AMERICAN OSTEOPATHIC ASSOCIATION

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July 9, 2013

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

The Honorable Joe Pitts
Chairman
Energy & Commerce Health Subcommittee
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Upton and Chairman Pitts:

On behalf of the American Osteopathic Association (AOA) and the more than 104,000 osteopathic physicians and osteopathic medical students we represent, thank you again for the opportunity to submit comments on your Committee's continued work to reform the physician payment system and to permanently repeal the Sustainable Growth Rate (SGR) formula for physicians participating in the Medicare program. Your continued engagement with the physician community and inclusion of numerous suggestions in the latest discussion draft iteration is commendable.

As we enter the latter half of the calendar year, we remain encouraged by the work to date. However, we continue to believe the Committee's swift movement toward releasing, marking-up, and approving a final legislative solution is vital. We reiterate our hope to seize the lowered cost of repeal, continued bipartisan interest, and momentum in finding a durable and long-term solution toward enactment of legislation into law this year. Thank you again for the opportunity to provide detailed responses on each of the questions posed by the Committee.

Comments and Recommendations

The AOA supports the Committee's approach thus far to develop a new and improved physician payment model to replace the SGR with a reformed system that appropriately values physician services, rewards physicians who strive to provide higher quality care, and promotes the development and expansion of innovative payment models as the path forward. We continue to believe this type of system will best account for and compensate physicians for the provision of quality care to their patients.

SEC. 1. REFORM OF SUSTAINABLE GROWTH RATE (SGR) AND MEDICARE PAYMENT FOR PHYSICIANS' SERVICES.

The AOA continues to believe it is imperative to provide differential payments during the period of stability. A differential providing a different conversion factor for all primary care, prevention, and care coordination services (as defined by E&M coding) would provide higher payment for those services. In contrast to a MedPAC type approach, we strongly advocate that budget neutrality within Medicare Part B not be applied for the purposes of providing these higher payments. Understanding the current fiscal environment we believe the offset for this higher conversion factor could be balanced with no update or negative updates incurred for those physicians failing to adopt new payment models, all within the 10 year budget window.

SEC. 1848A. FEE SCHEDULE PROVIDER COMPETENCY UPDATE INCENTIVE PROGRAM.

The AOA believes that the Update Incentive Program is appropriately aligned with our view that payment under the fee-for-service structure should be directly tied to quality. We support the Committee's decision to allow for election at the group practice or individual physician level for purpose of assessing performance. This approach will best evaluate provider competency for purposes of this update program.

Peer Cohorts

The peer cohorts that are included in the discussion draft lack explicit details related to assignment, size, and review/update of cohorts. As stated in our last round of comments, the AOA believes each physician should automatically be assigned to their specialty designated cohort, unless they opt out. In such case, the physician can choose from a more granular list of peer provider cohorts based upon the plurality of services they bill. Options for cohort designation as described provides the greatest level of flexibility to providers.

A physician's specialty certification is generally consistent with the services provided; however, there are certainly exceptions for some providers whose service offerings are more diverse, such as a primary care physician practicing in a rural area. In cases of cohort self-selection, the Secretary shall retrospectively verify the designation by reviewing plurality of service type billed during the year by the physician. If the physician does not meet verification criteria, the physician will be classified back into their specialty designated cohort by CMS.

In order to provide for adequate and equitable comparison of cohorts, those cohorts beyond specialty designation should be defined by the Secretary as being no smaller than the size of the smallest specialty (i.e. number of physicians). This will ensure that the more granular cohorts have a sample size comparable to the physician specialty cohorts, while also controlling for too wide an array of cohorts. The measure sets for all cohorts must fit within the core competency categories. The specific quality measures that fit under each of the categories may of course differ across cohorts.

Additionally, every 5 years the Secretary, in consultation with physician organizations, should review and possibly update the list of cohorts to ensure those in existence continue to meet the criteria of size and measurability initially set forth. This will provide a true gauge of whether the expanded list of cohorts is appropriate and meaningful.

The AOA again requests that for purpose of specialty designation, the AOA be specifically included along with ABMS and equivalent certification boards. The use of the ABMS list is not adequate as it does not reflect the certification of osteopathic specialties. The AOA accredits specialties for osteopathic physicians, and the American Board of Specialty Physicians accredits for allopathic physicians. The two lists together appropriately capture the breadth of certified practicing physicians.

The AOA believes that this is highly important as confusion has occurred in the past as a result of non-inclusion of the AOA as an accrediting body. For instance the ACA provision to increase Medicaid payment levels for primary care to Medicare levels neglected to list the AOA. CMS then included a correction in the physician fee schedule and subsequent guidance, CMS 2370-F, stating,

> *"The statute specifies that higher payment applies to primary care services delivered by a physician with a specialty designation of family medicine, general internal medicine, or pediatric medicine. The regulation specifies that specialists and subspecialists within those designations as recognized by the American Board of Medical Specialties (ABMS) the American Osteopathic Association (AOA) or the American Board of Physician Specialties (ABPS) also qualify for the enhanced payment. Under the regulation, "general internal medicine" encompasses internal medicine and all subspecialties recognized by the ABMS, ABPS and AOA."*

Core Competency Categories

The AOA believes that the core competency categories listed in the discussion draft appropriately reflect the provision of quality patient care. The measure sets as developed therein will reflect each specialty through solicitation of specialty society and public input. In the context of measure approval and development, the discussion draft refers to a consensus based entity. We recommend the National Quality Forum (NQF) as a proven entity with the ability to perform these functions.

Clinical Practice Improvement Activities

The AOA believes the Committee has appropriately provided for opportunities for physician specialty society and public input into development of clinical improvement activities. We appreciate the Committee's addition of language to ensure clinical practice improvement activities are coordinated with the development and selection of measures under existing programs. This is imperative to decrease disruption of current activities through transition, and imposing additional undue burden upon physicians.

The AOA supports efforts to minimize the participation burden on physicians by streamlining administrative requirements, facilitating reporting through registries and EHRs, and aligning Medicare payment quality measures 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 offer truly stable and predictable payment levels in order for physicians to appropriately plan their efforts to participate and fully invest in new models.

We agree with the Committee's decision that clinical practice improvement activities should be weighted based upon the aggregate contribution to quality. We also appreciate the Committee's recommendation of the necessity to appropriately risk adjust for population and geographic variances. In addition, we concur with the use of data collected from approved clinical registries for this purpose.

We also agree with the Committee's decision to allow clinical practice improvement activities to serve as substitute when there are insufficient quality measures applicable to a peer cohort to address an applicable core competency category. However, we believe this should be temporary in order to foster the continued development of appropriate quality measures for every cohort in each core competency category.

Feedback

The AOA appreciates the Committee's decision to utilize performance data reported through approved clinical registries to provide feedback to physicians. We also believe the Committee's approach to providing physicians with initial and ongoing feedback is appropriate. Access to timely and meaningful data is the foundation of any successful measurement of utilization and value. Physicians find it very difficult to make significant decisions based on old data. This data and feedback can help physicians transform their practices and improve patient care. More importantly, this data enables an individual physician to see where their practice and practice patterns are in comparison to others. This allows for a big picture understanding of where a physician falls that they currently are not privy to. Any feedback process must include a mechanism for provider review and appeal prior to payment adjustments.

SEC. 1848B. OPT OUT OF PHYSICIAN FEE SCHEDULE FOR PROVIDERS PAID UNDER ALTERNATIVE PAYMENT MODELS.

The AOA continues to believe that new "Alternative Payment Models" should be the default for physicians under the new payment system. The new quality based fee-for-service model or update incentive program should be an opt-out for those physicians unable to move into an alternative payment model. These options

still provide opportunities for all physicians to be successful; however, the alternative payment models are more consistent with the direction in which health care delivery should continue moving. The discussion draft refers to an entity that would be responsible for approving APMs. We recommend the Center for Medicare and Medicaid Innovation (CMMI) as a proven entity with the ability to do so under the direction of the Secretary.

The legislative text remains silent on how physicians choosing an alternative payment model will be paid for their services. It is also important to define how payment levels under each model will be appropriately aligned to avoid unbalanced payments to providers. Parameters to ensure the payment levels are adequate, appropriately updated, and are equitable across different payment model providers and with the Update Incentive Program providers are imperative. The amount of detail included in the discussion draft for purposes of the UIP would also be appropriate for alternative payment models.

Proposed Payment Scenarios for the Update Incentive Program

The AOA supports the "threshold" or "benchmark" Update Incentive Payment Model. We strongly believe that every physician should have the opportunity to achieve the maximum update. The alternative percentile approach does not allow for this, and does not appropriately incentivize the highest level of participation by physicians. In addition, the benchmark approach appropriately seeks the input of physician specialty societies to best determine the thresholds. It is our belief that this payment scenario will maximize physician buy-in to the program to view CMS as a partner in quality improvement, rather than a hindrance to the practice of medicine.

Committee Questions

The committee posed numerous questions regarding the legislative language. The AOA's position and response has been conveyed above in summary. Responses in greater detail on five specific questions posed by the committee follow:

Do you think the IG report will bring integrity to the reporting process? Does this process meet the required level of oversight? Are there any other safeguards, besides the IG, that could be implemented to ensure integrity in the reporting process?
While the discussion draft includes a provision calling for the Inspector General to audit the activities of CMS in carrying out the Update Improvement Program, it is unclear how that alone would directly bring integrity to the reporting process itself. In the EHR Meaningful Use program, CMS conducts direct audits of a sampling of providers to ensure the accuracy of their self-attestation for health IT use. CMS could similarly conduct direct audits of a sampling of providers participating in the UIP or APMs in order to ensure reporting integrity. Such an audit process should include an appeals process for providers. The AOA would additionally support an IG report on CMS' implementation of the program as laid out in the discussion draft to help ensure the program as a whole is functional, fair, accurate, and not overly burdensome to providers.

If providers decide not to participate in the Update Incentive Program, should they be held to the same standard? How should their payment updates be applied if they do not report on quality measures?
In order to transition our current system away from traditional fee-for-service with its inherent volume-based incentives, and to ensure a level playing field for all providers, there must be consequences for those who neither report on quality measures in the UIP nor participate in an APM. We do however maintain that appropriate financial incentives must be in place rather than strictly penalties. Providers who do not participate in the Update Incentive Program, or in Alternative Payment Models, should not receive payment updates, and in fact be subject to increasing negative payment updates after the period of transition. These

negative payment updates would best be phased in gradually (beginning, for example, a year or two into Phase II) to both allow physicians nearing retirement to phase out of the system, and to allow providers time to transition and become accustomed to the new programs. As well, the negative updates for those who do not participate in either program could also serve to offset the differential payments for primary care providers during the period of stability that we recommended in previous letters to the Committee.

Do you think the policy, as outlined in the discussion draft, can accommodate early adopters and those with minimal quality standards by the time Phase II goes into effect?
Alternative payment models that are currently based on a fee-for-service foundation already exist, such as the Patient-Centered Medical Home (PCMH) and Accountable Care Organizations (ACOs). Physicians who choose to adopt these models early (such as during the period of stability/Phase I) in preparation for a full transition should be rewarded for doing so through higher payment updates for the services they are providing.

In addition, physicians serving as a medical home should receive a per patient per month care coordination bonus payment, consistent with the Joint Principles of the Patient-Centered Medical Home developed by the founding organizations of the Patient-Centered Primary Care Collaborative (PCPCC), including the AOA. The AOA continues to support the National Committee on Quality Assurance (NCQA) PCMH recognition process allowing physician practices to reach advanced levels of recognition. The current Center for Medicare and Medicaid Innovation (CMMI) initiative should be scaled up to allow for national participation by all interested physicians. This will encourage physicians to adopt and embrace new payment models early in the process while still in fee-for-service so they are better prepared for the ultimate transition.

The AOA also supports physician-led ACOs that are built upon a patient-centered medical home. Akin to those PCMH physicians, ACO physicians should also be encouraged and rewarded for their early adoption of care innovations. While issues remain with the ACO model of care, the CMS program should be accelerated and expanded in concert with improving the program. Improvements to beneficiary assignment, physician participation in multiple ACOs, and addressing anti-trust concerns remain key. Additionally, new models of ACOs should be explored.

The Bipartisan Policy Center (BPC) has proposed Medicare Networks in this regard, which are similar to ACOs. Through the networks, BPC suggests an approach of higher payments for those early adopting physicians accepting 2-sided risk, based upon MEI. Those physicians choosing a 1-sided risk model would receive smaller updates equal to one-half of MEI. Beyond the initial period set forth for early adopters, any physician participating in these networks would receive updates equal to MEI, and all other providers would be shielded from payment reductions. We believe this is another viable mechanism for ensuring positive updates to early-adopting physicians during the period of stability.

There will also be physicians who choose not to enter into alternative payment models, but want to transition early to the Update Incentive Program. To incentivize such early adopters, the current PQRS program could be expanded to provide physicians with the opportunity to earn additional positive updates for meeting minimum quality standards beyond those already in PQRS.

The draft envisions a repertoire of quality measures and clinical practice improvement activities. Some have suggested also including efficiency measures. Should we also explore efficiency measures and other improvement activities?
As stated in our previous letter to the Committee, the AOA believes physician resource utilization data should be focused primarily on quality and outcomes measurements, not on cost-reduction and savings. Efforts to encourage efficient use of resources should complement and enhance the delivery of appropriate, evidence-based, patient-centered health care. Appropriately risk-adjusted and equitable benchmarking of physicians relative to their peers can encourage improved efficiency and adoption of evidence-based practice guidelines and/or health information technology into a physician's practice. For example, the introspective

look at how a fee-for-service physician is performing and using resources compared to a physician in a medical home or ACO can serve as incentive to undertake the structural and behavioral changes that are necessary to effectively move into a new payment model such as the PCMH or ACO.

It is important that the system first focus on quality before transitioning to cost and efficiency. Only those who have first proven to be high quality performers should be held accountable for cost. If efficiency measures are going to be used, then accountability for efficiency should be limited 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. There are many scenarios in which a physician's treatment decisions could easily save resources in other parts of Medicare—for example, additional office visits with a particularly complex patient, while costing more in Part B, could decrease hospital readmissions and emergency room visits in Part A. Similarly, additional time spent counseling a patient during an office visit (Part B) could result in Part D savings due to better medication adherence and management. The flow of health care dollars should not be limited to individual segments of the program.

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 not yet yielded significant value. These issues must be addressed before cost data can be used to influence payment decisions. We believe that soliciting physician organizations on development of efficiency measures is an important step to refining the necessary methodology to appropriately gauge the efficient use of health care resources.

People have expressed concerns about the effect of non-compliant patients on outcomes and thus outcome measures. Do you believe the draft policy adequately addresses the issue and protects providers who are reporting on quality outcome measures in the setting of non-compliant patients (i.e.: one of many aspects of risk-adjustment)?
The discussion draft provides for risk-adjustment to account for differences in geographic location and patient populations, which we have strongly advocated for in previous comment letters. Physicians should be compared to other physicians with similar practice mix in the same geographic area, with adequate attention to risk-adjustment. Unfortunately, non-compliant patients are a particularly difficult factor to account for in risk-adjustment methodologies.

The AOA believes in order to ensure accurate and fair measurement, appropriate case selection and exclusion criteria should be applied to process measures, and for outcome measures, appropriate risk adjustment for patient case mix and inclusion of adjustment for patient compliance/wishes. Appropriate data adjustments should be made to account for differences in the demographic characteristics, socioeconomic status, and health status of individuals so as not to penalize those physicians who tend to serve less healthy individuals who may require more intensive interventions. The attribution data to physicians for services delivered must be accurate. These risk adjustment and attribution models need to be properly tested and assessed on a condition-specific basis since these factors influence clinical or financial outcomes. Structural measures, such as the use of HIT, EHRs, and e-prescribing, will also play a role, as these tools, among other practice attributes, can help a physician achieve better outcomes. However, they do not emphasize improved outcomes in and of themselves, and therefore should also be weighted less.

We stress the importance of risk adjustment because determinants of the outcomes of patients are not entirely under the control of the physician. The attribution of results to the physician could be at the least unfair and potentially damaging for those physicians that serve disadvantaged communities. Our own analysis of factors affecting glucose control in diabetic patients in the AOA-Clinical Assessment Program (CAP) showed a large amount of variation attributable to factors not under the physician's control. Our

findings suggest that system factors (such as insurance type and level of coverage) and patient factors (such as compliance) have large effects on the level of control at the patient level. The prevalence of these factors in any sample a physician provides for PQRS can markedly influence the rate of control. Indeed, if we are reporting all-payer data to CMS, a physician who sees a larger portion of uninsured individuals (self-pay) would have markedly lower performance without risk-adjustment. The same example may be applied to patient compliance rates.

Questions to the Committee

The discussion draft provides substantial detail regarding the new payment system; however, we believe some critical questions remain:

- How will physicians choosing an alternative payment model be paid for their services? The Patient Centered Medical Home for instance is based upon fee-for-service payment with an additional care coordination payment for serving as the medical home. An ACO is based upon shared savings/risk. Other models will have their own payment methodology.
- How will CMS ensure that the payment for care coordination under the PCMH, shared savings under an ACO, and other payment levels are aligned appropriately?
- Will CMS develop parameters to ensure the payment levels are adequate, appropriately updated, and are equitable across different payment model providers and with the Update Incentive Program providers?

Summary

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. We look forward to seeing the final draft of the Committee's legislation, and working with you and your colleagues toward enactment of comprehensive physician payment reform legislation into law this year.

Sincerely,

Ray E. Stowers, DO
President

cc: Members, Energy & Commerce Committee