AMERICAN ACADEMY OF
OTOLARYNGOLOGY–
HEAD AND NECK SURGERY

February 26, 2013

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

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

Dear Chairmen Camp and Upton:

Thank you for the opportunity to provide comments and assist in your Committees' 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 remain to 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. **However, given the completion of early-year hearings and a nearly halved score from the Congressional Budget Office for repeal of the SGR, it seems the "stars are aligning" for a possible final resolution before the August recess.**

As a specialty, we recognized the unsustainability of the current system, and over the past six years, have positioned ourselves well for a future payment system based on quality and efficiency. Outlined below are some of the initiatives we have put in place and specific actions we have undertaken:

- A clinical practice guideline development process that has been recognized as a "best practice" by the AHRQ and recognized and cited in the Institute of Medicine's 2011 report on the development of trustworthy guidelines. To date, ten guidelines have been published;
- Partnered with a vendor to offer a web-based portal for members to more easily upload PQRS measures to CMS;
- Collaborated with the American Medical Association (AMA)/Physician Consortium for Performance Improvement (PCPI) on the development of two measure sets;
- Became the first surgical specialty to join the ABIM Foundation's *Choosing Wisely*® campaign; and
- Created an Ad Hoc Payment Model Workgroup to predict otolaryngic disease processes where payment reform is likely with outreach efforts to patient advocacy groups and private health insurance companies for their insight.

The AAO-HNS applauds your efforts to proactively develop a framework for moving beyond the current Medicare physician payment model. We recognize this proposal is in the very early stages of development, and we therefore urge the Committees to continue to seek the input of physician groups, which will be necessary to appropriately take into account the complexity, intensity, and associated risk in valuing services provided to patients. Based on the quality improvement efforts we are already actively engaged in, we believe the following are needed to move forward into a new payment system:

- Eliminate the SGR formula, and replace it with an evolved payment system that improves quality, lowers costs, and better integrates the delivery of care across all patient care settings;
- Provide the flexibility in a new system that is not "one-size-fits-all" and allows both physicians and patients the time to adapt and adjust with pilot programs to test and transition to the new system;
- Ensure adequate federal funding and resources to help testing, risk adjusting, and ongoing support of meaningful outcomes, process, and cost measures for continued ongoing efforts and additional measure development in the new system; and
- Incorporate elements of the present FFS system, along with a new payment model that is physician-led and tested for five to seven years before it is adopted, to provide timely, open access to sustainable, high quality care. We are committed to changing the current system, but it cannot be done reasonably and with stability in a shorter period of time.

Again, thank you and your staff for the opportunity to participate in this critical process, and please accept the following more specific comments, concerns, and/or observations:

PHASE 1: Repeal SGR and Provide a Period of Stable Payment Rates

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 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. **While we recognize the difficulties of the current fiscal climate, we believe that simply freezing payment rates during Phase 1 is ill-advised.**

We also support incorporating the current resource-based relative value services payment system in a new fee-for-service (FFS) payment model. However, it is not clear from your proposal or from initial discussions with your Committees what would happen to the current payment adjustments during the transition period. If there is a time to transition which offers the ability to create a system of measurement, does this mean the value-based modifier (VBM) system gets delayed or is superseded by this legislation? The VBM is scheduled for 2017 implementation for all physicians based on 2015 data and includes quality measures and cost measures, which for many specialties have yet to be developed.

Additionally, **we urge Congressional leaders to refrain from utilizing a budget-neutral framework** for determining payments since the future holds an increasingly older patient population who will require quality medical care. We respectfully encourage Congress to identify possible "pay-fors" outside of the Medicare system to pay down the initial debt associated with repeal of the SGR formula. Additional resources will then be created by efficiencies such as timely referral to specialists, halting duplicative tests, and using evidence-based care.

Finally, **we hope that the system can create 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.

PHASE 2: Reform Medicare's FFS Payment System to Better Reflect the Quality of Care Provided

The AAO-HNS believes fully 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 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.

Given the emphasis on measurement in your proposal, there would need to be some type of **federal funding to assist specialty societies in measures development and endorsement – some form of federal partnership for all specialties.** Federal resources must be implored to either work with all specialties or consider granting exemptions/extensions to smaller specialties that do not routinely deal with the high dollar 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.

More so than other surgical specialties, otolaryngology-head and neck surgery covers a broad scope of diverse sub-specialties (general otolaryngology, pediatrics, laryngology, broncho-esophagology, sleep medicine, otology, neurotology, rhinology, allergy, geriatrics, and facial plastics), which complicates the ability to create a disease-specific data registry that would meet the needs of the majority of our members. Comprehensive data warehousing is a cost-prohibitive solution, and current registry activity is limited to narrow condition-specific data collection. In addition, none of our available data are focused on the National Priorities Partnership (NPP) conditions that drive the quality improvement enterprise (ESRD, COPD, CAD, end-of-life care, DM, etc.). **Many specialties, including otolaryngology-head and neck surgery, can show expertise and experience in developing multi-disciplinary guidelines and performance measures, but do not have the resources to drive EMR development, registry initiation or integration or practice implementation, without systems-consulting and other resources.** Nor can we spread the costs over a large number of practitioners as can primary care. These factors are yet additional reasons why we strongly believe there is no "one-size-fits all" solution to Medicare physician payment and a federal partnership for all specialties is necessary.

After resources are identified through federal funding, we believe a transition of five to seven years is necessary to develop, test, validate measures, educate physicians on the measures, as well as to put a system in place to report the measures. In addition, the provision of **meaningful and timely data/feedback to physicians is necessary to help adapt and adjust behavior**. The current two-year lag is not acceptable moving forward. For example, 2013 PQRS reporting is the basis for 2015 payment adjustment. Quarterly reporting is ideal, and if this cannot be achieved, a slightly longer transition period would be acceptable.

We also understand that all stakeholders, particularly patients, benefit from the collection and analysis of physician quality data, and that it is important to provide patients, the public, and physicians with accurate information on comparative quality performances among providers. Furthermore, meaningful and accurate clinical outcomes and processes of care data must be generated by physicians. **However, the AAO-HNS is concerned that this phase would be based on risk-adjusted relative rankings among physician specialty peer groups without any testing of the measures developed in Phases 1 and 2. Further, we believe there needs to be a clear definition of peer groups and risk-adjustment.** We are concerned how a peer group would be defined to ensure a physician is correctly attributed to a peer-group not only from a specialty perspective (i.e. a pediatric otolaryngologist should not be compared to a neurotologist), but also by practice type (academic vs. community-based; large group vs. small group; and rural vs. inner city).

There are also significant hurdles associated with attributing care to a single physician and the effects of delivering complex care involving teams of physicians. We support the necessity of risk adjustment, which we strongly believe should include the recognition that a patient population's socioeconomic factors, co-morbidity, compliance, and adherence can have an impact on achieving ideal patient outcome goals. We believe that no physician group that takes on the risk of furnishing care

to high-risk Medicare beneficiaries should be penalized based on comparing their outcomes to physicians furnishing care to lower-risk patient groups. In addition, uncertainty as to whether a group will receive payment for taking on high-risk patients could dissuade groups from electing shared savings reimbursement options. We ask for additional clarification on the following:

- What risk-adjustment will be used? Who will develop the risk adjustment strategy?
- Do you envision moving toward procedure-based "risk-adjustment"? At the code level or practice-specific?
- How would you take into account that a physician's practice is dynamic and changes over time?
- How will patient-contributed data be assessed, valued, and included?

PHASE 3: Further Reform Medicare's FFS Payment System to Also Account for the Efficiency of Care Provided

As noted for Phases 1 and 2, resources would be needed to help physicians understand available data and better comprehend how they can become more efficient providers. Currently, physicians are provided very limited data in order to gauge efficiency of care. **The AAO-HNS strongly recommends that any attribution methodology used to generate physician reports be transparent, along with clear plans for evaluating the impact of the reports.**

Similarly, as noted above, the AAO-HNS also has concerns about the definition of peer groups and the importance of risk adjustment. This is important as the **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. As we work together to ensure a new system is designed to incorporate 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.

Moving forward, we believe a new payment system should be able to recognize ongoing, quality improvement activities that are being undertaken by societies, and the positive impact of these programs on the culture of the specialty and, over time, on performance in practice. **The AAO-HNS supports alternative payment models and has created an Ad Hoc Payment Model Workgroup** including 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 otolaryngic 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 otolaryngic services within communities. We hope to gain insight from the private health insurance perspective to learn more about where they find a need for payment reform in otolaryngology, which otolaryngology services would require payment reform the most, and for which procedures significant payment variations currently exist.

In addition, the AAO-HNS was the **first surgical specialty to join the Choosing Wisely® campaign**. The intent of this campaign is to "help physicians and patients engage in conversations about the overuse of tests and procedures and support physician efforts to help patients make smart and effective choices about their care" (www.ChoosingWisely.org). Our list of five tests and treatments that should be questioned was released last week alongside seventeen other societies.

BEYOND PHASE 3: Provide Information for Congress to Further Modify the Payment System

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, recent reforms support tying compensation to outcomes and quality. 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 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. Unfortunately, it may be too early to determine how these programs will fully impact the delivery of care.

We also emphasize the importance of maintaining a resource-based relative value services payment system. The strength of having such a system is that it is developed with physician input, with additional input by others stakeholders, who have the expertise to determine the appropriate complexity, intensity, and associated risk of a procedure which is key to establishing a fair and equitable payment system.

Further, the notion of "healthcare reform" must also extend to beneficiaries. Attempts must be made to better educate patients/beneficiaries about the costs associated with healthcare services and resources. **Without increased patient education and accountability, a large piece of the healthcare reform puzzle will be missing.** We believe outreach to patient advocacy groups will be an important part of this plan, and that these groups should be asked for input from their perspective on either specific areas of improvement needed for access to specialty-specific services, or for critical gaps in affordability of care for specialty services. Federal funding will be needed for patient education to alter expectations based on changes in treatment patterns.

OTHER ISSUES FOR CONSIDERATION: Developing Complementary Reforms to Improve the Practice Environment

The AAO-HNS encourages Congressional leaders to explore various health-related reforms that would positively impact the practice environment. However, **we believe that the focus of the current proposal should not expand beyond the concurrent repeal of the SGR formula and development of a new payment system.**

Moving forward, the AAO-HNS sees an opportunity for Congress and the physician community to again partner in addressing complementary healthcare reforms.

- Appropriate reforms to the medical liability reform system will help ensure that physicians, practicing within new quality and/efficiency guidelines, are afforded necessary liability protections. Since some medical expenditures are not always medically necessary, and instead relate to the fear of medical liability, legislative efforts to reduce these costs associated with "defensive medicine" could help save the healthcare system billions of dollars each year. Thus, tort reform coupled with utilization of clinical practice guidelines has the potential to lead to significant healthcare expenditure savings.
- 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.

In the coming weeks/months, the AAO-HNS appreciates the opportunity to work with Members of Congress and staff to provide input regarding the concurrent efforts to permanently repeal the flawed SGR formula and develop a new Medicare physician payment system that will provide necessary stability for physicians and ensure access to quality care for our nation's senior population. Again, thank you for the opportunity to comment on your efforts, and we stand 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

David R. Nielsen, MD
Executive Vice President and CEO