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April 24, 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:

The American Academy of Otolaryngology–Head and Neck Surgery (AAO-HNS) appreciates the opportunity to continue to 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. 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 efforts to the physician community.

In reviewing the Second Draft of the SGR Repeal and Reform Proposal, it is evident that you recognized many of the concerns we expressed in our letter dated February 26, 2013, and that this draft makes a concerted effort to avoid a "one size fits all" approach. 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.

We understand the Committees are interested in moving toward legislation that would repeal/replace the SGR formula within this calendar year, or in the very foreseeable future. The AAO-HNS strongly supports this effort and the goals of the second draft of the reform proposal. Since February, the AAO-HNS has put additional initiatives in place and has taken the specific actions regarding alternative payment model development, as outlined below:

- Participated in a face-to-face meeting with Patrick Conway, MD, at the Centers for Medicare & Medicaid Services (CMS), Center for Clinical Standards on April 8, 2013. The purpose of this meeting was to outline the comprehensive quality initiatives taking place within our specialty and to discuss and receive feedback on how we can attain credit for some of these initiatives, as well as to outline how current CMS quality programs could better meet the needs of otolaryngology-head and neck surgery.
- Participated in the April 9, 2013, Surgical Coalition Leadership meeting and collaborated in the Coalition's ongoing development of common principles for Medicare physician payment reform.
- Reaffirmed support of the Council for Medical Specialty Society's (CMSS) endorsement of the U.S. Department of Health and Human Services (HHS) National Quality Strategy.
- Communicated with national private payers including Aetna, WellPoint, and UnitedHealthcare to ascertain from the private health insurance perspective where there may be opportunity for payment reform in otolaryngology and which otolaryngology services may benefit most from an alternative payment structure.
- Supported two efforts focused on episode grouper development:

 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.

- Responded to an AMA call for nominations to provide an AAO-HNS representative to the CMS Brandeis project team working on episode groupers for specific orthopaedic conditions; and
- At the request of the ACS Surgical Quality Alliance (SQA) , joined a project led by the HCI3/Brandeis Project team group to develop a number of commercial episode groupers with a surgical focus, including some otolaryngology-head and neck procedures. The AAO-HNS Ad Hoc Payment Model workgroup, recently formed to predict otolaryngic disease processes where payment reform is likely, is involved with both of these efforts.

While the AAO-HNS is further investigating and reviewing these projects, we realize bundling may not be the correct solution for reimbursement in all cases for otolaryngology-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.

The AAO-HNS applauds your efforts to proactively develop a framework for moving beyond the current Medicare physician payment model. **While we recognize this second draft of the proposal is still in the early stages of development of an overall solution, we 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.** 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 on the second draft of your proposal.

A. PHASE 1: Stable, Predictable Updates

As previously stated, **we support full repeal of the current SGR formula**. Further, as highlighted in our initial comment letter, 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 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 believe 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 remains unclear from your proposal or from initial discussions with your Committees what would happen to the current payment adjustments during the transition period. If the time to transition offers the ability to create a system of measurement, does this mean the value-based modifier (VBM) system and other CMS quality initiatives and incentive programs will be delayed or 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.

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 access to highly-skilled specialty 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. 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 the next draft of the reform proposal, we urge the Committees to provide more specifics, if possible, regarding payment rates in Phase 1 and the plans to address current statutory payment adjustments. We appreciate the Committees efforts to thoughtfully develop the policy with input from the physician community as leaders work to gain bipartisan support to help push the "pay for" discussion forward in as positive a path as possible. Finally, we are interested in working with the Committees more on helping 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.

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

In addition to providing more specifics on the statutory payment adjustment in the next draft of the reform proposal, we look forward to receiving more specifics about the base rate and variable rate and the multiple ways that physicians can receive credit that will determine their variable, performance-based rate. At the Surgical Coalition meeting on April 9, we heard from your staff there will be some percentages of base rate versus variable rate in the reformed payment system, but that the specifics of the formula were not yet determined. We look forward to receiving more specifics on how the new model will provide incentive to those physicians who are high performers and go above and beyond the requirements. We support rewarding high performers at levels higher than 100 percent and reinforce our comment that the new framework should not be based on budget neutrality. **We understand the Committee is considering to "wipe the slate clean" each year and to allow physicians to, in effect, start over every year to work toward improved quality outcomes, and we are supportive of this proposal.** However, we are concerned that the costly transitions associated with current quality and health IT reporting programs – such as the implementation of ICD-10, electronic health records, and electronic prescribing – will only increase pressure on small specialty practices, such as ours, and will potentially negatively impact direct benefit to individual patient care. **We support integrating the proposed payment reform with current quality programs, but caution that interoperability of health information exchange will require additional time to be factored into the new framework.**

In addition to the comments above, the AAO-HNS appreciates the opportunity to provide responses to the questions specifically posed in the Second Draft of the SGR Repeal and Reform Proposal.

- How should the Secretary address specialties that have not established sufficient quality measures?

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, as 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. Indeed, for the past two years (2011 and 2012), the AAO-HNS has worked with CECity to make PQRIwizard available for PQRS reporting. PQRIwizard is a CMS qualified registry for the purposes of PQRS reporting. We have been encouraged by the level of engagement, and the number of AAO-HNS members reporting with PQRIwizard has grown each of the last two years. Through participation in PQRIwizard, AAO-HNS has access to the de-identified measure submissions of all of our members who participate, which could form the basis of an initial registry for our specialty if we are able to continue to grow the user base for this product.

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-HNS has not developed a comprehensive or ongoing disease-specific registry on behalf of our membership. We contributed monetarily and with staff/physician resources to the initial development of a surgical specialty data registry with the

Surgical Quality Alliance of the American College of Surgeons (ACS). For a number of reasons, this initiative did not move forward.

In addition, our participation in surgical registries such as the ACS National Surgical Quality Improvement Project (NSQIP) is limited due to the relatively low volume of inpatient surgical procedures performed by our members. Given the number of sub-specialties within otolaryngology (there are ten), it would be difficult for us 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. In addition, we recognize that clinical data registries would be enhanced with access to Medicare claims data and we urge the Secretary to provide a means for societies to obtain claims data for the purpose of enhancing registry outcome reporting.** We would encourage CMS not to stifle such innovation by failing to deem 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 support 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.**

- Is it appropriate to reward improvement in quality over time in addition to quality compared to peers?

The AAO-HNS believes it is appropriate to reward improvement in quality over time in addition to quality compared to peers, but we remain concerned about how "peer" is defined and how risk adjustment for patients would be integrated into the alternative payment models. 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. Furthermore, meaningful and accurate clinical outcomes and processes of care data must be generated by physicians. **However, as we mentioned in our previous letter, the AAO-HNS is concerned that Phase 2 would be based on risk-adjusted relative rankings among physician specialty peer groups without any testing of the measures developed in Phase 1. Further, we believe there needs to be a clear definition of peer groups and risk-adjustment.** Physicians should be correctly attributed to a peer-group not only from specialty perspective (i.e. a pediatric otolaryngologist should not be compared to a neurotologist), but also 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 the payment for taking on high-risk patients could dissuade groups from electing shared savings reimbursement options. **In the next draft of the reform proposal, we request 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?**

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- **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?**

  - Are there sufficient clinical practice improvement activities relevant to your specialty? If not, does your organization have the capability to identify such activities and how long would it take?

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

In our case, more so than other surgical specialties, otolaryngology-head and neck surgery covers a broad scope of diverse sub-specialties (general otolaryngology, head and neck oncology, pediatrics, laryngology, broncho-esophagology, sleep medicine, otology, neurotology, rhinology, allergy, geriatrics, and facial plastics). Presently, 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.). We believe that the AAO-HNS has the expertise and experience to develop multi-disciplinary guidelines and performance measures, but we do not have the resources to do this on a large enough scale to contribute guidelines and measures at a fast enough pace to adequately represent all of our subspecialties.

In fact, we started the process over two years ago working with the American Medical Association (AMA) Physician Consortium for Performance Improvement (PCPI) to develop an adult sinusitis measure set. The measure set was finalized last year, but has yet to go through the endorsement process with the National Quality Forum (NQF), which will not be in alignment with the Medicare rule making process because they will first need to be in the process of being tested and then must be submitted based on the NQF application timeframe. In addition to submitting comments when provided any opportunity to do so, we met with CMS requesting that the agency include the set of quality measures focused on adult sinusitis while the set is simultaneously receiving NQF approval to greatly increase the number of meaningful measures applicable to otolaryngology and boost participation in PQRS. **In the next draft of the reform proposal, we urge the Committees to include in the framework the need for the alignment of the current CMS quality programs and NQF endorsement process to allow for more measures to be available for use by specialists.**

We are encouraged by our recent discussions with CMS and meeting with Patrick Conway, MD, and will be working with CMS to ensure that these measures can be utilized by our members in calendar year 2014 for PQRS reporting. **We support the Secretary allowing specialties the ability to develop and implement measures. However, this is a costly endeavor that will require some sort of a funding source.** Recently, the PCPI made a strategic decision to change their model for performance measure development, and although a final model has not yet been released, it is clear that a future model will shift most costs to societies that had previously been absorbed by the AMA. In addition, as with other smaller surgical specialties, it is of paramount importance that electronic health record (EHR) vendors develop products that allow otolaryngologist-head and neck surgeons to report measures from the EHR. Until there is pressure from the government, vendors will not be responsive in making these changes to allow for the adequate capture of measures that are applicable to specialists.

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

- **Clinical Knowledge Products:** http://www.entnet.org/Practice/clinicalPracticeguidelines.cfm. To date, ten guidelines and three clinical consensus statements have been published by the AAO-HNS; two additional guidelines are in press and will be published this year. Of note, the AAO-HNS development process was recognized as a "best practice" by the AHRQ and cited in the Institute of Medicine's 2011 report on the development of trustworthy guidelines. We are now moving into adopting technical solutions to allow for implementation of guidelines into practice at the bedside.
- **Choosing Wisely list released in February 2013:** http://www.entnet.org/choosingwiselyUPDATE.cfm We became the first surgical specialty to join the ABIM Foundation's *Choosing Wisely*® campaign. Many AAO-HNS guidelines were used to develop our list of five tests and/or procedures that should be questioned by physicians in the care setting. We have already been notified that the State of Washington is promoting the AAO-HNS list to physicians within the state, so we are confident use will continue to expand and strongly expect this list of tests and/or procedures could be used in future payment models.
- **Database and survey studies undertaken by the AAO-HNS Patient Safety Quality Improvement (PSQI) Committee resulting in published journal articles accessible to members on topics such as:** Errors with Concentrated Epinephrine in Otolaryngology; Errors in Otolaryngology (2004 and currently being updated); Wrong Site Sinus Surgery; Surveillance and Management in Tracheotomy Patients; Airway Management in Laryngectomy patients (under development); 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.

We support the proposal for the Secretary to request that physicians submit clinical practice improvement activities as part of the new framework. We agree with the list of activities that the second draft included as part of the new program, but we request clarification that these activities are not meant to be mutually exclusive. Further, we request **more information on the proposal for the Secretary to convene an expert panel** to advise on the establishment and maintenance of the new program, including the process for selecting panel members, along with the size and who would be represented on the panel, and how the panel would interact with CMS and Congress.

- Should small practices have the ability to aggregate measurement data to ensure that there are adequate numbers of patient events to reliably measure performance? If so, how?

Using the National Quality Strategy as a basis, we support the measurement of the "six domains" at each of the following levels: individual physician, practice setting, and community, which will allow the focus to remain on clinical outcomes. Patient-centric, outcome-oriented measures are preferred at all three levels. This would allow for aggregate reporting to a registry, which CMS has indicated they are highly likely to accept. In addition, measures should be reported on a statistically valid sample size rather than defining reporting based on a fixed percentage or number of patients.

C. PHASE 3: Reward for Efficient Resource Use

- How much time is needed to refine the methodology for determining and attributing efficient use of health care resources?

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.

- Is it preferable to only have a payment implication based on efficiency for providers that meet a minimum quality threshold?

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 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.

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 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.

D. Provider Opt-Out for Alternative Payment Model (APM) Adoption

We agree with allowing physicians the flexibility to participate in an APM at any time. However, we request more details about how the Secretary will determine what services will be exempt from the new program and will continue to be reimbursed under fee-for-service or according to the payment arrangements of the model.

Questions for APM Adoption:

- What do you believe will be necessary to support provider participation in new payment models?

Federal resources must be employed to work with all specialties or consider granting exemptions/extensions to smaller specialties that do not routinely deal with the high cost or disease burden illnesses. PCORI, CMMI, and other grants are almost exclusively given to prioritized conditions and specialties, leaving little or no support for many specialties who are trying to navigate these processes alone, with insufficient resources. **We strongly urge the Secretary to provide funding assistance and time for pilot studies to support specialty physician participation in new payment models.** While there are currently some funding opportunities available, they are limited. For example, we spent a significant amount of time and effort to submit a grant application to the Patient Centered Outcomes Research Institute's (PCORI) Pilot Projects Grants Program to build and deploy ENGAGE, an application to facilitate shared decision-making, utilizing clinical practice guidelines, across the patient care team with

the patient at the center. However, while we were complimented on the high quality of our proposal, our application score did not fall within the fundable range for this program, and we received notification that our application was not accepted. The pool of applications was extremely competitive, with over 800 applications submitted and only fifty funded. We continue to seek opportunities to receive funding when opportunities arise, but we urge the Committees to include funding resources in the next draft of the proposal.

- What is a reasonable time frame for CMS to approve and adopt APMs?

As mentioned above, 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.**

- Should providers be able to participate in more than one payment model?

Yes, physicians should be able to participate in more than one payment model to foster collaboration and best practice and to allow for greater flexibility for increased participation. However, it would be difficult for most small practices to be able to navigate different payment models and we are concerned that many physicians will avoid new models just because they have no experience with them. There needs to be a way to engage in contracting and global systems that makes sense to the three to five practitioner practice. These practices are essential for access to care in rural areas and much of the United States. Additional geographic maldistribution is inevitable if such practices cannot thrive. We support the development of new innovative payment models that involve the patient, physicians, and payers. We also support the concept of incentive payment or shared savings programs between hospitals and physicians and encourage the removal of any legal barriers that may restrict 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. This will help reduce physician's sense of risk and uncertainty.

E. Reports on Improved Provider Fee Schedule and Alternate Payment Models

To ensure proper implementation, adjustment, and ultimate success of the new system, the AAO-HNS supports the submission of periodic reports to Congress.

F. Improvements upon Current Law

- What improvements upon current law do you believe will be required to support alternative payment model adoption?
  - ✓ **Appropriating the $75 million that was authorized** in Section 3013 of the Affordable Care Act to assist specialty societies in the development of measures and/or alternative mechanisms to provide outcome data (registry) and/or some other way of providing an "investment" to fund the development and implementation of quality measures.
  - ✓ **Providing access from CMS to claims data.** CMS has told specialty societies that they are handcuffed due to statutory concerns and therefore cannot provide us with data. If we could gain access to claims data and combine that with data from registries, it would assist with the development of valid outcomes measures on patient populations.
  - ✓ **Integration of current programs to eliminate negatives/penalties**, and instead base payments on positive incentives linked to quality improvement.
  - ✓ **Postponement of Stage 3 Meaningful Use**.

- What improvements upon current law will help ease the administrative burden upon medical providers and allow more time caring for Medicare beneficiaries?

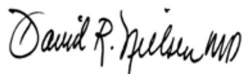
While it is of paramount importance to develop and implement an updated physician payment mechanism, **we urge Congress to refrain from viewing the problems associated with physician payment in a "vacuum."** Payment reforms impacting other healthcare providers should be considered and may be necessary 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 improvements in these areas should be considered in your deliberations regarding physician payment reform.** Adequate time will be needed to adjust to multiple moving parts to determine what in fact, improves care, with lenience required during the adjustment period. Unfortunately, it may be too early to determine how these programs will fully impact the delivery of care.

- What improvements upon current law would support the provision of quality health care delivery for Medicare beneficiaries?
  - ✓ 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.
  - ✓ Repeal of the Independent Payment Advisory Board to restore necessary Congressional oversight of Medicare payment and patient care policies.
  - ✓ Preserving the physician-led, team-based approach to care to ensure patient safety, quality care, and cost savings.

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.

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

Sincerely,



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