



Sound Policy. Quality Care.

July 9, 2013

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United States House of Representatives
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Washington, DC 20515

Honorable Joseph Pitts
United States House of Representatives
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Washington, DC 20515

Honorable Michael Burgess
United States House of Representatives
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Submitted electronically via SGRComments@mail.house.gov

RE: Feedback on June 28th Energy and Commerce Sustainable Growth Rate (SGR) Draft

Dear Representatives Upton, Pitts and Burgess:

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 June 28, 2013 draft legislation to repeal and replace Medicare's sustainable growth rate (SGR) formula. 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.

As a follow up to our comment letter on the previous draft of this legislation, the Alliance would like to reiterate elements which it believes are critical to any physician payment reform proposal. We once again urge 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 a viable fee-for-service (FFS) option;
- 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.

American Academy of Facial Plastic and Reconstructive Surgery • American Association of Neurological Surgeons
American College of Mohs Surgery • American Gastroenterological Association
American Society of Cataract & Refractive Surgery • American Society of Echocardiography
American Society of Plastic Surgeons • American Urological Association
Coalition of State Rheumatology Organizations • Congress of Neurological Surgeons
National Association of Spine Specialists • Society for Cardiovascular Angiography and Interventions
Society for Excellence in Eyecare

The Alliance appreciates the Committee's effort to incorporate public feedback into this more advanced version of the legislation. Listed below are our outstanding concerns, comments, and questions related to the framework released by the Committee on May 28th, which are still relevant to the June 28th draft.

- **The manner in which the base payment will be determined and updated is still undefined.** The Alliance recommends 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. Payments for all other Medicare providers are based in part on an inflationary factor, and physician payment should be no different.
- **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. Again, 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 Alliance reiterates its strong belief that if updates are to be based on quality evaluated through a newly proposed structure, existing programs and associated penalties must be repealed and replaced with programs that more accurately and meaningfully reflect the care provided by a range of physician practice types.** The language in the current draft 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 annual 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 medical specialty organizations, there is still little detail about the standards that measure developers would be held to when translating evidence into measures of accountability. As noted in our previous comments, 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, 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.

- It is not clear who the Committee envisions 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-stakeholder input is important, it is critical that this process be driven primarily 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 remains vague and inadequately reflects measure intensity and relevance.** We continue to question 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. For example, a 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 “checking a box” to indicate that, for example, smoking cessation counseling was offered. While we appreciate the language giving the Secretary authority to assign different scoring weights based on the type or category of quality measure within each peer cohort, this mechanism does not seem to account for differences between measure sets across peer cohorts. We urge the Committee to add language 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 Committee did not address the Alliance's previous concerns about **how to ensure widespread publication of core measure sets in specialty-appropriate peer-reviewed journals, which have independent editorial processes that are outside of the control of medical organizations.** As noted earlier, specialty societies are willing to use their own communication and education tools to disseminate information. However, we also believe that the Secretary and local Medicare administrative contractors, including Medicare’s Quality Improvement Organizations (QIOs), should be responsible for providing this basic information.
- **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) and the ABMS member 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 and requiring the development of quality measures to fit within each core competency. Furthermore, each of the core competencies may not be directly relevant to a particular specialty. For example, for surgeons and other procedural based specialties, the “population health and prevention” core competency is not tremendously applicable to the services provided by these physicians. Thus, it is important to have significant flexibility to ensure that any quality measurements or improvement programs best reflect the individual specialties. Should the Committee wish to maintain the core competency

concept, this provision should recognize physicians who comply with existing profession-defined core competencies, rather than requiring the development of a whole new set of competency requirements.

- **The timeline for soliciting public input and finalizing measure sets remains undefined.** The current language only states that there "shall be a reasonable public comment period on the provisional core measure set." The Alliance requests language to require a public comment period of at least 90 days and a final response that includes a robust discussion of *all* comments received, similar to the current regulatory process.

In addition, the Alliance has the following concerns, some of which were not raised in our original comment letter and some of which are relevant to the updates in the June 28th draft:

- The Alliance appreciates the Committee's effort to define the manner in which the update adjustment would take into account quality assessments. In Attachment A of this latest draft, the Committee seeks input on two potential models. The first is a "Threshold/ Benchmark Update Incentive Payment Model," under which a series of benchmarks would be established. Providers with performance composite scores exceeding the highest benchmark would receive the highest update, those with scores below the lowest benchmark would receive the lowest update, and intermediate benchmarks would receive intermediate update amounts. Specialty society and "other relevant stakeholder" input would be used to determine the benchmarks. The second option is a "Percentile Update Incentive Payment Model," under which all providers within a peer cohort would be competitively ranked by their performance composite score. Payment updates would correspond to the provider's percentile ranking compared to his/her peers. The top performers by percentile would earn the highest update and a smoothing formula would be applied to avoid payment cliffs progressing down the percentile curve as updates decrease with decreasing percentile values.

Given the Alliance's support for systems that incentivize participation in quality programs rather than reward or punish physicians based on flawed ranking systems, we strongly oppose the Percentile Update model and urge the Committee to instead support a system that rewards continuous quality improvement rather than one that pits physicians against each another. Head-to-head comparisons encourage adversarial behavior and perverse incentives, such as an increased risk of "gaming," and may result in serious beneficiary access to care issues as providers opt to treat only the healthiest or least complex patients in order to maximize their score relative to others. In addition, rankings often result in inaccurate performance data since high-ranked providers can be rewarded even if their absolute performance is poor and low-ranked providers may not be rewarded even if their absolute performance is good. While the competitive nature of rankings may promote efficiency, the adjustments needed to ensure that rankings result in accurate and meaningful data remain unrefined and cannot yet guarantee fair, statistically valid, and unambiguous comparisons that reflect substantial and verifiable differences in quality.

The "Threshold/Benchmark Update Incentive Payment Model" has the potential to achieve this goal so long as specialty societies and other relevant clinician stakeholders remain in control of determining appropriate benchmarks for their respective peer cohort and so long as requirements and methodologies are transparent and clearly described.

- The Alliance appreciates references to the use of qualified specialty registry data for purposes of performance assessment. However, **the framework does not necessarily recognize registry reporting, in and of itself, as a clinical practice improvement activity that may be eligible to be included under a peer cohort's final competency measure set.** Rather, it appears that the Committee's proposal takes a step away from the approach recently taken by Congress in the

American Taxpayer Relief Act (ATRA). ATRA directs the Centers for Medicare and Medicaid Services (CMS) to establish a mechanism so that physicians are able to meet the federal quality data reporting requirements under a number of Medicare programs through their active participation in other “deemed” quality measurement and improvement activities, such as specialty registries, medical board certification, and Regional Health Improvement Collaboratives. We encourage the Committee to incorporate the ATRA provisions, and allow physicians who participate in specialty registries to satisfy any requirements of a new payment system that places more emphasis on quality.

- The Alliance appreciates the committee's effort to provide regular performance feedback to physicians in "as real time as possible, but at least quarterly," and to commit resources to develop the infrastructure to provide physician feedback and conduct education, including the development of a web-based portal. However, the framework still does not specify a timeframe for providing feedback to physicians *prior* to holding them accountable for performance or whether this feedback would be public or confidential. **The Alliance recommends that confidential feedback at both the individual and group practice level should be provided to physicians for at least a year prior to holding physicians accountable for performance.**
- The revised framework proposes to use "contracting entities" to solicit and vet Alternative Payment Models (APMs) for immediate use or for testing via demonstration project. The Alliance appreciates the Committee outlining criteria that the contracting entity must adhere to and for giving the contracting entity the authority to request a waiver from any of these requirements to accommodate unique Alternative Payment Models. However, **we request that the Committee more clearly define who is eligible to carry out the role of "contracting entity" given the significant authority granted to these entities**, including the authority to specify measures that providers must report on under the demonstration (in consultation with affected providers). **We also request that the reference to "measures" in this section also include "clinical practice improvement activities" to ensure more flexibility in the testing of various payment models relevant to a range of practices and patient populations.**
- As noted above, an essential element of payment reform includes allowing patients and physicians to voluntarily enter into arrangements known as private contracts. Under current law, Medicare beneficiaries that choose to see physicians who do not accept Medicare are required to pay the physician's charge entirely out of personal funds – Medicare does not pay any part of the charge. In addition, physicians who choose to provide covered services to Medicare beneficiaries under private contracts must "opt out" of the Medicare program for two years, during which time Medicare does not pay the physician for any covered services provided to Medicare beneficiaries. These discriminating policies are inappropriate and prevent beneficiaries from seeking care from the physician of their choice. **Just as physicians may opt out of the new quality-based fee-for-service system into alternative payment models, so too should they be free to opt in or out of Medicare on a per-patient basis, while patients could pay for their care as they see fit and be reimbursed for an amount equal to that paid to "participating" Medicare physicians.**
- The current language regarding risk adjustment only accounts "for differences in geographic location and patient populations," which are interpreted to be factors such as age and co-morbidities. It does not, as written, adequately address the potential effect of patient non-compliance on outcomes nor does it necessarily address socioeconomic factors. **We request that the Committee expand the definition of risk-adjustment so that it accounts for patient non-compliance and socioeconomic differences.**
- The framework allows for group practice or individual physician level elections. We would like to know **what mechanisms would be available to individuals who do not want to be evaluated as part of a group that elected to be analyzed at the group level?**

- **The section defining "peer cohorts" should more explicitly identify the role of specialty medical societies in defining what they feel are the most appropriate cohorts for their specialty. For example, the relevant specialty may choose to define its cohort according to ABMS designation, National Plan and Provider Enumeration System (NPPES) designation-- which more accurately reflects subspecialties-- or other more relevant groupings.**
- Finally, we are disappointed that the Committee's draft fails to incorporate any medical liability protections and strongly urge you to do so in the next iteration of your proposal. If Medicare is going to move to a value-based healthcare system, it is essential that Congress pass medical liability reform. Federal legislation modeled after the laws in California or Texas, which include reasonable limits on non-economic damages, is the gold standard. However, other options should be considered as well, including the adoption of liability protections for physicians who follow best practices or clinical practice guidelines set forth by their own specialty societies. Additionally, physicians should be shielded from liability exposure resulting from their participation in national quality initiatives. If physicians are going to be required to follow government or other mandated treatment protocols, quality metrics and/or guidelines, then they should expect to be protected from litigation if they follow such guidelines, but are nevertheless sued. Physicians should not be required to choose between payment penalties for non-compliance with government quality standards on the one hand, and litigation from a patient for following such guidelines on the other.

The Alliance again thanks the Committee for the opportunity to provide feedback and looks forward to working with you to find a permanent and meaningful solution to the flawed physician payment system. We would be happy to discuss our concerns and principles with you, as well as any other questions you may have going forward.

Sincerely,

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