AMERICAN ACADEMY OF OTOLARYNGOLOGY–HEAD AND NECK SURGERY

November 12, 2013

The Honorable Max Baucus
U.S. Senate
Chairman, Finance Committee
Washington, DC 20510

The Honorable Dave Camp
U.S. House of Representatives
Chairman, Ways and Means Committee
Washington, DC 20515

Dear Chairmen Baucus and Camp:

The American Academy of Otolaryngology–Head and Neck Surgery (AAO-HNS) thanks you and your respective Committees for your continued dedication to permanent repeal of the flawed Sustainable Growth Rate (SGR) formula and appreciates the opportunity to offer comments regarding efforts to move toward a more dynamic payment model.

We understand this has been a major undertaking and appreciate your time and commitment to this critical endeavor. We also applaud your continued efforts to engage the physician community, including smaller medical specialties like the AAO-HNS, in this process, as well as your willingness to modify the draft proposal based on constructive feedback received.

The AAO-HNS feels strongly that a new payment model which is fair, equitable, and rewards the delivery of high-quality care will include provisions that:

- Allow physicians the opportunity to lead in the development of quality metrics and alternative payment models;
- Foster the sharing of best practices;
- Recognize the necessity of risk adjustment, in that a patient population's socioeconomic factors and co-morbidities can have an impact on achieving ideal patient outcome goals;
- Provide a system that keeps pace with the cost of caring for the nation's expanding senior population;
- Preserve fee for service as a payment option to provide stability during the transition to a performance-based payment system;
- Provide federal funding so that physicians can fully participate in quality improvement endeavors, including the development of alternative payment models (APMs), quality measures, and registries;
- Allow sufficient time (5-7 years) to develop/test/validate quality measures, educate physicians, and implement a system to report measures; and
- Reduce duplicative reporting burdens and/or penalties on physicians.

We are pleased to see that some of these elements have been incorporated into the draft framework, and we offer for your consideration the below recommendations on ways to integrate the remaining components into future proposals or legislative language.

I. SGR Repeal and Annual Updates

The SGR formula has failed to restrain growth and, in fact, may have exacerbated it by continuing to reward volume and failing to recognize efficiency. **We support full/permanent repeal of the flawed SGR formula.**

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.

Following repeal of the SGR, a period of stable payments will be necessary while physicians adapt and adjust to any new payment mechanism. We are concerned that the **10-year zero percent update**, as outlined in your recent framework, and a transition period of only three years, **will result in a net loss to physicians providing care** within the Medicare system. However, we would be agreeable to such a period given the following: 1) all three existing quality programs (PQRS, EHR MU, and VBPM) are consolidated into a budget-neutral, quality performance program that rewards providers who furnish high quality, high value care; and 2) costs incurred by physicians to meet any additional programmatic requirements during the period of stable payments are matched by payment increases. In addition, we support a concept originally advanced by the American Congress of Obstetricians and Gynecologists that would modestly **amend the discussion draft's 10-year zero percent updates to include a "trigger" for years 6-10 if inflation meets or exceeds four percent**. Under this approach, payment updates would be one-half the rate of inflation to help ensure physician payments keep pace with the costs of providing services and inflation as the transition to new payment models occurs.

II. Value-Based Performance (VBP) Payment Program

Under the proposal, Medicare payments to professionals would be adjusted based on performance in a single budget-neutral incentive payment program. Payments would be adjusted beginning in 2017 based on professionals' performance in 2015. **We support the 2016 sunset of the current CMS quality incentive program penalties (PQRS, EHR/Meaningful Use, Value-Based Modifier). However, please ensure the flaws and existing concerns associated with these programs do not re-appear in the newly-proposed VBP program.** For example, the VBP program could potentially improve current processes by aligning of the approval process for quality measures, such as those endorsed by National Quality Forum (NQF), AMA-Physician Consortium for Performance Improvement (PCPI), specialty societies. The consolidation or streamlining of these programs/processes would greatly increase the number of measures applicable to otolaryngologists and boost participation by 2015.

A. Assessment Categories

We stress the importance of inclusion of language specifying the ability of specialty societies to consult and collaborate with CMS and other agencies during the development and implementation of the VBP program.

i. Quality Measures

- **We strongly support the Committee's dedication to providing federal resources to ease the transition and assist specialty societies to develop applicable measures**. We encourage clarification about the source of the funding and how the funds will be prioritized among all stakeholders.

- **We firmly believe that public and multi-stakeholder input should be included in the process of measure development and selection via notice and comment period during annual rulemaking process**. In addition, specialties should develop a process to re-visit and re-certify guidelines and measures as new evidence becomes available, and differential "weight" should be afforded to "mature" measures.

- **We believe that both outcomes and process measures are important and should be the initial focus.** For specialties like otolaryngology, structural measures are less meaningful, and in many instances, do not apply to physician services.

- Congress must recognize that patient population socioeconomic factors and co-morbidities can have an impact on achieving ideal patient outcome goals. **As a result, appropriate risk adjustment and patient accountability should be included as critical components of any new VBP model. Also, further clarification of how to attribute a beneficiary to the physician who is not the primary care provider is needed.**

ii. Resource Use

- As the proliferation of registries and clinical data collection mechanisms increase, the data available for analysis of the relative resource use and complexity of services should also increase. The **availability and integrity of the data must be constant across services and providers in order to conduct a sound analysis of relativity.** Therefore, until all providers are collecting similar information, in a similar manner—likely through registries—the usefulness of this newly emerging data will be limited.

- **Incentives/funding for further development of clinical data registries** will not only assist in improving quality of care for patients, but could also contribute to improvements in data needs for purposes of valuing medical services.

iii. Clinical Practice Improvement Activities

In addition to the clinical practice improvement activities included in the discussion draft, we believe that all of the items in the following list of activities promote high quality care and enable all specialties to achieve higher "scores," and should therefore be an integral part of a new payment system.

- Provision of care consistent with specialty-specific, evidence-based, guidelines or application of decision support tools.
- Improved care organization and coordinated 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.
- Collection of feedback from beneficiaries on their care experience.

B. Performance Assessment and Weights for Performance Categories

We believe that access, equity and performance incentives, as well as physicians' acceptance of the payment reforms, would be enhanced by establishing a reasonable base rate and adjusting that rate up or down based on performance. We support reductions from the base rate for inadequate performance, as long as the methodology utilized is transparent and truly reflective of care provided by a particular group of providers.

We also support the proposal to allow physicians to choose whether the assessment of their performance - on quality and efficiency - occurs at the individual or group practice level. If they choose individual performance, then an incentive linked to the comparison of performance on a given year should be based on the prior year.

In addition, we encourage rewarding top-performers at levels higher than 100 percent, though this approach should not be budget neutral. **We urge the Committees to develop a 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.**

In the current framework, it remains unclear how the composite scoring would work in the first two years, 2017 and 2018. **We recommend that in 2017 and 2018 more weight be given to the quality measures aspect than resource use. As with other aspects of this framework, we ask that language be included to promote input by physicians and other stakeholders to CMS or the assigned agency, through the rulemaking process.**

C. Assistance to Small Practices

We appreciate the Committee addressing the issue of providing funding and assistance to practices of ten or fewer eligible professionals located in health professional shortage areas (HPSAs) or rural areas. We look forward to further clarification on the source of funding and additional detail about the process to implement this component of the proposed framework.

D. Feedback for Performance Improvement

The AAO-HNS supports the concept of requiring the Secretary to provide confidential feedback on provider performance in quality and resource use categories on a timely basis. Informational resources to help physicians understand and incorporate this feedback into their practices will be critical for success.

III. Encouraging Alternative Payment Model Participation

We also support the development of new and innovative payment models that involve the patients, physicians, and payers, as well as shared savings programs between hospitals and physicians and the removal of any legal barriers restricting these types of arrangements. In addition, the AAO-HNS is supportive of pilots and demonstration projects to determine if bundled payments or other alternative payment models are an appropriate mechanism to improve the Medicare payment system.

Federal resources must be employed to work with all specialties and/or exemptions/extensions should be considered for 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.

A. Timeframe for Development of APMs

We are concerned that there will not be applicable APMs available to all physicians by the mandated compliance year of 2017. A **phased-in approach allowing for a transition of at least five to seven years** to develop, test, and pilot APMs, as well to develop, validate, and educate physicians on measures appropriate to the specialty is needed.

There are many questions regarding the oversight of the APM process, including:

- Where would the authority for prioritizing and validating newly-developed APMs lie?
- How quickly could their work be done so that APMs are in place for all specialties?
- What is the process for societies to get access to data and technical assistance in modeling?

B. Otolaryngology-Specific Issues

While the AAO-HNS is committed to finding appropriate APMs for ENT participation, we face many of the same challenges, as with measure development, given how highly sub-specialized otolaryngology is as a surgical specialty. We hope to gain insight from the private health insurance perspective about opportunities for payment reform in otolaryngology and which otolaryngology services lend themselves to alternative payment methods.

Unfortunately, there is not one bundle/episodic model that could be developed for a disease condition that would be applicable to more than 50 percent of all otolaryngologists. We would require multiple bundles available across our twelve specialties (general otolaryngology, head and neck oncology, pediatrics, laryngology, bronchoesophagology, sleep medicine, otology, neurotology, rhinology, allergy, geriatrics, and facial plastics) for our physicians to participate. **As an example, Cleveland Clinic, who has made significant progress in development of episode bundles, has recognized two important issues:**

1. Out of the 25 bundles created in Ohio, none have been in otolaryngology-head and neck surgery due to the heterogeneity noted above; and
2. Due to the exclusions for co-morbidities among other technical requirements of defined bundles, even in areas of robust episodic bundling performance (e.g., orthopedic joint replacement), there is a maximum of 10 percent of Cleveland Clinic's revenue specific to that service-line coming in through episodic bundling – **far short** of the Committee's requirements proposed in this framework.

While the AAO-HNS Ad Hoc Payment Model Workgroup is working on creating ENT bundles for the Academy (as well as a communication methodology to get market innovations out to our members), we recommend significantly decreasing the percentage requirements of revenue that is required to come through the bundling delivery process for practices that demonstrate a defined volume of heterogeneity in their current revenue make-up, or an alternative methodology for participating in bundles which does not rely on a percentage of revenue model. **We hope the Committee will consider this critical reality in its future deliberations regarding APM participation.**

IV. Encouraging Care Coordination for Individuals with Complex Chronic Care Needs

The AAO-HNS supports encouraging providers to engage in coordination of care for all patients, particularly those with complex chronic care needs. We support the necessary coding changes to allow for reimbursement for all physician work aimed at coordinating care for Medicare beneficiaries, regardless of whether it is performed by a specialist or a primary care physician.

V. Ensuring Accurate Valuation of Services Under the Physician Fee Schedule

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 as physician payment reforms are implemented and alternative payment models are developed. 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. Review and vetting of the number of post-operative visits in a global surgical period is part of this review process.

However, if there are concerns on the part of Congress or CMS regarding a specific code, or group of codes, we recommend they specifically identify those codes and work through the AMA RUC process to

correct any perceived errors or misevaluation of the service rather than impose a tremendous burden on all surgical specialties, and/or CMS, to do an internal review of all surgical procedures with an associated global period.

VI. Recognizing Appropriate Use Criteria

The AAO-HNS agrees the Secretary should identify mechanisms, such as clinical decision support (CDS) tools, that could be used by ordering professionals to consult with appropriate use criteria and communicate to the Secretary that such consultation occurred. The AAO-HNS has otolaryngology-head and neck surgeon representation on the American College of Radiology's Appropriateness Criteria and supports relevant physician input into the development and use of appropriateness criteria for procedures.

VII. Expanding the Use of Medicare Data for Performance Improvement

The proposal would allow those that currently receive Medicare data for public reporting purposes (qualified entities "QEs") to provide or sell non-public data analyses to physicians and other professionals to assist them in their quality improvement activities. **We support the availability of data to physicians, but we urge Congress to require the data be provided in a format that can be easily analyzed, and believe that the Medicare data should be provided at minimal or no cost.**

VIII. Transparency of Physician Medicare Data

The proposal would require HHS to publish utilization and payment data for physician and other practitioners on the Physician Compare website. **The AAO-HNS supports providing patients and beneficiaries with information that allows them to make the best decision possible regarding their clinical care. However, we have continued concerns regarding current CMS proposals related to the Physician Compare Website.**

Presently, there are many problems with the Physician Compare Website; for example, inaccurate physician information regarding their associated specialty or misclassified physician specialties. CMS must carefully review and resolve these inaccuracies to ensure they develop an accurate and precise method of collecting, and displaying, information on the Physician Compare Website prior to any additional performance information being posted.

CMS should be cautious and discerning regarding what provider information is necessary and meaningful for a patient in order to make an informed decision about their care, and avoid over saturating the patient with too much information, which may not be relevant to their decision. **Rather than trying to align elements of the PQRS and VBM programs to the Physician Compare Website, we urge Congress to require that CMS distinguish Physician Compare as a solely public reporting website that focuses on communicating validated, meaningful information to patients using statistically significant sample sizes.**

IX. Conclusion

The comprehensive work completed this year in regards to the SGR is to be commended. For years, repeal of the SGR has faced two critical barriers—what to replace it with and the cost associated with reform. We look forward to working with your Committees to refine the proposal as outlined above. In addition, we would also like to recognize the positive—bipartisan and bicameral—approach utilized in developing your framework. It is through these collaborations that we find ourselves discussing the viability of possible solutions to the ongoing SGR issue.

We encourage you, your fellow lawmakers, and your respective staffs to continue with this approach as you discuss the offsets necessary for final passage of SGR legislation this year.

Again, the AAO-HNS appreciates the opportunity to work with you on this critical endeavor. With only weeks left in the year, the AAO-HNS stands ready to assist in any way possible. If you have any 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