO-HNS has access to the de-identified measure submissions of all of our members who participate, which could form the basis of an initial registry for our specialty if we are able to continue to grow the user base for this product. Given the number of sub-specialties within otolaryngology (there are ten), it would be difficult and extremely costly for us to advance a disease-specific registry that would meet the needs of the majority of our membership. **Therefore, we would request that the Secretary not make the requirements to become a qualified clinical data registry for the purposes of reporting measures overly burdensome.**

3. Shifting from a FFS system to an alternative payment model will be a major change for many physicians. Within the context of the current FFS system, how specifically can Medicare most effectively incentivize physician practices to undertake the structural, behavioral, and other changes needed to participate in alternative payment models?

- Participation in More than One Payment Model is Crucial

We believe that physicians should be able to participate in more than one payment model to foster collaboration and best practices and to allow for greater flexibility for increased participation. However, there needs to be a mechanism in place that helps practices with three to five practitioners engage in contracting and/or accessing global systems. Most small practices will find it difficult to navigate different payment models, and we are concerned many physicians will avoid new models just because they have no experience with them. These practices are essential for access to care in rural areas. Additional geographic maldistribution is inevitable if such practices cannot thrive.

We also support the development of new innovative payment models that involve the patient, physicians, and payers. We support the concept of incentive payments or shared savings programs between hospitals and physicians and encourage the removal of any legal barriers that may restrict these types of arrangements. We also support the concept of shared accountability and believe that more work needs to be done to stratify risk and share accountability across provider, patient, and system groups.

In addition, the AAO-HNS is supportive of pilots and demonstration projects to determine if bundling payments or other alternative payment models are an appropriate mechanism to improve the Medicare payment system. We are

currently evaluating potential alternative models of payment that might be best for otolaryngology, but realize bundling or episodes of care may not be the correct solution for reimbursement in all cases for otolaryngologist-head and neck surgeons. Use of pilots and demonstration projects will help reduce the sense of risk and uncertainty for physicians.

➤ Significant Costs Involved for Physicians and Specialties - Federal Resources Necessary to Support Provider Participation in New Payment Models

Federal resources must be employed to work with all specialties or consider granting exemptions/extensions to smaller specialties that do not routinely deal with the high cost or disease burden illnesses. PCORI, CMMI, and other grants are almost exclusively given to prioritized conditions and specialties, leaving little or no support for many specialties who are trying to navigate these processes alone, with insufficient resources. **We strongly urge Congress to provide funding assistance and additional time for pilot studies to support specialty physician participation in new payment models.** While there are currently some funding opportunities available, they are limited. For example, we spent a significant amount of time and effort to submit a grant application to the Patient Centered Outcomes Research Institute's (PCORI) Pilot Projects Grants Program to build and deploy ENGAGE, an application to facilitate shared decision-making, utilizing clinical practice guidelines, across the patient care team with the patient at the center. However, while we were complimented on the high quality of our proposal, our application score did not fall within the fundable range for this program, and we received notification that our application was not accepted. The pool of applications was extremely competitive, with over 800 applications submitted and only fifty funded. We continue to seek opportunities to receive funding when opportunities arise, but we urge the Committee to address funding mechanisms in developing its proposal.

The AAO-HNS also believes in the importance of quality measurement in evaluating physician services and in tracking performance improvement over time. The development, testing, risk adjusting, and ongoing support of meaningful outcomes, process, and cost measures, however, is a complex and resource intensive process. Funding for outcomes research and development of quality assessment tools will be costly, but are imperative in a new system that should be modeled on a value (cost relative to efficacy) standard. Most specialty societies do not have the infrastructure for all aspects or elements of measures development, and therefore, have relied upon shared resources through consortia or outside sources to assist with development, testing, and measures endorsement and ongoing measures maintenance.

We support rewarding top-performers at levels higher than 100 percent and that a new framework should not be based on budget neutrality. **We support a new system that would “wipe the slate clean” each year and allow physicians to, in effect, start over every year to work toward improved quality outcomes.** However, we are concerned that the costly transitions associated with current quality and health IT reporting programs – such as the implementation of ICD-10, electronic health records, and electronic prescribing – will only increase pressure on small specialty practices, such as ours, and will potentially negatively impact direct benefit to individual patient care. **We support integrating the proposed payment reform with current quality programs, but caution that interoperability of health information exchanges will require additional time to be factored into the new framework.**

➤ Improvements upon Current Law

The AAO-HNS believes that the following improvements upon current law will be required to support alternative payment model adoption:

- ✓ **Appropriating the \$75 million that was authorized** in Section 3013 of the Affordable Care Act to assist specialty societies in the development of measures and/or alternative mechanisms to provide outcome data (registry) and/or some other way of providing an “investment” to fund the development and implementation of quality measures.

- ✓ **Providing access from CMS to claims data.** CMS has told specialty societies that they are handcuffed due to statutory concerns and therefore cannot provide us with data. If we could gain access to claims data and combine that with data from registries, it would assist with the development of valid outcomes measures on patient populations.
- ✓ **Integrating current programs to eliminate negatives/penalties,** and instead base payments on positive incentives linked to quality improvement.
- ✓ **Postponing Stage 3 Meaningful Use.**

Tort reform and protection is needed from antitrust laws and legal interpretations that have yet to be addressed which inhibit physician collaboration, efficiency, and communication. Antitrust relief will be essential to the success of ACOs, in particular. Further, while it is of paramount importance to develop and implement an updated physician payment mechanism, **we urge Congress to refrain from viewing the problems associated with physician payment in a “vacuum.”** Payment reforms impacting other healthcare providers should be considered and may be necessary to ensure a fair, stable Medicare system emerges from your efforts.

In addition, the ability of physicians to meet many of the tenets of Meaningful Use, e-Prescribing, PQRS, while maintaining accuracy of diagnosis coding during the upcoming ICD-10 transformation and achieving the additional requirements for Accountable Care Organizations (ACOs) will all obviously affect physician reimbursement, and therefore improvements in these areas should be considered in your deliberations regarding physician payment reform. Adequate time will be needed to adjust to multiple moving parts to determine what in fact, improves care, with lenience required during the adjustment period.

Again, the AAO-HNS appreciates the opportunity to work with you, your staff, and other Members of Congress on this critical endeavor to reform the Medicare physician payment system. In the coming weeks/months, the AAO-HNS stands ready to assist in any way possible. If you have questions regarding the AAO-HNS positions stated above, please contact Megan Marcinko, Senior Manager for Congressional and Political Affairs, at 703-535-3796 or mmarcinko@entnet.org.

Sincerely,



David R. Nielsen, MD
Executive Vice President and CEO