AMERICAN ACADEMY OF
OTOLARYNGOLOGY–
HEAD AND NECK SURGERY

June 10, 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) appreciates the opportunity to continue to assist in your Committee's efforts to permanently repeal the flawed Sustainable Growth Rate (SGR) formula and develop a new payment system under the Medicare program. We strongly feel that input from clinical specialties such as the AAO-HNS is a valuable resource, and we thank you for your continued outreach to the physician community. As noted in our previous letter, 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.

While we recognize this draft legislation is still in the early stages of development in terms of an overall solution, we urge the Committee to continue its dialogue with the physician community, providing time for receiving feedback on more specifics about the framework you are envisioning as it is a critical partnership given the complexity, intensity, and associated risk in valuing services provided to patients. The AAO-HNS has submitted comments to each Congressional request, and we appreciate the opportunity for continued input as efforts move forward. **Also, 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 this year.**

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. 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 observations on the questions related to Phase I and Phase II of second draft of your proposal.

A. PHASE 1: Stable, Predictable Updates

1. What is an appropriate period of payment stability in order to develop and vet measures and build the necessary quality infrastructure?

As stated in our previous comment letters, 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.

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.

After resources are identified through federal funding, **we believe a transition of at least 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. This timeframe is particularly important and necessary for those smaller specialty societies comprised of multiple sub-specialties, like the AAO-HNS, who have yet to develop adequate measures and who are still in the early stages of developing a registry.**

As Congress continues to develop the policy associated with SGR repeal, we strongly urge leaders to work to gain bipartisan support to help push the "pay for" discussion forward in as positive a path as possible. **Utilizing a budget-neutral framework must be avoided for determining payments, and we strongly urge Congress to identify possible "pay-fors" outside of the Medicare system to pay down the initial debt associated with repeal of the SGR formula.** Once the debt has been eliminated, additional resources will likely be identified or made available as new efficiencies and cost reductions, such as timely referral to specialists, halting duplicative tests, and instituting evidence-based care become a larger aspect of the healthcare delivery system.

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 the new system, and failure to do so will limit access to care. While we recognize the difficulties of the current fiscal climate, **we oppose simply freezing payment rates and urge Congress to consider some payment update so physicians can continue to provide quality services to patients.**

Further, 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. Importantly, we agree that poor performance should lead to lower payment rates and would support reductions from the base rate for inadequate performance as long as the methodology utilized is transparent and truly reflective of care provided by that cohort of providers.

We also support incorporating the current resource-based relative value services payment system in a new fee-for-service (FFS) payment model. However, after the time to transition allows for the ability to create a system of payment based on a measurement system, we believe that the value-based modifier (VBM) system should be delayed until such time that more specifics become available regarding the new system's framework, or is superseded by this legislation. 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.

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

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.

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. **In order to develop and vet measures and build the necessary quality infrastructure for specialty societies like ours to move forward and participate in the new performance-based system, federal resources must be provided.** 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.). However, we continue to seek opportunities to receive funding when opportunities arise, but we urge the Committee to include funding resources in the next draft of the legislation.

Finally, as we discuss in more detail below, **we urge Congress to allow for a process to be developed by specialty societies and not require NQF endorsement.** 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), and instead allow societies to develop and test measures. Further, a defined process for measure 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. **This process requires additional time and resources and provides the foundation for our belief that a minimum of five to seven years is necessary for this process.** We also believe it to be important that measures not be used for payment determination until they have been reported by providers for at least one year prior to the start of a performance year. Additionally, there should be a notice and comment for proposed measures through an annual rulemaking process.

2. Considering the different levels of provider readiness, how do we balance the need for a stable period enabling providers to build and test the necessary quality infrastructure, while still incentivizing early innovators to move to Phase II, with opportunities for quality-based payment updates?

We are interested in working with the Committee to 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. Currently, a majority of otolaryngology private practices are made up of small practices of one to three physicians. As a result, we are concerned that these small practices would not have the same opportunity as those from large practices in urban areas, who have more resources available, to become "early innovators/adopters." We believe that implementing new reporting systems is disproportionately burdensome to smaller practices, and as such, offering incentives for early adopters could be prejudicial towards the small practices that are the cornerstone of both sophisticated, tertiary specialty care in all geographic areas and all medical practices in small town and rural markets. As such, we would oppose incentives for early adopters unless federal and other subsidies could ensure that the implementation of the new system was equally achievable for medical practices of all sizes.

Further, we believe that development of this type of system would likely limit access to patient care in more rural geographic areas. **Therefore, we do not agree with early innovators receiving additional incentives above and beyond current incentive programs at the expense of the solo or small physician practice. We do, however, support rewarding top-performers at levels higher than 100 percent, though the new framework should not be budget neutral. We also urge the Committee to develop 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.**

Further, we believe there needs to be a mechanism in place that helps practices with three 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. 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, and additional geographic maldistribution is inevitable if such practices cannot thrive.

3. What does a meaningful, timely feedback process look like for providers? What are adequate performance feedback intervals?

We 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. Meaningful, timely feedback includes information provided confidentially to physicians using transparent attribution methodology, along with clear plans for evaluating the impact of the feedback. **We also stress the necessity of risk adjustment, which we strongly believe should include the recognition that a patient population's socioeconomic factors and co-morbidity can have an impact on achieving ideal patient outcome goals.**

The AAO-HNS believes that 6 months is too short a period of time to allow for performance improvement to develop, but that the current two-year lag is not acceptable moving forward. **Therefore, we believe that one year is adequate time to allow performance improvement for a given year, and we strongly recommend providing physicians with quarterly reporting.** And, as noted above, resources will 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. **We strongly urge Congress to appropriate $75 million for assistance for specialty societies to develop measures as a way to provide outcome data. Further, we urge Congress to require the Secretary and CMS to provide data to physician specialty societies.**

4. How should Peer Provider Cohorts be defined to ensure adequate specificity while preserving adequate comparison group size and ability to develop appropriate measurement sets? For example, is using the American Board of Medical Specialties (ABMS) list adequate?

If the Committee moves forward using the term in the framework, **we believe that "Peer Provider Cohorts" could be defined as 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. If the patient is referred appropriately after seeing their primary care physician, this could decrease costs within the healthcare system and avoid unnecessary care for a patient. In addition, physicians should be correctly attributed to a peer-group not only from a sub-specialty perspective (i.e. a pediatric otolaryngologist should not be compared to a neurotologist), but also with regard to practice type (academic vs. community-based; large group vs. small group and rural vs. inner city). In addition, the predominant specialty should lead the construction of the parameters of the cohort.

We do not believe that using the ABMS list is adequate as it does not include all sub-specialties. For example, 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: neurotology, pediatric otolaryngology, plastic surgery within the head and neck, and sleep medicine) neurotology, facial plastics, and sleep medicine offer additional sub-specialty certificates (board certifications) that can be offered to board certified otolaryngologists. Additionally, not all of these sub-specialties have been "activated." For example, although pediatric otolaryngology is listed as a separate subspecialty by the American Board of Otolaryngology (ABOto), there is not currently an ABMS exam for pediatric otolaryngology, and providers are not able to obtain separate certification in it. Physicians are able to obtain advanced certification in allergy through the American Academy of Otolaryngic Allergy (AAOA), although this is not ABMS certification. Therefore, due to these reasons, along with the fact that the ABMS list does not include the complete list of recognized subspecialties within otolaryngology, we do not believe that using the ABMS list is sufficient.

5. Should the Peer Provider Cohorts also include patient, procedural, or disease-specific cohorts in addition to the traditionally-defined specialty groupings? Pros of this approach are that it would offer a more relevant basis for measure development and comparison between physicians, since many physicians perform outside of or in a narrow range of the "stereotype" description of their primary specialty. Cons are that it may create too vast of an array of cohorts. This may dilute the ability to develop meaningful quality measurement sets and comparison groups and impose excessive financial and administrative burden on the physician group as well as upon CMS. In addition to answering, please provide rationale.

If we understand peer provider cohorts correctly, we believe that such cohorts could include patient, procedural, or disease-specific cohorts in addition to the traditionally-defined specialty groupings. We agree with the pros and cons stated in the question posed by the Committee, particularly given the number of sub-specialties comprising otolaryngology and the fact that 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. Further, there will likely be some physicians who simply do not fit into a cohort because of the rarity of the diseases which they treat. Examples could include skull base surgeons who specialize in neuroendocrine tumors or academic airway specialists. We strongly recommend the new performance-based proposal allow for exceptions for these physicians.
We are concerned that too many cohorts will only lead to continued "silos of care" and will hinder increased coordination which is a core long-term goal of a new performance-based system.

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 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 the ability to have dialogue with CMS, and to provide comment on proposed cohorts, such as in a rulemaking process, for the development of any defined Peer Provider Cohort.**

6. Under the proposed revision of SGR which emphasizes best quality practices, non-physician providers who are currently paid under the Medicare payment system are also expected to be rated on quality measures. Do these non-physician providers need unique measurement sets compared to physician providers?

We agree that both physicians and non-physician providers should develop appropriate measures to improve the quality of care provided to patients. Non-physician providers should have their own measures for services that only they provide. However, similar to any comprehensive clinical practice guideline development process, all appropriate stakeholder input should be considered in measure development and a public comment period should be included as part of the review process. Any non-physician measures that include a physician component that non-physician providers do not have certification and training for, should include physicians in in the development phase to ensure they have input on the services related to the specialty. Further, physician groups should allow non-physicians the same opportunity to provide input on related measures (e.g. otolaryngology includes audiologists in development and review of clinical practice guidelines when applicable).

B. PHASE 2: Portion of Payment Based on Quality through Update Incentive Program (UIP)

1. Understanding that the proposed payment system relies on reporting, how should existing programs such as, but not limited to PQRS, EHR/Meaningful Use, VBM be transitioned into the new system? Are there aspects of the current systems that should be retained, modified, or discarded?

We support incorporating current CMS quality incentive programs, PQRS, and EHR/Meaningful Use into the new system, but strongly urge Congress to postpone implementation of Stage 3 Meaningful Use or superseding this stage with the new performance-based payment system. Many physicians will not meet Stage 2 due to the complexity and cost. Further, at present, we believe the only organizations that may be able to qualify will be large hospital systems with employed physicians and we are concerned that the small practice will be at a disadvantage. Integration of current programs, eliminating negatives/multiple penalties, and basing payments on positive incentives linked to quality improvement is essential. For example, allowing physicians to report PQRS quality measures to satisfactorily report for both PQRS and the clinical quality measure requirement of Stage 2 Meaningful Use will reduce the burden placed on physicians to report quality measure data across multiple quality programs. As the transition period moves forward, we recommend reviewing the system and incorporating programs and processes from pilot programs that are successful into Phase 1 and transition for Phase 2.

In addition, to increase the number of quality measures applicable to otolaryngologists and other specialties with numerous sub-specialties, **we urge Congress to require CMS to work to streamline the timeframe and approval process for quality measures physicians can report as part of the PQRS program.** The alignment of the approval process for quality measures available for reporting, such as those endorsed by National Quality Forum (NQF), AMA-Physician Consortium for Performance Improvement (PCPI), specialty societies, and CMS would greatly increase the number of measures applicable to otolaryngologists and boost participation by 2015. An example of such alignment is the development and approval of a set of quality measures focused on adult sinusitis, which were developed by the AAO-HNS Foundation (AAO-HNSF) in collaboration with PCPI in 2011. However, due to timing constraints, we are still awaiting testing and approval via the NQF process. More on the alignment issues is discussed in our response to question number eight below.

Further, we believe that the value-based modifier (VBM) system should be postponed until such time that more specifics become available regarding the new system's framework, or until it is superseded by the new performance-based payment system. CMS has recognized that the proposed core set of quality measures for the VBM program does not cover the full range of conditions prevalent in the Medicare population or varied physician specialties. They include some measures as a starting point for the value modifier because they assess highly prevalent and high-cost conditions and also include preventive services. However, presently, none of our available data are focused on the National Priorities Partnership (NPP) conditions that drive the quality improvement enterprise, so this impacts the types of measures that otolaryngology and its 10 sub-specialty societies would be allowed to use. This issue needs to be addressed in the new system's framework and more specifics need to be provided to determine whether or not the VBM program should continue or be incorporated into the new performance-based payment system.

2. How do we align and integrate quality measurement and reporting with existing and developing specialty registries? How can registries support provider feedback and streamline provider reporting burden?

The AAO-HNS believes that the Secretary should allow physician participation in other quality activities, such as participation in a clinical data registry, as a means to meet the requirements for satisfactory participation in alternative payment models to earn incentive payments and avoid penalties. We support any efforts to increase physician participation in registries and in quality improvement initiatives as outlined below. Expanding the available mechanisms for reporting will support engagement in these programs.

The AAO-HNS continues to engage our members and promote their participation in current CMS initiatives such as PQRS and the EHR incentive program. **For the past two years (2011 and 2012) the AAO-HNSF has worked with CECity to make PQRIwizard available for PQRS reporting.** PQRIwizard is a CMS qualified registry for the purposes of PQRS reporting. We are encouraged as the number of members reporting with PQRIwizard has grown each of the last two years. Through participation in PQRIwizard, the AAO-HNSF 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.

As addressed in our February comments, while our specialty has been engaged in many aspects of patient safety and quality over the past ten to fifteen years (clinical practice guideline and consensus statement development, measures development, active engagement with SQA, NQF, AMA-PCPI and AQA, etc.), **at the current time the AAO-HNSF has not developed a disease-specific registry on behalf of our membership. Given the significant number of sub-specialties within otolaryngology, it remains difficult to advance a disease-specific registry that would meet the needs of the majority of our membership.** However, we continue to research the best methods for reviewing clinical data, including outcomes, and to provide benchmarking data on the procedures treated by our specialty. **As such, 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.** In particular, we are aware that it may take several years of data collection and analysis before meaningful steps can be taken in quality improvement. We would encourage CMS not to stifle such innovation by not deeming such activities as qualified for the purposes of quality reporting.

Furthermore, to support such innovation in clinical quality reporting and to promote participation in such programs, we suggest that the reporting requirements differ from those currently outlined for current CMS initiatives, like PQRS reporting. **We encourage the Secretary to allow for 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.**

Finally, incorporating clinical data registries into the current PQRS, EHR/MU and eRx programs is necessary since current claims data does not provide sufficient insight into the quality of care provided by a physician. Aligning clinical data with improvements to claims data is the most robust path forward toward true quality improvement. The AAO-HNS supports the steps already taken by Congress to address this issue as related to PQRS and responded to a Request for Information (RFI) issued by CMS seeking input on how it may deem certain clinical registries as sufficiently meeting the requirements of the PQRS program. This would allow physicians participating in approved clinical registries to be deemed to have met the PQRS requirements. Use of reporting through clinical data registries should be expanded to the EHR Incentive Program and other areas as applicable.

3. What Clinical improvement Activities best promote high quality clinical care and should those activities be required as an integral part of a quality-based payment system?

We believe that all of the items in the following list of activities promote high quality care and should be an integral part of Phase II. All of the activities listed below should be available for physicians for participation in the new program and they should not 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.

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.
- **Database and survey studies undertaken by the AAO-HNS Patient Safety Quality Improvement (PSQI) Committee resulting in published journal articles accessible to our 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.

4. What process or processes could be enacted that would ensure quality measures/measurement sets maintain currency and relevance with regard to the latest evidence-based clinical practices and care delivery systems? How would these processes ensure that quality measures evolve with data accumulation and advancement in measure development science, and appropriately account for the relative value of measures as they relate to best possible patient care?

An infrastructure needs to be developed that monitors evidence and data and makes appropriate refinements. **Specialties should develop a process to re-visit and re-certify guidelines and measures as new evidence becomes available. The AAO-HNS has a published clinical practice guideline development process which has been recognized as "best practice" by the IOM and AHRQ.** Our process incorporates multi-stakeholder input and public comment periods which should be part of any recognized measure development and clinical practice guideline development process as discussed in item 7 (see below).

As the proliferation of registries and clinical data collection mechanisms increases, the data available for analysis of the relative resource use and complexity of services should also increase. However, we caution that the availability and integrity of the data must be constant across services and providers in order to conduct a sound analysis of relativity, and therefore, until all providers are collecting similar information (likely through registries), the usefulness of these newly emerging data will be limited. Incentives 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.

In addition to working with provider organizations and consensus organizations such as the National Quality Forum (NQF) in the development of the quality measures and clinical improvement activities, all measures, improvement activities, and performance standards should be required by the Secretary to go through the federal notice and comment rulemaking process. **An annual review of all measures could be burdensome and is not necessary. Instead, CMS (with input from providers and other stakeholders) should 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.**

5. Quality measures are categorized into process, structural, and outcome measures. Should these measures be differentially weighted in a quality scoring system? If so, how?

We believe that outcomes and process measures are both 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 allow for the ability to have differential weights that evolve with time

and as the measures mature. As with the development of other methodology and policy development, this should be part of an annual rulemaking process with the opportunity for public comment. Efficiency should not be a component of any measurement until the system has evolved and matured (Phase III).

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 the payment for taking on high-risk patients could dissuade groups from electing shared savings reimbursement options. The following questions should also be considered in the rulemaking process and comment period:

- ✓ **What risk-adjustment will be used?**
- ✓ **Will use of "risk-adjustment" be at the code level or practice-specific level?**
- ✓ **How to take into account that a physician's practice is dynamic and changes over time?**
- ✓ **How will patient-contributed data be assessed, valued and included?**

Finally, 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.

6. From a variety of backgrounds, providers newly enter (or re-enter) the Medicare system throughout the year. Since these providers have no reference baseline with regard to quality reporting in the Medicare system how should the system account for their payment during their "observation" year?

The AAO-HNS believes at least one observation year is needed for new physicians to become acclimated with the system, followed by an additional year to report measures, and then a year to learn/improve. We recommend a base increase after year one, when data is reported.

7. Should public and multi-stakeholder input be used during the measure development and selection processes? If so, are there current CMS or non-CMS mechanisms that could be applied?

We firmly believe that public and multi-stakeholder input should be included in the process of measure development and selection, and there must be a notice and comment period during annual rulemaking for the opportunity to provide comments on measure development and selection processes.

As previously mentioned, the AAO-HNS guideline 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. Our process includes involvement of stakeholders, including other specialties, sub-specialties, consumer representatives, and non-physician provider groups during the guideline development phase. During the review process, we also offer opportunity for these stakeholders and the public to provide comments that are reviewed and considered by the guideline panel for inclusion in the final product. We are now moving into adopting technical solutions to allow for implementation of guidelines into practice at the bedside. Our guidelines, with the highest level of peer-review literature available, are utilized for the development of evidence-based statements which can then form the basis for developing measure sets. A recent example is the AAO-HNS development of the adult sinusitis measures in conjunction with the AMA PCPI which was based on the AAO-HNSF Clinical Practice Guideline on Adult Sinusitis.

8. In the interest of transparency, a public comment opportunity is vital to the quality measure development and approval process. Are there current mechanisms that are both substantive and nimble enough to meet the policy framework in the discussion draft of the legislative language?

There are several current mechanisms available for measures to be reviewed and approved. While they are substantive, they are not aligned well and would need modification to meet the policy framework in the discussion draft of the legislative language. For example, the CMS call for measures and the NQF Measure Application Partnership (MAP) process are not currently aligned. The MAP may make recommendations to CMS, but there is not adequate time for CMS to review the recommendations prior to the time period included in the rulemaking process. There is also not enough time for MAP to respond to public comment prior to forwarding on to CMS. Therefore, we urge Congress to require that these processes be aligned and that the comment process is incorporated into rulemaking in a timely fashion.

9. Methods linking quality performance to payment incentives must be fair to providers and faithful to the goals of a value-based payment system. Many strategies have been proposed; examples include comparing providers to each other versus to benchmarks. Please suggest method(s) of quality-based payment which meet the goals of fairness and fidelity, and one that promotes provider collaboration and sharing of best practices to achieve a learning healthcare system.

The AAO-HNS believes in the importance of quality measurement in evaluating physician services and in tracking performance improvement over time. **The AAO-HNS strongly agrees with using a threshold as a basis for measurement, rather than a ranking system.** 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 would recommend physicians receiving additional payouts for each incremental improvement, so that they are paid along the continuum once they hit a minimum threshold of performance. Over time, the threshold can rise, but the threshold should be transparent and available to physicians at the beginning of the performance measure period.

We also strongly urge Congress 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, and each year the slate should be wiped clean. We also support participation in a quality improvement program or other clinical improvement activities as this promotes the learning aspect and not just a measurement program.

Further, as noted above, **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.

We also support the development of new innovative payment models that involve the patient, 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 bundling 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, and with insufficient resources. **We strongly urge the Secretary to provide 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.

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 continues to support 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 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.

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