Alliance of Specialty Medicine

Testimony for the Record
Before the House Energy and Commerce Committee
Subcommittee on Health
Hearing Entitled
"Reforming SGR: Prioritizing Quality in a Modernized Physician Payment System"

Wednesday, June 5, 2013

Chairman Pitts, Ranking Member Pallone, members of the Committee, and honored guests, the Alliance of Specialty Medicine (the Alliance) would like to thank the House Energy and Commerce Committee for the opportunity to provide feedback on its May 28, 2013 draft legislation. The Alliance strongly supports your intent to repeal Medicare's sustainable growth rate (SGR) formula and to replace it with a payment system that places greater emphasis on quality and efficiency. The Alliance is a coalition of medical specialty societies representing more than 100,000 physicians and surgeons dedicated to the development of sound federal healthcare policy that fosters patient access to the highest quality specialty care.

Our written testimony will not only detail some outstanding questions and concerns regarding the Fee Schedule Provider Competency Update Incentive Program, which the Committee proposes as Phase 2 of its Medicare payment reform proposal, but also briefly outline our suggestions and principles for SGR reform. We would be happy to discuss our concerns and principles with you, as well as any other questions you may have going forward.

The Alliance again thanks the Committee for the opportunity to provide feedback and looks forward to working with you to refine this legislation and work toward a permanent and meaningful solution to the flawed physician payment system.

Many of the Alliance's specialty society member organizations currently have, or are in the process of developing, physician-driven quality improvement initiatives, including the development of clinically-relevant performance measures based on evidence-based guidelines, the management of clinical data registries and enhanced maintenance of certification (MOC) programs. While more work remains, these physician-driven initiatives often result in a more accurate snapshot of specialty care and produce more relevant feedback to specialty physicians than current federal initiatives, which lack sufficient flexibility to accommodate different specialties and care settings, rely on measures that are inadequately risk adjusted and not necessarily linked to better patient outcomes, and divert significant resources away from direct patient care due to administrative complexities.

Taking these experiences into account, the Alliance appreciates the opportunity to share with the Committee the following outstanding questions and to offer potential solutions regarding the Fee Schedule Provider Competency Update Incentive Program, which the Committee proposes as Phase 2 of its Medicare payment reform proposal:

- **The manner in which the update adjustment would take into account quality assessments is a significant issue that remains undefined.** It is critical that the Committee clarify this point and

then seek public feedback on its recommendation. Quality programs must rely on positive incentives rather than penalties to encourage participation and trust in the system and to ensure that physicians can continue to invest in quality improvement infrastructure and provide patients with the access to care that they deserve. Physicians should not have to start out from a negative and then have to "claw" their way back up to a payment rate that still may not even cover the cost of practice.

- **The manner in which the base payment will be determined and updated is another critical issue that is undefined**. The Alliance supports the use of the Medicare Economic Index (MEI), which is more predictable than the SGR or other mechanisms, and more accurately captures the true costs of providing physician services.

- **Any system that replaces the SGR should incentivize participation in quality programs rather than reward or punish physicians based on flawed ranking systems.** Publicly available rankings provide little value in terms of educating the public or promoting quality care unless they reflect substantial and verifiable differences in quality. Unfortunately, the methodologies to accurately make these assessments remain flawed. Much work still needs to be done to ensure risk adjustment and attribution methods are fair, statistically valid, result in unambiguous comparisons, and do not lead to cherry picking of less risky patients or otherwise impede patient access to care. As such, we urge the Committee to instead consider a system that recognizes and rewards continuous quality improvement rather than one that pits physicians against each another. Evidence demonstrates that quality is improved when physicians are provided confidential feedback in a non-punitive environment. For educational and improvement purposes, confidential feedback reports may include information regarding how a particular physician or physician group compares to national or regional benchmarks, however, **we strongly oppose head-to-head comparisons**. Additionally, the methods used to make any comparisons must be transparent and clearly described.

- **The Alliance strongly believes that, if updates are to be based on quality evaluated through a newly proposed structure, existing programs and associated penalties need to be repealed and replaced with programs that more accurately and meaningfully reflect the care provided by a range of physician practice types as provided by the respective societies.** Our current understanding of the May 28th language suggests that the competency updates would piggyback on existing federal quality programs, such as the Physician Quality Reporting System (PQRS) and Electronic Health Record (EHR) Incentive Program. In particular, language giving the Secretary the authority to "coordinate the selection of quality measures…with existing measures and requirements, such as the development of the Physician Compare Website" and "with measures in use under other provisions of section 1848" leads us to believe that existing programs would remain in place and that the competency update would create additional responsibilities for physicians that could further erode patient-centered care. The Alliance has serious concerns about expanding upon what are already administratively burdensome programs that rely on metrics of questionable value and include future penalties that, when combined, could reduce physician's payments by almost ten percent. Similarly, in the section discussing methods for assessing performance, the Secretary is given the authority to incorporate methods from comparable physician quality incentive programs. This is concerning because the methods employed under current programs are seriously flawed, have undergone little testing, and often result in inaccurate assessments, which breeds frustration and mistrust among physicians. **As such, we urge the Committee to include language to ensure that the PQRS, EHR Incentive Program, and the Physician Value-Based Payment Modifier (VBM)**

Program are repealed and replaced by any new SGR replacement programs incorporating physician quality.

- **The proposed quality measure development process remains vague.** While we are pleased that the quality measure development process would rely on best clinical practices, and that the Secretary may consider measures developed by medial specialty organizations, there is little detail about the standards that measure developers would be held to when translating evidence into measures of accountability. Current standards, such as those used by the National Quality Forum (NQF), are often too resource intensive to justify specialty society investment, too lengthy to allow for timely implementation, and too rigorous to accommodate the testing of more innovative approaches to quality improvement, such as reporting to a clinical data registry. We encourage the Committee to preserve specific current minimum standards -- such as transparency, minimum sample sizes, basic auditing and data integrity/validation criteria, and ongoing evaluations of the effectiveness and feasibility of measures -- without being overly prescriptive and limiting the development of more innovative measures or approaches to quality improvement.

  At the same time, there is no need to reinvent the wheel and waste resources. In cases where a specialty has already invested in the NQF process and NQF-endorsed measures already exist, those measures should be used to the extent that they are supported by the relevant medical specialty society.

  We also question who would meet the definition of "other relevant stakeholders" eligible to develop measures. Measure development must be led by relevant clinical experts, who are most familiar with the clinical literature and best equipped to decide on the most appropriate strategies for treating specific diagnoses, procedures, and patient populations. While multi-disciplinary input is important, it is critical that this process be driven only by clinicians with relevant clinical and topical knowledge.

- **The language requiring the Secretary to select a "sufficient number" of quality measures for potential inclusion in each peer cohort is vague and inadequately reflects measure intensity and relevance.** In terms of the provisional core measure set, it is unclear how the Secretary will ensure that each peer cohort is being held to a similar level of accountability in terms of range of measures, measure complexity, and reporting burden. While there is language giving the Secretary authority to assign different scoring weights based on the type or category of quality measure, this seems to relate more to the calculation of the composite score for individual physicians within a peer cohort rather than differences between measure sets across peer cohorts. For example, a single measure evaluating whether a specialist reported regularly to a clinical outcomes registry may require heavy investments in data collection tools and the collection of more numerous and more robust data points, including outcomes, than individual process of care measures which often require little more than the checking of a box to indicate that things such as smoking cessation counseling were offered. Therefore, we urge you to adopt mechanisms to ensure that all peer cohorts are held to a similar level of accountability even if their measures differ in number, type or focus.

- **The requirement to develop core competencies appears unnecessary and duplicative of current requirements of the certifying boards.** We do not fully understand the rationale for including yet another layer of unnecessary regulatory requirements. The medical profession already fulfills a

series of requirements aimed at ensuring compliance with various core competencies. This starts during a physician's medical residency training, with the requirements set forth by the Accreditation Council for Graduate Medical Education (ACGME) and the individual specialty Residency Review Committees (RRCs), and continues with initial board certification and maintenance of certification, pursuant to the requirements of the American Board of Medical Specialties (ABMS) boards. We believe that the process for developing meaningful quality measures and other quality improvement programs can move forward without creating the additional process of defining core competency categories.

- **The timeline for solicitation of public quality measure input remains undefined.** We urge you to legislatively require that the public comment period related to quality measures be open for at least 90 days and that the final response include a discussion regarding all of the comments received, similar to the current regulatory process.

- **The timeline for finalizing measure sets remains undefined.** Measures should be finalized at least one year before the first day of a performance period. Similarly, the Secretary should provide confidential feedback reports to physicians, including new fee schedule providers, for at least one year before holding them accountable for performance.

- **It is unclear how the Secretary will ensure widespread publication of core measure sets in specialty-appropriate peer-reviewed journals should a journal refuse to publish such information.** Most peer-reviewed journals have independent editorial processes and medical organizations, therefore, have no control over what gets published in these journals. Thus, we urge you to define alternative mechanisms that may be used to ensure that physicians who will be held accountable by these core measures are appropriately informed of the programmatic requirements. The Secretary and local Medicare carriers should be responsible for providing this basic information. Certainly, the specialty society members of the Alliance are also willing to use our available communication tools to educate physicians about applicable quality measures, processes and programs that would qualify for the quality portion of their payment.

In addition to the specific questions outlined above regarding the May 28th proposal, the Alliance believes that the following elements are critical to any physician payment reform proposal and urges the Committee to embrace the following principles:

- Repeal of the SGR, followed by a minimum 5-year period of stability in Medicare physician payment;
- Positive financial incentives for higher quality care rather than penalties and withholds;
- Physician-led quality improvement that allows the medical profession and medical specialties to determine the most appropriate and clinically relevant quality improvement metrics and strategies for use in future quality initiatives;
- Flexible criteria that allow physician participation and engagement in delivery and payment models that are meaningful to their practices and patient populations, including FFS;
- Legal protections for physicians who follow clinical practice guidelines and quality improvement program requirements;
- Repeal of the Independent Payment Advisory Board (IPAB); and,
- Allowing for voluntary private contracting between physicians and Medicare beneficiaries.

Finally, in the attached appendix, the Alliance has outlined the extent to which a majority of its member organizations are engaged in quality improvement activities, including participation in national multi-stakeholder coalitions; engagement in public and private payer quality recognition programs; and the development of quality measures, health information technology (HIT) products, and clinical data registries.

Thank you again for taking into consideration our written comments.

Alliance of Specialty Medicine

Sound Policy. Quality Care.

The Alliance of Specialty Medicine, a coalition of 13 national medical specialty societies representing approximately 100,000 physicians and surgeons, appreciates the opportunity to provide Members of Congress and their staff with a snapshot of specialty society quality improvement activities. Specialty societies are engaged in a variety of efforts to improve both quality and efficiency in health care and have developed robust infrastructures to support specialist engagement in those activities. Through this work, specialty medicine has found that there is no "one-size-fits-all" approach to raising the bar on quality and that the optimal model will depend on the clinical context. As such, the Alliance firmly believes that the long-term potential to close the gap on quality and achieve better value in health care lies in the ability to accommodate multiple aligned quality improvement strategies. We urge Congress and public and private payers to support flexible approaches to quality improvement, which recognize activities that are clinically relevant to specific physician practices and meaningful to individual patients, rather than any singular approach.

Below we outline the extent to which a majority of Alliance member organizations are engaged in quality improvement activities, including participation in national multi-stakeholder coalitions; engagement in public and private payer quality recognition programs; and the development of quality measures, health information technology (HIT) products, and clinical data registries.

American Academy of Facial Plastic and Reconstructive Surgery

- Exploring the development of a clinical data registry
- Few quality measures are available for AAFPRS members in existing quality programs
- Implemented an educational portal to facilitate lifelong learning, including CME tracking, MOC and clinical research

American Association of Neurological Surgeons/Congress of Neurological Surgeons

- Established the National Neurosurgical Quality Outcomes Database (N^2QOD)
- Engaged in enhanced MOC activities
- Regularly produce, review and endorse evidence-based clinical practice guidelines
- Developed the Self-Assessment in Neurological Surgery (SANS)
- Participates in the ACR Appropriateness Criteria program for diagnostic imaging
- Promoting development of episode-of-care payments for two common neurosurgical conditions
- Several quality measures are available for neurosurgeons in existing quality programs, but they are not meaningful indicators of quality
- Exploring opportunities to collaborate with EHR vendors
- Members of the NQF, AMA PCPI, SQA, and PEHRC

American College of Mohs Surgery

- Exploring the development of a clinical data registry
- Collaborated on the development of Appropriate Use Criteria (AUC) for Mohs Surgery
- Few quality measures are available for ACMS members in existing quality programs
- Members of the NQF and AMA PCPI

American Gastroenterological Association

- Launched the AGA Digestive Health Outcomes Registry, which is integrated into gGastrov4, a certified EHR technology
- Developed Practice Improvement Modules (PIMs) for Procedural Sedation/Patient Safety, which is now included as part of the ABIM Approved Quality Improvement (AQI) Pathway
- Launched the Bridges to Excellence IBD Care Recognition program through the Health Care Incentives Improvement Institute (HCI3)

- Participating in the ABIM Foundation's Choosing Wisely Campaign
- Developed a bundled payment model for screening colonoscopy
- Several quality measures are available for AANS/CNS members in existing quality programs
- Members of the NQF, AMA PCPI, AQA Alliance, and PEHRC

American Society of Cataract and Refractive Surgery

- Participating in the development of a clinical data registry with the American Academy of Ophthalmology and other ophthalmic organizations
- Established the Integrated Eye Care Delivery Model, which serves as a medical "eye care" home
- Many quality measures, including outcomes measures for all of the major eye care conditions, are available for ACSRS members in existing quality programs
- Members of the AMA PCPI and IHE Eye Care

American Society of Echocardiography

- Exploring the development of a clinical data registry
- Developed Appropriate Use Criteria (AUC), in collaboration with other imaging medical societies and subspecialty societies, for a variety of imaging modalities effort to guide physicians in determining a rational, quality approach to the use of diagnostic imaging
- Participating in the Image Gently Campaign
- Participating in the ABIM Foundation's Choosing Wisely Campaign
- Several quality measures are available for ASE members in existing quality programs
- Members of the AMA PCPI, IHE Cardiology and DICOM

American Society of Plastic Surgeons

- Launched the Tracking Operations and Outcomes for Plastic Surgeons (TOPS) clinical data registry, and a PQRS Registry with CECity
- Engaged in MOC activities
- Collaborated with EHR vendors on HIT solutions for plastic surgeons
- Several quality measures are available for ASPS members in existing quality programs
- Members of the AMA PCPI and SQA

American Urological Association

- Launched a PQRS Registry with CECity and developing a clinical data registry
- Participating in the AMA's NQRN and the National Registry Coalition
- Participating in the ABIM's Choosing Wisely Campaign
- Several quality measures are available for AUA members in existing quality programs
- Exploring opportunities to collaborate with EHR vendors
- Members of the NQF, AMA PCPI, SQA and PEHRC

North American Spine Society

- Developing a clinical data registry
- Participation in the ABIM's Choosing Wisely Campaign
- Development of clinical guidelines and appropriateness criteria for spine
- Several quality measures are available for NASS members in existing quality programs
- Members of the AMA PCPI

Society of Cardiovascular Angiography and Interventions

- SCAI members participate in the NCDR clinical data registry
- Engaged in MOC activities
- Several quality measures are available for SCAI members in existing quality programs
- Members of the NQF and IHE Cardiology

ACRONYM KEY

ABIM – American Board of Internal Medicine
AMA PCPI – American Medical Association Physician Consortium for Performance Improvement
DICOM – Digital Imaging and Communications in Medicine
EHR – Electronic Health Records
HIT – Health Information Technology
IHE – Integrating the Healthcare Enterprise
MOC – Maintenance of Certification
NQF – National Quality Forum
AMA NQRN – American Medical Association National Quality Registry Network
PEHRC – Physician EHR Coalition
SQA – Surgical Quality Alliance