



AMERICAN OSTEOPATHIC ASSOCIATION

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April 15, 2013

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

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

Dear Chairman Camp and Chairman Upton, and Members of the Committees on Ways & Means and Energy & Commerce:

On behalf of the American Osteopathic Association (AOA) and the more than 100,000 osteopathic physicians and osteopathic medical students we represent, thank you for the opportunity to submit comments on your proposal's second iteration to permanently repeal the flawed Sustainable Growth Rate (SGR) formula for physicians participating in the Medicare program, replace it with a reformed system that recognizes new payment models, and provide a more consistent and equitable payment structure for physicians.

The AOA appreciates the Committees' continued work in this regard and willingness to adopt many of the suggestions made by the physician community thus far. As we continue to develop a Medicare physician payment model consistent with the delivery of coordinated, quality, and efficient health care we must not lose sight of the best elements of those solutions that are currently being discussed as well as the importance of a timely well thought final product. We remain appreciative that your outlined approach relies on physician-led quality measurement development and clinical improvement activities, in addition to physician led alternative payment models.

We urge you to continue in the spirit of cooperation that this joint proposal signals as we transition to a much overdue new physician payment system benefitting physicians and patients alike. The collective voices of physicians and policy makers of all political views and from both sides of the Capitol remain vital.

Goals of Reform

The AOA continues to support the goals of physician payment reform as outlined in this second iteration. We share in your belief that predictability and stability of payments is paramount. Further, providing options that enable providers to determine and select the payment model that best fits their respective patient mix and practice setting is key to improving the health care system. We also appreciate your recognition that improving the practice environment through reducing practice costs and administrative burden serves only to improve patient care and the time physicians can spend with their patients as we continue to strengthen the physician-patient relationship.

Phase I: Stable, Predictable Updates

The AOA strongly supports the period of stability that is established in your proposal. As stated in our initial comments on the first draft proposal, we recommend a period of stability of at least five years, during which

all providers are protected from reductions in their annual payment rates and in turn receive positive updates in line with increased practice costs as defined by the Medicare Economic Index (MEI). We further believe positive updates for all physicians should also include a differential providing a higher update for all primary care, prevention, and care coordination services (as defined by E/M coding). For example, this could mean updates of +0.5% for all physician services, and an additional 2.5% update for all primary care, prevention, and care coordination services. We again stress our position that budget neutrality within Medicare Part B should not be applied for the purposes of providing these higher payments. The AOA firmly believes silos should instead be broken down across the entire Medicare program to reflect the value of services and savings, with budget neutrality applied in that manner.

Additionally, all existing incentive payment programs such as the primary care and general surgery bonus, electronic health records incentive payments, Physician Quality Reporting System (PQRS), and others should continue through this period of stability – since they are so closely aligned with the current Medicare payment formula. An immediate transition to a new payment model would undermine the investments that have already been made in these important programs. Once new reporting requirements are in place, physicians should no longer be held to penalties under the old model and should be fully transitioned into the new improved system(s). The lack of stability and predictability in the current system has been a hindrance to physicians' full investment in these programs and ability to innovate their practices, and should not be further exacerbated.

Phase II: Portion of Payment Based on Quality through Update Incentive Program (UIP)

The AOA supports the concept of a portion of physician payment being based upon quality improvement. We agree with the Committees' proposed approach of including a base rate that is predictable and stable as the foundation for physician payment. In addition, the variable rate tied to performance must carefully account for appropriate risk-adjusted data. We believe that if implemented properly, quality improvement activities will prepare physicians for their further and continued participation in alternative payment models.

Physicians and other providers should largely drive the update incentive program (UIP) as outlined in this proposal. To that end, we support enabling providers to choose whether assessment of quality occurs at individual or group level. We further support a provider review and appeals process as part of the UIP determination. Physicians must take the lead in developing, updating, and implementing quality measures to improve patient care. A third-party driven process could lead to greater loss of physician autonomy, more interference with clinical judgment, added regulatory/administrative burdens, the stifling of innovation, and the demise of individualized care.

The proposal's call for measures and clinical practice improvement activities to go through an annual update process is of great concern. This timeframe would be too short, could be very disruptive to quality improvement, and may not reflect advances in the clinical evidence base. Appropriate time must be allowed for measure improvements to be proposed, commented on, approved, and coded into EHR, registry, and other reporting systems. A 3-5 year review period would be far more feasible and appropriate. Development of an exception process for those measures that become obsolete outside that window will be of value.

The proposal calls for establishing an alternative, similar program for non-physician providers. We support this concept and believe non-physician providers should be held to equally high standards for providing the same quality care as physicians. The program must also ensure the services to be provided and measured are within the non-physician provider's respective scope-of-practice.

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

The AOA fully supports the recognition of alternative quality improvement activities that account for the diversity of medical practice and that facilitate reporting, learning, and improvement in an environment that

encourages voluntary participation rather than instills fear, frustration, and/or apathy. To recognize a more diverse range of quality improvement activities, minimum standards should be set to ensure data integrity and true commitment to improved patient care. The Secretary should work closely with physician societies to ensure sufficient quality measures are developed in a timely manner.

The AOA supports empowering physicians to determine quality and efficiency measures that are most clinically meaningful, rather than a one-size-fits-all methodology. By allowing each specialty to determine its own measures and clinical improvement activities, the unique needs and approaches of each group would be integrated. While the current standards for measure validity, appropriateness, and testing employed by entities can be overly restrictive and too resource intensive to keep up with the constantly evolving science of medicine, where possible, we would hope to see a system of performance build on the more effective elements of current processes. Transparent measure development and analytic processes, the use of minimum sample sizes, basic auditing requirements (comparable to those currently used under the PQRS), ensuring that the measures align with the current state of the evidence, and feedback mechanisms that guide improvement based on collected data should all be included therein.

This could help ease transitions, and maximize investments that have already been put into the system. It is also critical that measures are developed by relevant clinical experts, that reporting timelines are reasonable and do not adversely affect patient care, and that the burden of reporting requirements on practices is carefully evaluated before transitioning to more rigorous requirements.

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

Physicians should be provided with various opportunities for their quality care to be recognized and rewarded. The proposal suggests three options - score on quality measures relative to peers; significant improvement in their own quality score from the previous year; and executing clinical improvement activities. We support each of the three options and further believe they should be sequentially phased in. For purposes of reward, execution of clinical improvement activities should be viewed as the first step toward improved quality. During this time, risk-adjustment, evaluation of measure validity, and attribution issues should be carefully evaluated and resolved. The next appropriate step would be reward based upon relativity to peers and/or improvement over time ensuring that physicians do not remain at the base level of executing clinical improvement activities.

The structure should account for a constantly evolving clinical evidence base and for the need to fill existing evidence gaps by recognizing clinical improvement activities, such as registry reporting, that allow for the ongoing collection of data that can shed light on the effectiveness of different treatment protocols and the responses of different patient populations. Specialty societies should be permitted to update federally recognized measures and quality improvement activities regularly so that they align with the current state of the evidence. This may require changes throughout the year that may not necessarily align with the federal rule-making cycle. In line with our belief that changes should occur on a 3-5 year cycle, physicians should only be held accountable for adhering to such changes given at minimum a 12-month notice in order to minimize confusion and other reporting challenges. It would be the responsibility of specialty societies, with the help of CMS, to educate members about these changes and encourage them to incorporate these updates into practice.

The AOA's Clinical Assessment Program (CAP) is a recognized registry for participation in the PQRS program. A web-based performance measurement program, CAP analyzes data abstracted from patient medical records in order to evaluate clinical practices against evidence-based guidelines. The overarching purpose of CAP is to improve patient outcomes and ultimately increase quality of patient care. Use of CAP for PQRS has been highly successful. Over 90% of participants in CAP for PQRS have successfully submitted data using CAP, and bonus incentives for PQRS participants in 2010 were \$3600 on average. For

2012, the AOA offered 22 measure groups and all individual measures in PQRS, and reported 264 eligible professionals through the AOA CAP registry.

The AOA is also working with the osteopathic certification boards to incorporate CAP into Osteopathic Continuous Certification (OCC), the osteopathic counterpart to the American Board of Medical Specialties' Maintenance of Certification (MOC) program. One of the components of OCC is the demonstration of evidenced based practice and a commitment to lifelong learning. Participation in the CAP would provide evidence to satisfy this requirement, and new CAP modules are being developed to meet the needs of the specialty boards.

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 AOA represents all specialties and believes that there are sufficient relevant clinical practice improvement activities for the majority of specialties. Work to identify those activities that are most relevant is a continuous process through the collaborative work of stakeholders. In recognizing that, 3-5 years would be an appropriate target for development of such measures that do not currently exist.

The AOA would also like to use this opportunity to highlight the value of specialty Board-sponsored quality improvement initiatives, which we believe can serve as an excellent proxy for federal quality reporting requirements. Most of these programs, including all 18 of the AOA's Specialty Certifying Boards, now require (or are in the process of requiring) that professionals engage in systematic practice performance measurement and demonstrate improvements in patient care as part of maintaining continuous certification. These programs require professionals to continuously monitor performance feedback, to compare their performance to clinical guidelines and similar peers in their field, to identify improvement goals, and to demonstrate actions to improve upon practice and to assess the impact of such improvements.

Since these programs are developed with the input of relevant clinical experts, they are often less onerous and more meaningful than federal or externally imposed programs. Professionals often can select from a range of educational interventions and practice improvements designed for sustained improvement in patient care, and personal practice performance is measured against national standards among similar peers within the specialty with similar patient populations. At the same time, these programs are developed and monitored under distinct and independent authorities that ensure high quality standards.

Board certification programs also are not restricted by additional traditional limitations of most federal quality reporting programs. Unfortunately, the PQRS continues to rely largely on claims-based data, which was developed primarily for billing purposes and does not necessarily reflect all the nuanced elements of clinical care. On the other hand, registries and other data collection methods used for board certification and maintenance of certification are able to capture more robust clinical data and provide a more accurate and complete picture of the patient and the care provided. The PQRS, for the most part, also only provides a snapshot of care provided to a limited population (i.e., Medicare patients). This population has distinct traits related to age and multiple chronic conditions that are not necessarily reflective of a physician's traditional case mix.

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?

Yes, we believe this should be an option for small practices. In order to account for changes or advancements in quality improvement activities, specialty societies could be required to update and/or replace measures and recognized quality improvement activities once a certain reporting or performance threshold is met among its membership. For example, once a certain percentage of applicable members were found to be reporting regularly and satisfactorily to a specific registry, the specialty society may begin to require that registry participants demonstrate how they use collected data to make changes in care (similar to the staged approach for meaningful use under the Electronic Health Record Incentive Program).

Physician societies should be given the flexibility to select the appropriate reporting or performance thresholds to trigger such updates, providing the thresholds adhere to pre-determined parameters set by CMS (e.g., measures must be updated or replaced once they reach 90% performance rates). They also should be allowed to set distinct thresholds for each recognized quality improvement activity. Such a process would minimize physician complacency and ensure continual progress.

Phase III: Reward for Efficient Resource Use

The AOA supports an *optional* opportunity for providers meeting a minimum quality score threshold to earn additional incentive payments based on efficient use of health care resources. Physicians should continually strive to improve the quality of care provided to their patients and should be rewarded in doing so. We continue to believe that this should only be a reward and not a penalty which is consistent with this proposal. We support the proposal's inclusion of risk-adjustment, accounting for geographic differences, and choice of individual versus group measurement.

State and local medical societies can play a role in the development of standards by having a voice in the measure and policy development process of national societies. Local societies are best equipped to understand their members' needs and local variances, and can ensure the consensus national standards are reflective of them as a whole. It should be noted that if quality improvement measurement is evidence-based and has appropriate risk-adjustment mechanisms, local variances should not inhibit accurate assessment of quality.

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

We believe that the proposal's approach of requiring the Secretary to solicit physician organizations on the efficiency measures is an important step to refining the necessary methodology to appropriately gauge the efficient use of health care resources. The provision of appropriate and timely data to physicians in doing so is of great importance and will affect the time necessary to refine efficiency methodology. One of the most challenging and frustrating aspects of the current set of federal quality programs has been the lack of timely understandable feedback. Access to timely and meaningful data is the foundation of any successful quality improvement program. Physicians find it very difficult to make meaningful decisions based on old data.

Public and private payers continue to struggle with how to accurately measure physician resource use. Efficiency measures and methodologies that are most appropriate for a range of practice types and patient populations must be carefully evaluated before widespread implementation. Risk-adjustment and attribution methodologies are still woefully unrefined and resource-use feedback reports distributed to physicians to date have proven to be of little value. These issues must be addressed before cost data can be used to influence payment decisions.

We therefore recommend CMS provide physicians with access to timely and meaningful data on at minimum a quarterly basis or as close to "real-time" as possible. As we transition to greater reliance on EHR and registry data, Congress may need to invest additional resources and re-evaluate the impact of current regulations related to data privacy and security to ensure they do not impede the collection and distribution of valuable data. It is also critical that any accountability program that includes negative payment adjustments and the public reporting of data include a clear and fair appeals process. Since the goal is improvement and education, physicians should be given the opportunity to make care adjustments based on feedback rather than being penalized for performance.

The structure should account for a constantly evolving clinical evidence base and for the need to fill existing evidence gaps by recognizing activities, such as registry reporting, that allow for the ongoing collection of data that can shed light on the effectiveness of different treatment protocols and the responses of different patient

populations. Physician societies should be permitted to update federally recognized measures and quality improvement activities regularly so that they align with the current state of the evidence. This may require changes throughout the year that may not necessarily align with the federal rule-making cycle. As such, physicians should not be held accountable for adhering to such changes on anything less than a 12-month cycle in order to minimize confusion and other reporting challenges. It would be the responsibility of physician societies, with the help of CMS, to educate members about these changes and encourage them to incorporate these updates into practice.

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

The AOA believes that the system should first focus on quality before transitioning to cost and efficiency, as is the case in this proposal. Only those who have first proven to be high *quality* performers should be held accountable for cost. We also support the proposal's limiting accountability for efficiency to rewards, and not penalties. Penalizing physicians for providing care that is viewed as less than optimally efficient could inadvertently lead to under-treatment. More importantly, in measuring efficiency we believe that it is important that the barriers between Medicare silos be terminated. The flow of health care dollars should not be limited to individual segments of the program.

As Congress considers alternative ways to ensure physician accountability for performance, it is critical that it continue to recognize the value of taking a crawl-walk-run approach. Accountability programs need to start simple. Initially, physicians should be recognized for the act of regularly collecting meaningful practice data and analyzing it in a confidential manner (similar to key case collection requirements of some certifying boards). Data collection, alone, has proven to be a valuable exercise that naturally results in improvements in care. This could then evolve into a process whereby physicians are recognized for using the data to attempt to make improvements in practice based on evidence based metrics (similar to Performance in Practice programs also used under some Maintenance of Certification programs). Only after physicians are familiar and comfortable with these new processes and only after regulators, specialty societies, and other technical experts have had adequate time to test appropriate attribution methods and account for varying risk should physicians be held accountable for actual performance.

Provider Opt-Out for Alternate Payment Model (APM) Adoption

The AOA strongly supports enabling and incentivizing providers to participate in alternative payment models (APMs). These payment models would be an alternative to the UIP system that is detailed in the proposal's Phase II. We believe that the alternative payment models should capture many of the quality improvement activities that are being suggested in the UIP system. Models like the patient-centered medical home (PCMH) and accountable care organizations (ACOs) are already moving in that direction.

We continue to believe that there should be a strong effort to transition the entire health care delivery system away from the current fee-for-service structure. We urge the Committees to strengthen the language in this section and better incentivize participation in APMs as an alternative to the UIP. APMs should be the primary focus of any new payment system. A UIP should serve as an alternative for those who are unable to make APMs work for their practice – not the reverse. We continue to believe that those practices unwilling to transition to an APM or UIP system should receive negative annual updates.

Additional details should be developed regarding how APMs will be assessed and approved by the Secretary. According to the proposal, quality measures developed in Phase II would most likely apply to APMs. This approach seems appropriate; however, specific details would be useful.

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

Incentives must be in place to encourage physicians to move to innovative APMs. CMS should take appropriate steps to ensure continued direct involvement of physician organizations. The guidance of the

societies will benefit providers by way of continued open communication with CMS as well as a leadership stake in the success of efforts to transition to APMs. Physicians must view the APMs as consistent with the trajectory of medicine rather than an exercise in futility.

The AOA supports efforts to minimize the participation burden on physicians by streamlining administrative requirements, facilitating reporting through registries, EHRs, and alignment with PQRS and private payer initiatives. This will further encourage physicians to view CMS as a partner in the transition to new payment models as efforts are made to ease the transition. Again, it will be necessary for the period of stability to truly offer stable and predictable payment levels in order for physicians to appropriately plan their efforts to participate and fully invest in new models.

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

Alternative payment models should be developed, tried, and evaluated in order to determine which are of value to physicians and their patients. This period of trial can occur within a 5-7 year window providing the Secretary has the ability to advance those payment models that are proven to be effective. Our earlier referenced minimum five-year period of stability in Phase I would be an ideal target for approval and adoption to occur. CMS through the work of the Center for Medicare and Medicaid Innovation (CMMI) is already in the process of vetting models and should be encouraged to rapidly begin developing additional models that are well suited for both primary care and specialty care physicians.

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

The AOA has consistently held the belief that a "one-size-fits-all" approach to physician payment is not appropriate. We further believe that a provider should not be excluded or discouraged from participating in more than one payment model if doing so is reasonable for their respective practice and does not hinder their ability to provide high quality patient care. This flexibility further recognizes the growing, changing, and varied patient population with unique geographic characteristics that today's physicians are providing care to.

Improvements upon Current Law

What improvements upon current law do you believe will be required to support alternate payment model adoption?

The AOA remains committed to working with Congress to ensure that positive payment updates are realized throughout the transition process. The predictability and stability of payment rates remains of paramount concern as we work to encourage adoption of new models. Current law under the SGR does not achieve either of these goals and only serves to hinder innovation and improvement of the health care delivery system. Another impediment to predictability lies within the premise of the Independent Payment Advisory Board (IPAB) that will tie physician services to a target much like the SGR that has been proven time and time again to not work, and should therefore be repealed.

In addition, payment incentives for all primary care services must be made permanent. Current law does not reflect the connections within the respective parts of the Medicare system. The silos that the system currently operates under must be broken down in order to maximize its effectiveness. Finally, as we look to achieve a higher level of care within the system, efforts to reform the medical liability system must not be overlooked. The impact of defensive medicine on cost and on service utilization is not consistent with the savings that can be realized with APMs. Removing the unnecessary burdens on physicians under the current system are essential for physicians to readily adopt new models being proposed.

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

The AOA appreciates CMS' efforts to align its various programs; however more steps need to be taken to streamline the requirements, such as the various data submission deadlines involving such programs as the PQRS, value-based payment modifier, the EHR incentive program, and e-Prescribing Incentive Program.

These deadlines and other reporting requirements must be better aligned to eliminate the administrative burden and confusion caused by the current demands. The "imminent storm" associated with implementation of these programs creates a burden faced by physicians in complying simultaneously.

Reducing physician reporting burden and confusion is critical. The AOA believes that reporting burden will be reduced if physicians are provided with the flexibility to choose which quality improvement activities and reporting mechanisms are most applicable to their practice. The current PQRS structure confines physicians to a limited set of measures that are not necessarily relevant or meaningful, which breeds frustration and resentment.

What improvements upon current law would support the provisions of quality health care delivery for Medicare beneficiaries?

CMS attempted to employ a phased approach with the PQRS, which only recognizes reporting, as opposed to actual performance, and gradually transitions from incentives to penalties. A similar approach has been proposed for the Physician Value-Based Modifier Program. However, these two existing programs differ from the proposal being discussed today in that they rely on measures that are some construe as lacking in relevance and clinical value (largely due to the limitations of claims-based measurement). Physicians would be much more inclined to invest in and trust a system that relies on more clinically diverse, relevant, and meaningful measures. Their investment is would also rely upon appropriate financial incentives to offset the associated costs, and not driven by their aversion to facing penalties.

One of the most challenging and frustrating aspects of the current set of federal quality programs has been the lack of timely comprehensible feedback for physicians. Access to timely and meaningful data is the foundation of any successful quality improvement program. Physicians find it very difficult to make meaningful decisions based on old data.

We therefore recommend CMS provide physicians with access to timely and meaningful data on at minimum a quarterly basis. As we transition to greater reliance on EHR and registry data, Congress may have to invest additional resources and re-evaluate the impact of current regulations related to data privacy and security to ensure they do not impede the collection and distribution of valuable data. It is also critical that any accountability program that includes negative payment adjustments and the public reporting of data include a clear and fair appeals process. Since the goal is improvement and education, physicians should be given the opportunity to make care adjustments based on feedback prior to being penalized for performance.

Closing

In summation, it is important that the system first focus on quality before transitioning to cost and efficiency, as is the case in this proposal. Only those who have first proven to be high *quality* performers should be held accountable for cost. We also support the proposal's limiting accountability for efficiency to rewards, and not penalties. Penalizing physicians for providing care that is viewed as less than optimally efficient could inadvertently lead to under-treatment. More importantly, in measuring efficiency we believe that it is important that the barriers between Medicare silos be terminated. The flow of health care dollars should not be limited to individual segments of the program. In fact, we believe that the removal of barriers between Parts A and B is one of the most important steps Congress can and should take when establishing new delivery and payment models. The role of appropriate and timely data must also be recognized and accounted for.

The AOA recognizes that numerous offsets will be considered as part of any final package. Some of these might include priority issues such as comprehensive medical liability reform and repeal of the IPAB. While we continue to champion these issues, our first and foremost priority is reform of the physician payment system, and bipartisan agreement on both policy and offset is vital.

The AOA and our members appreciate the opportunity to share these thoughts, views, and recommendations with the Committee. Again, we applaud your work toward addressing this critical issue and stand ready to work with you, collectively, to identify and implement new delivery and payment models that promote quality and efficient care for all patients.

Sincerely,

A handwritten signature in black ink, appearing to read 'Ray E. Stowers', written in a cursive style.

Ray E. Stowers, DO
President

C: Members, Ways & Means Committee
 Members, Energy & Commerce Committee