

AMERICAN ASSOCIATION OF
NEUROLOGICAL SURGEONS

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May 25, 2012

The Honorable Dave Camp, Chairman
Ways and Means Committee
U.S. House of Representatives
1102 Longworth House Office Building
Washington, DC 20515

Subject: Medicare Sustainable Growth Rate (SGR) Reform

Dear Chairman Camp:

On behalf of the American Association of Neurological Surgeons (AANS) and the Congress of Neurological Surgeons (CNS), representing 4,000 practicing neurosurgeons in the United States, we appreciate the opportunity to provide you and the Ways and Means Committee with feedback on how to reform Medicare's sustainable growth rate (SGR) formula. As noted in your letter dated April 27, 2012, it is essential that Congress consider the input from the physician community as it moves forward to tackle this ongoing vexing issue. As requested, we will structure our comments in response to the specific questions included in your letter.

Before turning to your questions, however, neurosurgery would like to take this opportunity to share our views on several other principles related to Medicare reform:

- ❖ Fundamental reform of the entire Medicare program is essential to solving the SGR problem. Congress needs to break down Medicare's silos; update deductibles and co-pays; and move toward a defined contribution rather than a defined benefit program. Making changes to the current physician payment system, without incorporating larger programmatic changes, is like rearranging the deck chairs on the Titanic.
- ❖ The SGR must be immediately repealed and Congress needs to provide a bridge for patients and providers to transition to the new Medicare system. During this transition period, it is important for Congress to provide stability in the physician payment system. Additionally, it is imperative that seniors maintain the ability to select the physician of their choice; hence fee-for-service must remain a viable option (now and into the future). To further enhance timely access to care by the physician of their choice, patients and physicians should be permitted to enter into private contracts without penalty to either party.
- ❖ Medicare beneficiaries need access to all physicians – primary care and specialists alike. It is therefore critical that Medicare policy support an adequate workforce to care for our aging population. To this end, Medicare payment policy should not play favorites and differentiate payment rates based on physician specialty designation. Additionally, to ensure that the nation is training enough physicians, Medicare should continue to maintain its financial support of graduate medical education.
- ❖ Quality should be determined by the profession, not by the federal government or other third parties. It is vital that any quality or outcomes data be sufficiently risk adjusted. Medicare's

current punitive quality programs should be scrapped or drastically revised. Not all specialties and patients are the same, and the current “one-size-fits-all” approach is not resulting in meaningful quality improvement in neurosurgery.

- ❖ The Independent Payment Advisory Board (IPAB) must be repealed. Concentrating Medicare policy decisions in the hands of an unelected, unaccountable government body is exactly the wrong way to tackle our current and future Medicare program challenges. IPAB-related cuts will likely reduce, not enhance, quality of care.
- ❖ It is essential that Congress pass common sense, proven, comprehensive medical liability reform, particularly if Medicare and other third party payers are going to move to a value-based healthcare system.

Modernizing Medicare is Essential to Addressing the SGR Problem

Unquestionably, for nearly half a century, the Medicare program has provided exceptional healthcare for the elderly. As you know, however, the current Medicare program is clearly on an unsustainable path. With an aging population and rising healthcare costs, it is therefore imperative that Congress take immediate action and adopt meaningful reforms. Only after modernizing and improving Medicare, can we be assured that our nation’s senior citizens will continue to benefit from this critical entitlement program well into the future.

Along those lines, the AANS and CNS recommend the following:

- **Breaking Down the Medicare Silos.** Simply making changes to the current Medicare payment system, without incorporating larger programmatic changes, is like rearranging the deck chairs on the Titanic. From a structural point, the current “silos” are a significant contributing factor to today’s antiquated Medicare program. Medicare’s separate Parts A, B, C and D do not reflect the modern realities of practice, including, in particular, shifts in the site-of-service. For example, many procedures that were once done in the hospital inpatient setting (Part A), are now performed in a Part B, ambulatory setting (e.g., ambulatory surgery center or physician office), although the separate programmatic dollar streams have not changed. It is clear that today’s Medicare beneficiary views his or her Part A and B benefits as a single insurance program.

To modernize the program, the AANS and CNS believe that we need to move from Medicare’s current defined benefit structure to a defined contribution model. Like the Federal Employee Health Benefit Program (FEHBP), this bipartisan premium support model would pay Medicare beneficiaries a certain sum toward the purchase of an insurance policy that provides a defined set of services. Seniors would then pick from an array of health plan choices, allowing them to choose the plan that works best for them. It is essential that such a system incorporates consumer protections and that the premium subsidies are adequate to provide beneficiaries with appropriate coverage for their medical needs. To this end, the premium subsidy must be risk-adjusted so that the sickest beneficiaries are not unfairly penalized because of their health status. While we are not in a position to determine the actuarial data necessary to calculate the premiums, we support the concept that lower-income seniors should receive a higher federal subsidy than wealthier seniors. Finally, it is important that all current Medicare beneficiaries are allowed to remain in the existing Medicare program -- if they so choose -- and we believe that it makes sense to align the Medicare and Social Security eligibility ages.

- **Improving Medicare Out-of-Pocket Limits and Cost Sharing.** One way to ensure that the Medicare program remains a viable benefit for the country’s senior and disability population is to modernize and improve the patient cost-sharing component. This could be accomplished in a number of ways including modifications to the current deductibles, co-payments and out-of-pocket

limits. Again, we believe that it is reasonable for wealthier beneficiaries to contribute more to the system, while at the same time protecting the most economically vulnerable from significant out-of-pocket exposure.

Providing a Bridge to a New Medicare System

The Medicare program is only as strong as its component parts, and without an adequate physician workforce, the system will fail to meet the needs of our aging population. There are a number of recommendations that we would like to raise in this regard.

- **Repealing the Sustainable Growth Rate Formula.** One critical factor that is causing more and more physicians to reconsider their participation in Medicare is the flawed sustainable growth rate (SGR) system. As you are well aware, this is an issue that has plagued physicians and their patients for more than a decade, and the AANS and CNS believe that it is essential for Congress to provide stability in the physician payment system and prevent the draconian pay cuts that physicians face in the upcoming years – beginning with a cut of nearly 30 percent on January 1, 2013. Providing this payment stability by replacing the current SGR with statutory updates that reflect medical inflation will provide an essential “bridge” to a new Medicare system.
- **Maintaining a Viable Fee-for-Service System.** Policymakers on both sides of the political aisle have been critical of Medicare’s current fee-for-service system and have suggested that it must be eliminated. We take issue, however, with the notion that fee-for-service medicine is the root of all healthcare evils. Many physicians may not want or be able to participate in alternative delivery system/payment models, so it is imperative that a viable fee-for-service option remain in place. While it may not be perfect, fee-for-service is not the sole contributor to the problems with the current Medicare physician payment system.¹ To the contrary, fee-for-service provides patients with the ability to select the physician or other healthcare provider of his or her choice, and preserving this option for Medicare beneficiaries is especially critical for those patients seeking specialty care – particularly neurosurgical services. We therefore encourage you to take steps to ensure its viability as an option in any new or transitional Medicare system.
- **Allowing Patients and Physicians to Privately Contract.** Despite Congress’ efforts to prevent the yearly SGR-related cuts, practice expense costs have far outpaced payment rates. This is a trend that is likely to continue into the future, particular for high-risk specialists like neurosurgeons, which pay exorbitant medical liability insurance premiums. The AANS and CNS, therefore, believe that you should consider an additional patient-centered solution for reforming the Medicare payment system -- allowing Medicare beneficiaries and physicians to privately contract for Medicare covered services without penalty. The Medicare Patient Empowerment Act (H.R. 1700) incorporates this model, which would permit patients and physicians to voluntarily enter into arrangements, known as private contracts, to receive medical services. Beneficiaries would be allowed to use their Medicare benefit to offset a portion of the contracted fee and physicians would not be required to “opt out” of the Medicare program for two full years.

Maintaining an Adequate and Well Trained Physician Workforce

An appropriate supply of well-educated and trained physicians is an essential element to ensure access to quality healthcare services for all Americans. And like all Americans, Medicare beneficiaries need access to all physicians – primary care and specialists alike. Unfortunately, the nation is facing a serious shortage of physicians, particularly as baby boomers age. According to the Association of American Medical Colleges, by the year 2025, there will be an overall shortage of 130,600 physicians -- roughly

¹ National Center for Policy Analysis, John Goodman Health Policy Blog, “Is Fee-For-Service the Problem?” March 28, 2012. Scandlen, Greg. <http://bit.ly/HITwAr>

half (65,800) of the shortage will be in primary care and the other half (64,800) surgeons and other procedural specialists.² It is therefore critical that Congress take steps to ensure that Medicare policies support an adequate workforce to care for our aging population.

To this end, the AANS and CNS strongly believe that Medicare policy should not play favorites and differentiate payment rates based on physician specialty designation. The justifications for providing bonuses to primary care simply no longer exist as more medical students are seeking positions in primary care and the country faces shortages of equal magnitude in the specialty physician population. Additionally, to address the overall physician shortage crisis, strategies to meet physician education and training needs must be employed. While medical schools in the U.S. have increased their enrollments, and additional medical and osteopathic schools have been established, the number of Medicare-funded residencies has been capped by law at 1996 levels. The solution for increasing physician numbers, therefore, involves not only increasing medical student class size and the number of medical schools, but also increasing the number of funded residency positions. The AANS and CNS believe that since all Americans benefit from a strong supply of physicians, all payers of healthcare – including the federal government, the states and private payers – should help fund graduate medical education. To ensure an adequate supply of physicians, Congress should, therefore, at a minimum, maintain Medicare's current financial support of graduate medical education.

Restructuring and Streamlining Quality Improvement Programs

Organized neurosurgery is fully behind efforts to improve the quality of care that neurosurgeons deliver to our patients and we share with the public a sense of urgency and responsibility to meet the challenges of creating a sustainable healthcare system. And while Congress has taken the first steps towards implementing quality improvement programs, Medicare's Physician Quality Reporting System (PQRS), electronic health record (EHR) program and value-based payment modifier all need to be scrapped or drastically revised to better incorporate a workable and meaningful system for collecting and reporting clinical data. The current "one-size-fits-all" approach simply will not result in better patient outcomes. As an alternative to the current approach, the AANS and CNS recommend that Congress adopt a *pay-for-participation* system under which data regarding physician quality are collected in a non-punitive environment and analyzed using accurate risk-adjustment mechanisms. Under such a system, physicians should receive performance feedback continually and in a timely manner. It is also essential that the determination of quality remain in the hands of the profession, rather than by the government or other third parties.

To this end, neurosurgery has developed a centralized and nationally coordinated effort to allow individual neurosurgeons and practice groups to measure and analyze practice patterns and outcomes through a clinical registry. The details of this initiative are outlined below in answer to your specific questions on this topic.

Eliminating the Independent Payment Advisory Board

Established by the Patient Protection and Affordable Care Act (PPACA), the Independent Payment Advisory Board (IPAB) is a 15-member government board appointed by the president. The principal responsibility of this board is to cut Medicare spending, and the proposed spending cuts automatically go into effect if Congress does not replace the recommendations with cuts of equal magnitude. Congress only has a very short window of time in which to pass its own proposal -- making it a virtual certainty that the board's recommendations would be adopted. The AANS and CNS are certainly mindful of the need to curb Medicare spending, but we believe that leaving Medicare policy decisions in the hands of an

² Association of American Medical Colleges, Center for Workforce Studies, "The Impact of Health Care Reform on the Future Supply and Demand for Physicians Updated Projections Through 2025" June 2010. <http://bit.ly/hC24QZ>

unelected, unaccountable governmental body, with minimal congressional oversight and no judicial review, will negatively affect timely access to quality neurosurgical care.

Adopting Medical Liability Reform

Most Americans agree that the current medical-legal system is broken and in dire need of reform. As you know, the practice of defensive medicine adds unnecessary costs – by some estimates as much as \$200 billion annually -- to the healthcare system for little or no added value. If Medicare and other third party payers are going to move to a value-based healthcare system, it is essential that Congress pass common sense, proven, comprehensive medical liability form. The AANS and CNS support federal legislation modeled after the laws in California or Texas, which include reasonable limits on non-economic damages, and the Congressional Budget Office has found that such reforms will provide approximately \$50 billion in savings to the federal government.

We are also open to exploring other options, however, including the adoption of liability protections for physicians who follow best practices or clinical practice guidelines set by their own specialty societies. Legislation like the Provider Shield Act (H.R. 816), would shield physicians from liability exposure resulting from national quality and practice standards or guidelines. 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 guidance on the other.

Answers to Questions Posed in April 27 Letter:

Rewarding Quality and Efficiency

1. How does your organization think quality, efficiency, and patient outcomes should be incorporated into the Medicare physician payment system? (Please include details on experiences with non-Medicare payers that could be instructive.)

Unfortunately, Medicare's PQRS, EHR program and value-based payment modifier all need to be scrapped or drastically revised to better incorporate a workable and meaningful system for collecting and reporting clinical data. As noted, the current "one-size-fits-all" approach simply will not result in better patient outcomes. While we are not opposed to incorporating quality into the Medicare program, rather than employing the current approach, the AANS and CNS firmly believe that a pay-for-*participation* system, under which data regarding physician quality are collected in a non-punitive environment and analyzed using accurate risk-adjustment mechanisms, is the best approach. Under such a system, physicians should receive confidential performance feedback continually and in a timely manner.

Tying Medicare reimbursement to a series of programs like those referenced above, which use "check-box" measures that are completely meaningless to neurosurgeons, will in no way improve quality and patient outcomes. Any Medicare reimbursement system that is based on quality should be structured around specialty society clinical data registries, which is a much more meaningful way of improving the value of healthcare than the current government and private sector-sponsored programs.

2. To what extent has your organization developed and/or facilitated the use of:
 - a. Quality and outcome measures?

To date, organized neurosurgery has not yet developed specialty-specific quality and outcomes measures. The primary deterrent has been cost and a lack of data to support process and outcomes measures in neurosurgery. We are, however, committed to improving quality and outcomes through the collection of clinical and other patient data through a registry mechanism. Comprehensive registry data can then be used to develop specialty-specific quality and outcomes measures that will be more meaningful than the current “check box” measures contained in the PQRS, EHR, and other third-party payer efforts.

Although neurosurgery has not yet developed its own set of specialty-specific quality measures, the AANS and CNS are actively engaged in the measure development process. We currently have representatives to the American Medical Association’s Physician Consortium for Performance Improvement (PCPI), the National Quality Forum (NQF), the AQA and the Surgical Quality Alliance (SQA). Through these relationships, neurosurgery has participated on numerous panels and workgroups and has provided input and expertise in the development of a variety of quality measurements that may be relevant to some neurosurgeons and their patients.

b. Evidence-based guidelines?

Neurosurgery is actively engaged in the development and review of evidence-based practice guidelines. We recognize that clinical practice guidelines are potentially useful tools for improving the quality of clinical patient care; although it is imperative that these guidelines are of the highest possible quality and do not result in the inappropriate restriction of physician decision-making. It is important to remember, however, that neurosurgeons do not practice “cookbook” medicine and guidelines are just that – *guidelines*. Each patient is unique, and must be treated as such to ensure that he or she receives optimal clinical care.

The AANS and CNS support the observations of the Institute of Medicine, which has suggested that the highest quality clinical practice parameter guidelines meet the following criteria:

- The recommendations are supported by adequate levels of evidence;
- The guidelines are produced by inclusive, balanced, and appropriately trained panels of clinical practice stakeholders that are multidisciplinary when appropriate;
- The guidelines follow a validated and strict evidence based methodology; and
- The guidelines are updated at reasonable time intervals.

High quality evidence-based clinical practice parameter guidelines should take precedence over lower quality formal consensus statements and/or appropriateness criteria. As such, formal consensus statements, appropriateness criteria and other clinical directives employing a less rigorous methodology should only be utilized in health policies, regulatory measures, government and third-party payer demonstration projects, and reimbursement policies when up-to-date, high quality, multidisciplinary evidence-linked clinical practice parameter guidelines do not exist for the condition or circumstance in question. Additionally, it is vitally important that, in all instances, sufficient latitude and exception criteria exist and are codified to allow for clinically indicated flexibility based on relevant subspecialty expertise, complex or unusual clinical circumstances and/or individual patient needs.

Detailed information about neurosurgery’s guidelines-related activities, including a comprehensive list of guidelines that we have developed or endorsed, is available on our website at: <http://www.cns.org/advocacy/jgc/default.aspx>

c. Patient registries?

The AANS and CNS strongly support the use of clinical data registries. Clinical data registries are valuable tools that support evidence development, performance assessment, comparative effectiveness studies, and the adoption of new treatments into routine clinical practice. Registries can provide high-quality evidence on par with randomized clinical trials (RCT), while offering the added value of documenting patient experiences in everyday clinical practice rather than operating under the strict eligibility and treatment protocols required by RCTs. Regularly observing patient responses to treatment can provide important insights into which patient care strategies work best in actual practice.

As outlined in more detail below, organized neurosurgery has recently launched its own clinical data registry.

d. Continuous quality improvement programs or strategies?

The AANS and CNS are fully behind efforts to improve the quality of care that neurosurgeons deliver to our patients and we share with the public a sense of urgency and responsibility to meet the challenges of creating a sustainable healthcare system. To that end, we believe that prospective, systematic tracking of practice patterns and patient outcomes will allow neurosurgeons to improve the quality, efficiency and, ultimately, the value of care. In support of this mission, the AANS, in cooperation with a broad coalition of other neurosurgical societies including the CNS, Society of Neurological Surgeons (SNS) and American Board of Neurological Surgery (ABNS), created the NeuroPoint Alliance (NPA), a not-for-profit corporation, in 2008. The NPA coordinates a variety of national projects involving the acquisition, analysis, and reporting of clinical data from neurosurgical practice using online technologies. It is designed to meet the quality care and healthcare research needs of individual neurosurgeons and neurosurgical practices, national organizations, healthcare plans, biomedical industry and government agencies.

To meet the growing need for tools to measure and promote quality care, the NPA collaborated with several national stakeholders to create an unprecedented program: The National Neurosurgery Quality and Outcomes Database (N²QOD). This resource will allow any U.S. neurosurgeon, practice group, or hospital system to contribute to and access aggregate quality and outcomes data through a centralized, nationally coordinated clinical registry. The N²QOD is primarily designed to serve as a continuous national clinical registry for neurosurgical procedures and practice patterns along the lines of the very successful Society of Thoracic Surgeons' database. The primary goals of this registry are to:

- Establish risk-adjusted national benchmarks for the cost and quality of common neurosurgical procedures.
- Allow practice groups and hospitals to analyze their individual morbidity and clinical outcomes in real-time and, in doing so, facilitate the development of new care initiatives.
- Generate both quality and efficiency data to support claims made to public and private payers.
- Demonstrate the comparative clinical effectiveness of neurosurgical procedures.
- Facilitate the conduct of essential multicenter trials and other cooperative clinical studies.

We are presently conducting a pilot registry involving approximately 40 leading neurosurgical practice groups from all regions of the United States, including academic and private groups in both rural and urban settings. The primary aim of this 12-month pilot is to demonstrate the feasibility of collecting high-quality, validated, aggregate practice data on a national scale. The initial registry project will focus on treatment of diseases of the lumbar spine due to the pressing need expressed by many groups around the country for outcomes data in this practice area.

As the registry grows, we will be adding additional subspecialty modules to evaluate care in the areas of cerebrovascular, trauma, tumor, pain and functional neurosurgery. As an aside, the N²QOD is the first and only national registry in the U.S. assessing one-year quality of life after surgical treatment.

In order to better support the administration of this evolving effort, the NPA has partnered with the Vanderbilt Institute for Medicine and Public Health (VIMPH) to manage the collection and analysis of standardized data across neurosurgical practices. The VIMPH is a nationally recognized leader in the field of health services research and quality improvement, with advisory positions and funding from the Agency for Healthcare Research and Quality (AHRQ), the National Institutes of Health (NIH), and the Institute of Medicine (IOM). The VIMPH was chosen by the NPA from a short list of leading national public health institutes due to their recognized expertise and experience facilitating multi-center quality improvement and health services research initiatives.

In brief, the registry functions as follows:

- Participating N²QOD practice sites collect data related to the care of patients undergoing specified types of neurosurgical procedures at their facilities each week.
- This data is collected from the medical record, pre-and post-operative validated survey assessment procedures and interviews.
- That data is entered into a HIPAA secure, web-based portal (the Research Electronic Data Capture, or REDCap™, database) and transmitted to the institution (VIMPH) serving as the registry for analysis.
- VIMPH, among other activities, uses this data to 1) establish new national practice benchmarks for the quality of surgical procedures; and 2) provide reports back to the practice sites about the risk-adjusted quality of their services compared to the national benchmarks.
- The NPA is providing oversight for the entire project. Data transfer and data use are governed by Business Associate Agreements between the sites, NPA and VIMPH.

In addition to the N²QOD project, the NPA also provides the portal for the NeuroLog database system developed by the ABNS. The NPA portal serves as the vehicle for candidate neurosurgeons who are in the process of board certification to submit practice data, or for ABNS Diplomates who are participating in Maintenance of Certification (MOC) to submit key cases required by ABNS. It also provides a tool for those participating in Medicare's PQRS to enter practice cases.

More information about the NPA, its projects and the REDCap™ system is available at: <http://www.neuropoint.org/> and <http://project-redcap.org/>.

e. Electronic health records?

Neurosurgeons are currently working towards adopting and incorporating electronic health records (EHR) into their practices to improve quality of care, provider workflow, patient safety and efficiency. However, stringent, overly ambitious incentive program requirements and the inability of specialists to tailor the program to their practice are hindering widespread adoption of health information technology by neurosurgeons. Implementing a program that allows for flexibility and for physicians to adopt objectives and measures that enhance and meet the needs of their practice will result in extensive use of technology to advance the country's health care system. Unfortunately, that program does not yet exist.

Neurosurgery understands that the Health Information Technology for Economic and Clinical Health (HITECH) requires meaningful use of EHRs, but it provides for broad discretion in regards to implementation and program requirements. In addition, we recognize that the widespread and proper use of HIT will help transform healthcare by facilitating health information exchange, reducing inefficiencies, and improving quality of care, but to achieve the intended outcome financial incentives must be associated with realistic and practical measures to support the use of EHRs. Onerous measures and aggressive thresholds will not accomplish these goals.

The AANS and CNS, therefore, support a non-punitive staged approach to implement EHR meaningful use, but this approach must take into account the current technological realities and the additional financial and administrative costs that will be incurred by physician participation in the current program. At present, the current EHR meaningful use standards are not specialty or surgeon friendly. In order to meet many of the measures, physicians must “check-the-box” to meet standards or report zero values. In addition, EHR systems are very costly to implement and maintain. Many of the requirements require hiring at least one additional full-time equivalent (FTE) staff person, and implementing and maintaining EHR systems can cost practices hundreds of thousands of dollars – often with little or no demonstrated benefit to patients. Neurosurgeons in solo or small practices are contemplating whether meaningful use is worth the cost and hassles.

And we are not alone. In the April issue of *Health Affairs*, Hsiao, et al³ highlight that the Center for Medicare and Medicaid Services (CMS) estimated in 2010 that 36 percent of Medicare-eligible professionals and 15-47 percent of Medicaid-eligible professionals would demonstrate meaningful use in 2011. However, their survey results show much lower adoption of Stage 1 meaningful use (11 percent) even though 51 percent indicated they intended to apply. It is evident that the low adoption rate is due to the overly burdensome program reporting requirements and physicians’ EHRs not having the capabilities to meet meaningful use. Most likely, the adoption numbers will decline if CMS moves forward with the proposed Stage 2 requirements.

3. What clinical improvement activities have been developed and are supported by your organization or have otherwise been used effectively by your members?

As stated above, organized neurosurgery has established the NeuroPoint Alliance (NPA), which is implementing a variety of programs to support clinical improvement. NPA-related projects include:

- The National Neurosurgery Quality and Outcomes Database (N²QOD), which is actively recruiting practices to participate in this data registry effort;
- A portal for the NeuroLog database system developed by the ABNS, which serves as the vehicle for candidate neurosurgeons who are in the process of board certification to submit practice data;
- A portal for ABNS Diplomates who are participating in Maintenance of Certification (MOC) to submit key cases required by ABNS.

Additionally, the AANS and CNS have a wide variety of cutting-edge continuing medical education (CME) offerings, including our annual scientific meetings, subspecialty and regional education conferences and procedure-specific practical courses. The CNS maintains the Self-Assessment in Neurological Surgery (SANS) Lifelong Learning program, and through the CNS University of Neurosurgery, it offers online courses and webinars.

³ Hsiao Chun Ju, et al. Most Physicians Were Eligible For Federal Incentives In 2011, But Few Had EHR Systems That Met Meaningful-Use Criteria. *Health Affairs* No. 5 (2012).

A complete list of the AANS and CNS education programs are available on our websites at: <http://www.aans.org/Education%20and%20Meetings.aspx> and <http://www.cns.org/education/>.

4. Have non-Medicare payers recognized or rewarded these clinical improvement activities? If so, how?

To date, we are not aware of any non-Medicare payers that are currently recognizing or rewarding neurosurgeons who participate in any of our clinical improvement activities. However, we have had ongoing discussions with the Blue Cross-Blue Shield Association, regarding its Blue Distinction Program. Unfortunately, at the present time, they are not interested in partnering with us or recognizing N²QOD participation as a mechanism to receive Blue Distinction. We are hopeful, however, that future collaboration is possible when they go through another program re-design. The AANS and CNS actively plan to reach out to other major private payers in the near future to enhance the incentives for neurosurgeons to report clinical data to our registry.

5. Is there anything else your organization would like to share with the Committee on how to reward physicians for high quality, efficiency, and patient outcomes?

It is absolutely critical that Congress understand that not all physicians, or their specialty societies, are “in the same place” in terms of quality improvement, and with a handful of exceptions, this is especially true in the case of some surgical subspecialties. Thus, before Congress implements a Medicare payment system that is more significantly tied to quality, efficiency and patient outcomes, a lot of thought must be given so that physicians are encouraged – not discouraged – to participate in such a program.

One reason some specialties are not as far along on the quality improvement continuum, is because most of the efforts to date have focused on a limited set of quality measurements that are largely irrelevant for many physicians, particularly specialists. For example, whether or not the hospital where a neurosurgeon is practicing scores high quality marks for ensuring that its patients receive aspirin when they burst into the emergency room complaining of chest pains has no bearing on whether or not that is a quality hospital for neurosurgical care. Similarly, it is meaningless for a neurosurgeon that treats malignant brain tumor patients to regularly counsel their patients on the evils of smoking, another common quality measure. Or take the case of a neurosurgeon who follows the quality protocol of administering antibiotics one-hour before performing a spine operation thereby receiving the quality “gold star,” yet at the same time that patient continues to experience significant back and leg pain because the outcome was suboptimal. These are the measures by which neurosurgeons may be measured, yet because these quality metrics lack relevance, most of our members are not actively engaged in the current Medicare quality improvement programs.

As you can see from the above description of our NeuroPoint Alliance (NPA) and our National Neurosurgery Quality and Outcomes Database (N²QOD), however, our specialty is making a serious attempt (and, parenthetically, a significant financial contribution) to establish a quality improvement program that makes sense for neurosurgeons and their patients. Unfortunately, we are still in the infancy stage, with only a modest number of practices currently enrolled in our pilot program. Rest assured, however, that at the heart of our strategic plan is expanding this program nationwide to ensure that virtually all neurosurgeons are reporting clinical data. But we aren't there yet.

At this point, Congress should repeal -- or significantly revise -- the current PQRS, EHR, and value-based payment modifier programs and replace these with initiatives that are specialty-centric. Again, there is no “one-size-fits-all” approach to quality improvement, and the best thing Medicare could do is support the efforts of the individual medical specialty societies. One thing is certain: the top-down, government driven approach is not going to improve the quality of neurosurgical care.

Alternative Payment Models

1. Are there quality-enhancing alternatives to fee-for-service, such as bundled payments and shared savings models that your members have experience with or are developing with private payers?

As previously stated, the AANS and CNS do not believe that fee-for-service needs to be eliminated from the range of options available to Medicare beneficiaries and the physicians who take care of them. That said, neurosurgery supports the development of innovative payment and delivery models and see the value that this may provide in terms of coordination and efficiency of patient care. We believe, however, that the jury is still out on whether alternatives such as bundled payments and shared savings will lead to widespread quality improvement at a reduced cost. Furthermore, models, such as Kaiser, the Mayo Clinic and the Geisinger Health System may work for some physicians, but they may be completely unworkable or impracticable for others.

While we recognize that policymakers want to establish new programs that reward clinicians for high-quality, high-value care, we believe it is premature to assume coordinated care or shared savings models will adequately accomplish these goals. In fact, recent studies have shown that current demonstration programs aimed at improving quality and lowering costs may be falling short of expectations.⁴ Additionally, the current efforts to improve coordination of care may in fact be driving up costs due to market consolidation. As you know, the Patient Protection and Affordable Care Act (PPACA) created the Center for Medicare and Medicaid Innovation (CMMI), which is currently evaluating various health system reform delivery models. However, until these models are adequately tested and evaluated – a process that could take many years -- it is premature to assume that these will produce workable systems. For example, we still do not know if the accountable care organization (ACO) model can work for all physicians, whether it will improve care coordination, reduce costs and improve quality. The same goes for bundled payments, a demonstration project that we understand is not open and/or applicable to all specialties. Data that comes out of the bundled payment demo will therefore not provide enough information to evaluate this model's utility for all specialties.

From our perspective, rather than mandating physicians to participate in one or another shared savings program, during the transition to a premium support structure for Medicare, Congress should enhance the opportunities for such arrangements to develop in the marketplace, which is already happening (although not necessarily because of the incentives provided through the CMMI). After a number of years, we may have sufficient data to fully assess the costs, benefits and feasibility of these different healthcare delivery models, but until that occurs, Congress should refrain from forcing Medicare providers – and patients -- into these programs.

Patient Involvement and Regulatory Relief

1. How does your organization think physicians can encourage beneficiaries to seek appropriate, high-value health care services?

⁴ See for example, Andrew Ryan, Ph.D., et al. Making the Best of Hospital Pay for Performance. N Engl J Med 2012; 366:1557-1559. April 26, 2012. This article notes:

A second wave of studies of the first 3 years of the Premier Demonstration program raised doubts that it had in fact improved care. Even more discouraging were results from the second phase of the program, beginning in 2006, which introduced a new payment-incentive structure, bringing the program more in line with Medicare's evolving VBP plans... However, these changes did not catalyze additional quality improvement; under the new scheme, improvement relative to comparison hospitals actually declined. At about the same time, a hospital-based pay-for-performance program implemented by Medicaid in Massachusetts, with incentives approximately five times the size of those used in the Premier Demonstration program, also showed that pay for performance had no effect on quality.

When patients are given adequate information from trusted sources they are able to make informed decisions about their healthcare. Clearly today's medical market place is a complicated morass of often conflicting and incomplete information, making it very difficult, at times, for patients to identify the providers of high-value healthcare services. Patients and physicians need a trusted source (or sources) of such information so we can be partners in achieving high-value healthcare. The AANS and CNS would be thrilled, for example, if private websites, such as Health Grades, were held to higher accountability standards to ensure that these entities offer accurate information to the public.

Unfortunately, Medicare's own attempt at providing the public with information on physicians is a mess. One of our primary concerns with the *Physician Compare* website is that neurosurgery is not listed as a specialty on the drop down menu on the homepage. Neurosurgeons are grouped with neurologists or listed as a subspecialty within neurology. A user would not know that they have the option to search for a neurosurgeon until they click on "neurologists" and then select the subcategory "surgery-neurological". The second area of concern involves the inaccuracy of physician data contained in the *Physician Compare* database. In regards to querying information, when we have performed a search on a random sample of our Medicare-participating members by specifying the town and state, the site turns up "0" results. Only when their specific name is entered does their entry come up, and then the record is often inaccurate. Despite repeated requests to CMS to make basic corrections to this website, these inaccuracies remain.

Public reporting of physician biographic and quality data may be useful to the public to help them navigate, along with their primary care physician, the healthcare system. But until we can have confidence that such information is accurate, it will be of little utility to patients, and worse, may in fact be detrimental.

2. Are there administrative and regulatory burdens that your organization sees as barriers to fundamental delivery system reform? If so, please describe.

As mentioned above, the federal government should not mandate or throw its weight behind any particular delivery system reform option; rather it should allow the market place – with appropriate regulatory oversight – to foster reforms at the grassroots level. As stated earlier in this letter, one of the principal barriers to delivery system reform is the current structure of the Medicare program with its different payment silos. Moving to a modernized, premium support model for the overall Medicare program will help inject competition and choice into the Medicare marketplace, thereby encouraging the development of range of system options that will best meet the individual needs of seniors.

Another barrier to fundamental delivery system reform is the continued lack of interoperability between health information technology systems. This is true in the private sector, and is also a problem with the current technology capability with CMS, whose operational systems are antiquated. CMS must be given adequate funding to update their operational systems to allow for real-time data sharing with physicians and other providers. A true evidence based quality measurement program cannot be put into practice unless IT systems can work together to allow us to fully measure the value of the healthcare that we are delivering.

Finally, there are a number of legal barriers that persist that may prevent the development of alternative delivery system models. These include the current program integrity laws (e.g., anti-kick back and Stark self-referral); state certificate of need requirements; antitrust barriers; and HIPAA privacy rules. Congress should ensure that these laws and regulations are not unduly impeding the development of collaborate arrangements among healthcare providers.

3. Are there unnecessary administrative and regulatory burdens that your organization sees as taking valuable time away from seeing patients and/or increasing costs to the Medicare program? If so, please describe.

The Medicare program is a mindboggling labyrinth of complicated, sometimes conflicting, rules and regulations and this is only more so since the passage of the PPACA. While the list is long, probably the issues that are most burdensome and problematic at this time – producing little or no value to patients and the Medicare program overall – are the conversion to the ICD-10 coding system, the penalties under the electronic prescribing (e-Rx) program, the PQRS, the EHR incentive program and the value based payment modifier. As we have already outlined our concerns about the PQRS and EHR programs above, we won't further detail our thoughts on those matters here.

ICD-10-CM. As you may know, CMS will be transitioning to the new ICD-10-CM diagnosis code system. Implementing ICD-10-CM requires physicians and their office staff to contend with 68,000 diagnosis codes – a five-fold increase from the current 13,000 diagnosis codes. This is a monumental administrative and financial burden for physicians, requiring education, software conversion, coder training, and testing with payers. The transition will impact many aspects of physician practice, including verifying eligibility, obtaining pre-authorization for services, documenting the patient's visit, research activities, public health reporting, quality reporting and submitting claims. As HIPAA-covered entities, physicians are responsible for complying with this costly and onerous transition to ICD-10-CM. The AANS and CNS have encouraged the Department of Health and Human Services (HHS) to delay for at least one year – until October 2014 – the implementation of this system. However, we believe the more rational approach is to hold off on the implementation of ICD-10-CM altogether. We understand that the federal government will ultimately be implementing ICD-11-CM a few years after the implementation of ICD-10-CM. Since ICD-11-CM is now being developed and beta testing is just around the corner, we believe it would be more sensible – and certainly more cost effective – to bypass ICD-10-CM and go straight to ICD-11-CM when it is rolled out worldwide in a few years.

Value-Based Payment Modifier. The AANS and CNS believe that the value-based payment modifier program is an ill-defined and flawed approach to assessing quality and efficiency in Medicare⁵. It is therefore premature to incorporate this program into a new Medicare payment system before it has been fully tested and evaluated. The long list of unanswered questions about this program are too numerous to outline in this letter, but involve many issues related to the methodology. For example, we are concerned that the data will not be accurately risk adjusted, as it will be derived primarily from administrative billing data. Thus the reports may reveal the *quantity* of services performed, but provide little or no useful information regarding the *quality* of care delivered. Utilizing non-risk adjusted claims data may also result in "cherry-picking" whereby certain physicians treat healthier patients, leaving the sicker patients to seek their care from physicians practicing at academic medical centers or other tertiary care centers -- unfairly penalizing the latter. Additionally, the list of quality and outcomes measures may not be applicable to many physicians and physicians may be inappropriately lumped together in the same comparison group. Finally, based on the minimal information CMS has provided, it appears CMS does not have the appropriate technological infrastructure to even handle the program and to implement it properly and we are aware that many of our physicians who should be receiving resource reports in the initial pilot phase of the program have in fact received nothing.

⁵ It should be noted that the principle underlying the value-based payment modifier stems from the conclusions drawn from the work done by Dr. Elliott Fisher at the Dartmouth Atlas. The Dartmouth folks posited that physicians in certain parts of the U.S. over-treated and over-charged patients, to no benefit. Since the passage of PPACA, this conclusion has been challenged, and Dr. Fisher himself has acknowledged that the Dartmouth Atlas measures should not be used to set payment rates.

See for example, Cooper, Richard. The Demise of Dartmouth, but Who's To Blame? Buz Cooper, MD Blog Post. February 18, 2010. <http://bit.ly/KTMFIJ>.

See also, Abelson, Reed, et al. Critics Question Study Cited in Health Debate. *New York Times*. June 10, 2010. <http://nyti.ms/CMN5mU>.

Cuts on Top of Cuts. Physicians are also facing present and future financial penalties if they do not successfully participate in multiple Medicare programs, including the e-prescribing program, the EHR meaningful use program, and the PQRS. In addition, physicians are being required to meet separate requirements under these three overlapping health IT programs and have been, and will be, unfairly penalized if they decide to participate in one program over the other. These burdens are coming at the same time that physicians are trying to undertake meaningful payment and delivery reforms. Of course, all of the costs and payment cuts under these programs are on top of the ongoing threat of steep Medicare physician payment cuts due to the flawed SGR along with the 2 percent deficit reduction sequester cuts. Physicians are doing everything they can to be compliant with these various program requirements, but due to the simultaneous implementation dates, it is creating mass confusion among neurosurgeons, along with an financial and administrative burden. Taken together, these cuts alone will take a huge toll on physician practices and patient access to care.

The following chart highlights the worst case scenario facing physicians. At this time, we also do not have an assessment of the financial impact of the value-based payment modifier or any IPAB-related cuts so this scenario is fluid.

	SGR Update	Deficit Reduction Sequester	PQRS	e-Rx	EHR	Value Based Payment Modifier	IPAB
2013	-30.9	-2		-1.5			
2014	0.9	-2		-2			
2015	1.2	-2	-1.5		-1	?	?
2016	1.4	-2	-2		-2	?	?
2017	0.7	-2	-2		-3	?	?
2018	0.1	-2	-2		-3	?	?
2019	-0.1	-2	-2		-4	?	?
2020	0	-2	-2		-5	?	?
2021	0.2	-2	-2		-5	?	?

The cumulative pay cut to physicians under all these programs through the year 2021 is a whopping 85%! At the same time, according to this year’s Medicare Trustees’ Report, practice costs (as measured by the Medicare Economic Index, or MEI) will grow by 22.3% over this same period. It is clear that physicians cannot absorb cuts of this magnitude so it is imperative that Congress act to modify these flawed programs, including eliminating these penalties.

Concluding Thoughts

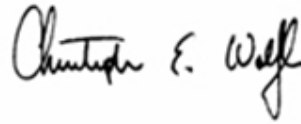
Chairman Camp, thank you for your efforts to seek ways to improve the Medicare physician payment system. Clearly, the current SGR formula is fundamentally flawed and patients and physicians deserve better than the “kick-the-can” approach Congress continues to employ each time we reach the reimbursement cliff. With a looming 30 percent payment cut next January, the time for a permanent, workable and sustainable solution is long overdue. We caution you to move carefully, however, so as to not replace one faulty system with another.

We look forward to working with you on this and other important health policy issues. If you need further information or have any questions, please don't hesitate to contact us.

Sincerely,



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cc: House Ways and Means Committee Members

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