Alliance of Specialty Medicine

Sound Policy. Quality Care.

July 22, 2013

Honorable Fred Upton
United States House of Representatives
2183 Rayburn House Office Building
Washington, DC 20515

Honorable Henry Waxman
United States House of Representatives
2204 Rayburn House Office Building
Washington, DC 20515

Honorable Joseph Pitts
United States House of Representatives
420 Cannon House Office Building
Washington, DC 20515

Honorable Frank Pallone, Jr.
United States House of Representatives
237 Cannon House Office Building
Washington, DC 20515

Honorable Michael Burgess
United States House of Representatives
2336 Rayburn House Office Building
Washington, DC 20515

Honorable John Dingell
United States House of Representatives
2328 Rayburn House Office Building
Washington, DC 20515

RE: Feedback on the House Energy and Commerce Sustainable Growth Rate (SGR) Bipartisan Committee Print Released on July 18, 2013

Dear Representatives Upton, Waxman, Pitts, Pallone, Burgess, and Dingell:

In recognition of your ongoing, bipartisan efforts, **the Alliance of Specialty Medicine (Alliance) strongly supports your effort to repeal and replace Medicare's sustainable growth rate (SGR) formula** and looks forward to working with the Committee to further refine the legislation. 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, and we would like to take this opportunity to express our appreciation and outline the provisions we support in the bipartisan Committee print released on July 18.

The Alliance is encouraged by and appreciative of the Committee's efforts to include key elements which the Alliance believes are critical to any physician payment reform proposal, including:

- Repeal of the SGR, followed by a minimum 5-year period of stability in Medicare physician payment;
- 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 preserving a viable fee-for-service (FFS) option; and
- Legal protections for physicians who follow clinical practice guidelines and quality improvement program requirements.

In addition, we appreciate your efforts to address previously outlined concerns by specifically including the following changes in the July 18 Committee print:

- While the Committee opted not to include an update of the base payment based on the Medicare Economic Index (MEI), **we appreciate your efforts to include a positive update of 0.5%,** which ensures physicians will not start in the negative**.**
- While the Alliance still has concerns with the negative incentives outlined in the legislation, **we are appreciative that the Committee included a performance measurement model that relies on meeting certain achievable benchmarks rather than pitting physicians against each other.** We continue to urge the Committee to emphasize the role of professional societies and other relevant clinical experts in determining measure weights and setting thresholds for each peer cohort.
- **We appreciate your changes to the Quality Incentive Update Program,** including requiring that the Secretary develop a minimum per year caseload threshold so that those who do not meet this threshold would not be subject to the 5% reduction for non-participation, providing clarification that a single measure can satisfy multiple domains, and expanding the "measures" in this section to also potentially include "clinical practice improvement activities".
- **We are supportive of the changes to the performance period –** to ensure that it spans 12 consecutive months and ends as close as possible to the beginning of the year for which such adjustment is applied. We understand, after conversations with your staff, that given the requested 12 month reporting period, it was difficult, due to timing issues, to make additional changes with respect to the reporting timeframe (given that CMS will likely need the complete five years to develop sufficient models) or to alter the public feedback period. However, we still request that the bill language specify a timeframe (of at least one year) for providing confidential feedback to physicians *prior* to holding them accountable for performance (as the bill language already does for those who "first become eligible professionals"), as well as to clarify that there be at least 90 days of public feedback before a final measure set is adopted.
- **We appreciate that you acknowledged our concerns with the measures being limited to those developed by the National Quality Forum (NQF),** given that the consensus standards endorsement process is 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 support your changes to clarify the application of the framework for group practice and individual physician level elections.**
- **We appreciate that peer cohorts can be classified "across eligible professional organizations and other practice areas, groupings, or categories" and support the process by which an eligible professional can self-identify his or her peer cohort.**
- **We appreciate your changes to eliminate the confusing "core competency" terminology, which would have added an additional layer of regulatory burden.**
- While the Alliance requested that you more fully define risk adjustment to address the potential effect of patient non-compliance on outcomes and to address socioeconomic factors, **we are thankful that you simply clarified through broader language that there would be "appropriate risk adjustments**," without additional qualifiers.
- **We want to thank you for your revisions related to the "contracting entities" to solicit and vet Alternative Payment Models (APMs)**. In particular, we are appreciative of the changes to more clearly define who is eligible to carry out the role of "contracting entity" given the significant authority granted to these entities and to ensure more flexibility in the testing of various payment models relevant to a range of practices and patient populations.
- **We support your revisions related to the publication of measures in specialty-appropriate peer-reviewed journals,** which clarifies the requirement that measures only be *submitted* to such journals, but not necessarily published. The modified language maintains the spirit of evidence-based medicine and transparency, while recognizing the independent editorial processes that are outside the control of professional societies.
- **We thank the Committee for additional changes that would support efforts to educate professionals through multiple approaches**, including a national dissemination strategy and outreach by Medicare contractors, as well funding to pursuit these efforts.

- While we continue to urge the Committee to include language to ensure that the Electronic Health Record (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, **we appreciate that the Quality Incentive Update Program would integrate with the current PQRS** so that satisfactory participation in the new program would qualify a professional as satisfying PQRS requirements.
- **We appreciate that reporting to a qualified clinical data registry would continue to be recognized under the Quality Incentive Update Program.**
- **We are very pleased with the provision requiring HHS to make claims data available to qualified clinical data registries so we can combine that data with clinical data to conduct more extensive research and analysis on quality improvement efforts.**

The Alliance further notes that the latest Committee print includes two new problematic provisions. The first provision provides HHS with the authority to collect data on volume and time for services, establish a reporting group of physicians (including specialists), and then provide payments to the reporting group for reporting. Using that information, for 2016, 2017, and 2018, the Secretary is to more closely examine mis-valued services and make RVU adjustments. While we are appreciative of the Committee's efforts to ensure such processes are driven by appropriate data, the Alliance is very concerned about the proposal, due to its unnecessary and duplicative nature. As you are aware, the AMA/Specialty Society Relative Value Scale Update Committee (RUC) already provides recommendations to the CMS for the valuation of new and revised codes as well as codes identified as mis-valued under the Five-Year Review of Work. This existing process assures physician input from a variety of disciplines to examine potentially mis-valued physician services, and we believe is more effective than a concurrent CMS process. In addition, by focusing on a small subset of physicians reporting the information, it is likely that the information gathered will be inappropriately biased. **Therefore, we urge you to delete the provision related to mis-valued codes.** The second new problematic provision is related to medical homes. While we appreciate that the provision acknowledges that the newly proposed HCPCS codes could also be used for certain specialists, we remain concerned with legislatively creating any particular codes, rather than relying upon the current regulatory processes. **Therefore, we urge you to delete the provision related to care coordination and medical homes.**

The Alliance again thanks the Committee for the opportunity to provide interactive feedback over the past several months as this legislation has been developed. We appreciate that many of the concerns the Alliance expressed have been addressed in the July 18 Committee print and we look 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 [including eliminating the Independent Payment Advisory Board (IPAB), adding medical liability reform, and providing for private contracting], as well as any other questions you may have going forward.

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