AMERICAN ACADEMY OF
OTOLARYNGOLOGY–
HEAD AND NECK SURGERY

July 11, 2013

The Honorable Fred Upton
U.S. House of Representatives
Chairman, Energy and Commerce Committee
Washington, DC 20515

Dear Chairman Upton:

The American Academy of Otolaryngology–Head and Neck Surgery (AAO-HNS) thanks you and the Committee for your continued dedication to permanently repealing the flawed Sustainable Growth Rate (SGR) formula and the concurrent development of a new payment system under the Medicare program. As this process continues, we strongly urge the Committee to continue its collaboration with medical specialties such as the AAO-HNS, as these organizations can provide a wealth of knowledge in regards to how specialty physicians may or may not be able to adapt to the various payment models being put forth in the evolving legislative framework. As noted in our previous letters, we look forward to working with Congress to resolve the many details that remain to be considered in creating a system which is fair, equitable, and most importantly, rewards the provision of high quality care.

The flawed SGR formula has had a crippling effect on the physician community for the last decade and has prevented some physicians from fully embracing other healthcare reform initiatives due to the inherent payment (and cash flow) instability in the system. The Committee's effort this year, coupled with a favorable score from the Congressional Budget Office (CBO), represents our best opportunity to date to replace the SGR.

While the AAO-HNS commends the Committee for its work to date on this critical issue, we caution that the process of developing a payment model to replace the SGR must allow adequate time to carefully craft a solution that will endure for many years to come and truly be the best proposal for all providers, their practices, and most importantly, their patients. We urge your Committee to continue to work with the House Ways and Means Committee and the Senate Committee on Finance to ensure a bipartisan, bicameral solution can be achieved **by the end of year**.

The AAO-HNS has submitted comments to each Congressional request, and we appreciate the opportunity to do so again. **However, given the time constraints associated with the latest legislative draft, our organization is offering comments on only the questions we believe have the most significant impact on otolaryngology—head and neck surgery.** Again, thank you for the opportunity to provide input on this important process and please accept the following comments/concerns regarding the legislative draft and questions from June 28, 2013.

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.

I. Update Incentive Program

A. Provider Peer Cohorts

Under the proposed payment scenarios for the Update Incentive Program, the Committee notes the following:

> "The replacement policy to SGR proposes an improved, quality-based fee for service (FFS) payment system wherein fee schedule providers are financially recognized for providing high quality care as compared to evidence-based quality measures. While there are multiple conceivable methods to apply these financial incentives for quality care, two options are described below.
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> The basis for each payment model is derived from the fee schedule provider's performance with regard to the quality measure set of their self-selected Peer Cohort. Performance compared to each competency based measure (or clinical practice improvement activity in Phase I) yields a numerical score, the aggregation of which results in a composite score. All fee schedule providers participating in the Update Incentive Program will receive a composite score at the end of each performance period. The composite scores can then be used in one of two proposed ways to determine the fee schedule provider update."

As stated in our previous comment letters, **although we support the repeal of the SGR formula and the development of new payment models, the AAO-HNS feels strongly that the current FFS system should remain the standard in the short-term and, for certain physician practices, the longer term as well.** Further, a period of stable payments following the repeal of the SGR formula will be necessary while physicians adapt and adjust to any new payment mechanism. In addition, a reasonable amount of time will be needed for physicians to receive meaningful and timely data/feedback to help adapt and adjust behavior. We strongly 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.

We do not agree with using only the ABMS list to define categories of peer cohorts. The ABMS list is not adequate as it does not include all sub-specialties, and we strongly urge the Committee to consider allowing for exceptions or other mechanisms to allow for categories that are not included in the ABMS list. For example, the ABMS list does not include the complete list of recognized subspecialties within otolaryngology. Otolaryngology-head and neck surgery includes general otolaryngology and ten sub-specialties—pediatrics, laryngology, broncho-esophagology, sleep medicine, otology, neurotology, rhinology, allergy, geriatrics, and facial plastics. The ABMS list only includes four of the ten sub-specialties within otolaryngology, so we do not believe that using the ABMS list is sufficient.

The AAO-HNS believes that "Peer Provider Cohorts" should be more clearly defined, particularly if providers will need to self-select their Peer Cohort. Our recommended definition would be groups of physicians who have a shared particular event, during a particular timespan, based on the disease process or the specialty. A cohort based on disease process could be a possibility for otolaryngologist-head and neck surgeons, but would depend upon how and when the otolaryngologist or specialist received the patient. The AAO-HNS also has

concerns about the definition of peer groups and the importance of risk adjustment. This is important as **varying patient socioeconomic factors can impact patient care.**

It is also not clear how to attribute the beneficiary to the physician who is not the primary care physician. **We stress the necessity of risk adjustment, which we strongly believe should include the recognition that a patient population's socioeconomic factors and co-morbidities can have an impact on achieving ideal patient outcome goals.** As we work together to ensure a new system incorporates quality outcomes and efficiency, Congress needs to look at global outcomes of various interventions independent of the provider. Some interventions are simply not routinely successful, no matter who performs them. Creating a financially sustainable Medicare system will depend on committing monies where they can do the most good, and data must be available on certain interventions independent of which practitioner performed them. These are hard decisions, but they must be made. **We urge Congress to require transparency and ensure the ability of the medical community to have dialogue with CMS. Physicians must be able to provide comment on proposed cohorts, such as in a rulemaking process, for the development of any defined Peer Provider Cohort.**

B. Update Adjustment Taking Into Account Competency Assessments

1. The "Threshold" or "Benchmark" Update Incentive Payment Model

In the proposed legislation, this model includes the following:

> "Under this scenario, all fee schedule providers have the opportunity to achieve the maximum update. As part of the quality measure set development process for each Peer Cohort, Specialty society and other relevant stakeholder input will be used to determine benchmarks (thresholds), which will be published prior to the performance period. A series of these benchmarks will be established with a composite score exceeding the highest benchmark receiving the highest update, and a composite score below the lowest benchmark receiving the lowest update. Intermediate benchmarks will receive intermediate update amounts. The number of benchmarks is to be determined and public comment on this variable as well as the overall concept is invited."

The AAO-HNS agrees with many of the aspects of how the draft legislation ties measurement to payment. However, we believe that many of the details associated with such a process will require additional consideration. **The AAO-HNS strongly agrees with using a threshold as a basis for measurement, rather than a percentile update model (see Question One).** It is concerning that the legislation does not clarify whether the percentile update model would be budget neutral. Further, the percentile update model may cause unnecessary competition among physicians for rank which could significantly limit the creation of models of success to which all physicians can aspire – where physicians are not only rewarded for good ideas, but are also encouraged to share those ideas with their peers. We believe that only physicians meeting a minimum quality score threshold should be eligible to earn additional incentive payments based on efficient use of healthcare resources. A threshold proactively sets the bar and allows everyone to know what is needed to achieve the goal. **We support the concept of allowing corresponding update levels based on reaching different benchmarks.** Such a process would allow for physicians to receive additional payouts for each incremental improvement, so they are paid along the continuum once they achieve a minimum threshold of performance. Over time, the threshold can rise, and we agree that **the thresholds should be transparent, with the applicable metrics available to physicians at the beginning of the performance measure period.**

2. Measures and Performance Assessment

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, is however 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.

We believe a transition of at least five to seven years is necessary to develop, test, and validate measures; educate physicians on the measures; as well as to put a system in place to report the measures. This timeframe is particularly important and necessary for those smaller specialty societies comprised of multiple sub-specialties, like the AAO-HNS, who are developing measures, but have yet to develop adequate measures in each of the sub-specialty areas that are relevant to each practice, and who are still in the early stages of developing registries. Also, the cost of measures development, feasibility testing, and implementation can only be spread over a much smaller cohort of specialists, which further limits the speed of progress.

We agree with the proposal to allow CMS or other entities to qualify registries that facilitate reporting of quality measures that are endorsed by organizations such as the National Quality Forum (NQF), but also non-endorsed measures developed by medical societies with appropriate rigor and validity. It is essential for the success of this program to not limit the development of measures solely to the discretion of the Secretary of the Department of Health and Human Services (Secretary), which creates a bottleneck and slows progress, and instead allow societies to develop and test measures. Further, a defined process for measure stewardship including development, introduction and discontinuation is essential to any new performance-based system. The measures must be evidence-based and field-tested to validate the measures for accuracy, sensitivity, specificity, and burden associated with collection of information. While we appreciate the inclusion of stakeholder input regarding the provisional core competency sets and then the final competency measure sets, we strongly believe that **all measures, improvement activities, and performance standards should be required by the Secretary to go through the federal notice and comment rulemaking process, including time for review during the proposed rule, before the measure set is made final (see Question Six).**

As with the development of other methodology and policy development, **we further agree that the methodology for developing measure sets (and clinical quality improvement activities) should be made public and included as part of an annual rulemaking process with the opportunity for public comment (see Question Six).** Further, we stress that an annual review of all measures could be burdensome and is not necessary. **Instead, we agree with the proposal to include the requirement for CMS (with input from providers and other stakeholders) to review the latest scientific evidence to consider adding new measures and refining or dropping existing ones as needed to enhance the value of the quality measurement system for providers, patients, and payers.**

The AAO-HNS believes that another way to link quality to payment is to include efficiency measures. While this could add value to the payment system and potentially improve care provided to patients, we feel strongly that this should not be a component of any measurement until the system has evolved and matured (Phase III). Efficiency must be tied to established standards of validated quality measurement, otherwise resource use and cost reductions can be achieved by lowering quality and harming individual and population health outcomes. **Therefore, we believe that efficiency**

measures should be explored (see Question Eight), along with other improvement activities, for inclusion to the payment system after allowing at least 5-7 years for the new payment system to develop and mature. As addressed below in section II, development of measures is a resource-intensive process and will require funding from federal sources.

II. Opt Out Through Alternative Payment Model (APM)

Moving forward, we agree that a new payment system should be able to recognize ongoing quality improvement activities that are being undertaken by societies as well as the positive impact of these programs on both the culture of the specialty and performance in practice. **We agree with allowing physicians the flexibility to participate in an alternative payment model at any time.** This will foster collaboration and best practice and allow for greater flexibility for increased participation, as well as invite new creative methods for incentivizing quality care and effective resource use as described below.

In addition, the AAO-HNS strongly agrees with the development of pilot 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. And, regardless of what reforms are ultimately adopted, a fee-for-service payment option will need to remain an integral part of physician payment for the foreseeable future. Further, use of pilot and demonstration projects will help reduce the sense of risk and uncertainty for physicians.

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 further support the concept of shared accountability and believe that more work needs to be done to stratify risk and identify, attribute, and share accountability across provider, patient, and system groups (Question Nine).**

To explore the use of alternative payment models, the AAO-HNS has created an Ad Hoc Payment Model Workgroup, which includes physician leaders with expertise in payment, quality improvement, and research. The goal of this group is to review current and future payment trends in otolaryngology-head and neck surgery and other specialties. We are looking to predict otolaryngology disease processes where payment reform is likely and focus on care path development for future use by otolaryngology-head and neck surgeons. This will include outreach to patient advocacy groups to determine if there are any access issues in obtaining otolaryngology services within communities. 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. We look forward to the opportunity to provide the Committee with additional input related to this area. **(See Questions 11, 12, and 13)**.

III. Issues Not Addressed in Draft Legislation

The draft legislation does not address the need for resources identified through federal funding for outcomes research and development of quality assessment tools. 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. Further, we believe there needs to be a mechanism in place that helps small practices (for example, those with one to five practitioners) engage in contracting and/or accessing global systems. This would allow physicians the opportunity to participate in more than one payment model to foster collaboration and best practices and to allow for greater flexibility and increased participation while not impairing patient access to specialty care provided by these smaller groups, especially in underserved areas.

We strongly encourage the Committee to consider the inclusion of language providing federal resources for specialty societies like the AAO-HNS to develop and vet measures and build the necessary quality infrastructure. This support will allow for greater opportunity for otolaryngologists to move forward and participate in the new performance-based system. While there are some resources available, funding is limited and often allocated first to the groups with the National Priorities Partnership (NPP) conditions (ESRD, COPD, CAD, end-of-life care, DM, etc.). Although we will continue to seek opportunities to receive funding when they arise, we urge the Committee to include funding resources in the next draft of the legislation.

As mentioned above, 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. However, **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, and with insufficient resources. Ideally, any piece of Medicare physician payment reform legislation should **include funding assistance and time for the completion of pilot studies to support specialty physician participation in new payment models.** While there are currently some funding opportunities available, they are limited.

In addition, it is important to ensure that **physician payments keep pace with the costs of providing services and inflation during this transition period**. The ability to offset physician costs is necessary to implement a new system, and failure to do so will limit access to care – especially in rural areas. While we recognize the difficulties of the current fiscal climate, we oppose simply freezing payment rates and urge Congress to consider some positive payment update so physicians can continue to provide quality services to patients.

The AAO-HNS strongly opposes a "claw-back system" in which rates are cut up front – perhaps significantly – for all physicians with any gains toward a zero update or rate increase based on performance. We believe that access, equity and performance incentives, as well as physicians' acceptance of the payment reforms, all would be enhanced by establishing a reasonable base rate and adjusting that rate up or down based on performance. Therefore, **we urge the Committee to include language specifying that payment rates would not be frozen during the five to seven years transition period to the new payment system.**

Finally, we note that the proposed legislation does not specifically address the value-based payment modifier (VBM). We support incorporating the current resource-based relative value services payment system in a new fee-for-service (FFS) payment model. However, we believe that the value-based modifier (VBM) system should be delayed until after physicians have had the time to transition to a new system of payment based on measures. The VBM is scheduled for 2017 implementation for all physicians based on 2015 data and includes quality and cost measures, which for many specialties have yet to be developed. **As such, the AAO-HNS recommends that language be included postponing the VBM until such a time that more specifics become available regarding the**

new system's framework, or until it is superseded by the new performance-based payment system.

IV. Conclusion

Again, the AAO-HNS appreciates the opportunity to work with you, your staff, and other Members of Congress on this critical endeavor. 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