Alliance of Specialty Medicine

Sound Policy. Quality Care.

April 15, 2013

To the House of Representatives Committees on Ways & Means and Energy & Commerce:

The Alliance of Specialty Medicine (the Alliance) would like to thank the House Energy and Commerce and Ways and Means Committees for the opportunity to provide feedback on the second iteration of its SGR replacement proposal. 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.

The Alliance believes that the following elements are critical to any physician payment reform proposal:

- 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;
- Positive financial incentives rather than penalties and withholds;
- Flexible criteria that allow physician participation and engagement in delivery and payment models that are meaningful to their practices and patient populations, including FFS;
- Elimination of penalties and cumbersome reporting requirements associated with current federal quality reporting programs, such as the PQRS, EHR Incentive Program, and Value-Based Modifier, while allowing physicians and specialties to retain elements of these programs that are appropriate and relevant for use in any new quality improvement program;
- Legal protections for physicians who follow clinical practice guidelines and quality improvement program requirements;
- Repeal of the IPAB; and,
- Allow for private contracting.

Attached to this letter are more detailed guiding principles for value-based payment and delivery reforms that reflect the needs of specialty medicine. We would be happy to discuss these principles and any other questions you may have going forward.

The Alliance appreciates the opportunity to provide feedback and looks forward to working with the committees to find a permanent and meaningful solution to the SGR.

Sincerely,

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 and 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

Guiding Principles for Value-Based Reforms Relevant to Specialty Medicine

The long-term potential of Medicare and other federal initiatives to close quality gaps and achieve better value in healthcare lies in the ability to accommodate multiple aligned strategies rather than any singular approach. Current payment and delivery reforms focus primarily on primary care and often have little relevance to specialty providers. As a result, participation rates and buy-in among specialists remains low.

As Congress works to implement a Medicare payment system that is more significantly tied to quality, efficiency, and patient outcomes, it must give careful consideration to ways in which it can encourage, rather than discourage, participation among a broader swath of healthcare professionals. There is no "one-size-fits-all" approach to quality improvement and programs that rely on arbitrary measures and insufficiently tested methodologies to alter physician reimbursement will only deter specialists from more engaged participation and further restrict patients from accessing the high value care they deserve. **It is critical that value-based reforms account for the fact that optimal models are varied and depend on the clinical context.**

Listed below are guiding principles for value-based payment and delivery reforms that reflect the overarching needs of specialty medicine.

Physician-Driven Quality Measurement

Measure development must be led by relevant clinical experts, who are best equipped to decide on the most appropriate strategies for treating specific diagnoses, procedures, and patient populations. Multidisciplinary teams of experts should be employed, when applicable, to ensure the highest level of clinical accuracy and to ensure that measures are meaningful and relevant to all healthcare professionals to which they may apply. It is especially critical that the federal government consult with relevant specialty societies at the earliest stages of measure development. Currently, specialty societies are often omitted from this process and are not given the opportunity to share critical clinical input until the measures are well-developed and more challenging to modify.

While evidence-based approaches to measurement are preferred, current standards, such as those used by the National Quality Forum (NQF), are often too resource intensive to justify 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-- which may provide the very data needed to fill current gaps in the evidence. Most, if not all, specialty societies regularly provide input into the current measure development process. However, few have actually taken the lead on measure development, citing cost and lack of data to support validated measurement as the primary deterrents.

Instead, many of these specialties have found greater value investing in alternative approaches to quality improvement, such as the collection of clinical and patient-reported outcomes data through registries. While registries also require a large investment of resources, specialty societies often realize a greater return on investment since registries can serve multiple functions, such as monitoring the effectiveness of various care patterns while at the same time building the evidence base for more meaningful, specialty-focused measures. Specialty-developed registries also tend to promote greater trust and buy-in among specialists, who view these tools as more relevant and meaningful to their practice than the current "check box" measures used in federal and other third party reporting initiatives.

Despite the current challenges posed by the current measure development and endorsement process, we believe that there are important elements that can serve as minimum standards under a payment system that better recognizes more meaningful and flexible approaches to quality. These include standards that ensure transparent processes, the use of minimum sample sizes, basic auditing and data integrity/validation criteria, and ongoing evaluations of the effectiveness and feasibility of measurement approaches. We also oppose arbitrary timelines for updating measures and other clinical improvement activities. Such updates should conform to the evolving clinical evidence base and other lessons learned from activities such as data collection rather than within a standard amount of time.

Flexibility

The need to move beyond a one-size-fits-all approach to quality measurement is long overdue. Payment reforms should offer physicians the flexibility to choose from a wide variety of measures and quality improvement strategies that are most relevant and meaningful to their practice setting and patient populations. This should include: process-of-care measures for which evidence shows that better performance leads to better outcomes; measures that evaluate outcomes directly; and structural measures that encourage the use of technology and other infrastructure, such as registries, to improve quality and efficiency.

The use of standardized or federally mandated core measure sets should be limited and "menu" options expanded since there are very few measures that apply equally to all physicians. Alternatively, programs could rely on broader core *objectives* that set overarching goals while giving physicians the freedom to specify the manner in which they are implemented (e.g. setting the goal of greater physician use of clinical decision support tools, but letting the individual physician decide on the most appropriate use of the technology in his/her practice setting).

Gradual Implementation

Reforms that hold physicians accountable for quality and overall value should be phased in gradually. Transition periods should last a minimum of five years to allow for careful and ongoing evaluations of effectiveness (e.g., links to better outcomes), accuracy (e.g. reliable risk adjustment and attribution methodologies), feasibility (e.g., consideration of reporting burden), and unintended consequences (e.g., mechanisms to prevent the avoidance of high risk, costly patients). The overarching goal should be to establish an ongoing learning environment that encourages physicians to continuously engage in the systematic measurement of practice performance.

Following a crawl-walk-run approach, physicians initially should be recognized for more basic, yet meaningful clinical improvement activities, such as regular collection and analysis of practice data in a confidential manner. Data collection, alone, has proven to be a valuable exercise that naturally results in improvements in care. This could then evolve into a process whereby physicians are recognized for using collected data to make improvements in practice and to demonstrate the impact of such improvements. Only after risk adjustment and attribution methodologies are adequately tested and fine-tuned for accuracy and physicians are given the opportunity to become accustomed to regular and meaningful performance feedback should this data be used for public reporting and for payment adjustments based on performance measurement.

Even performance-based payment reforms should be phased in gradually, focusing initially on a provider's own improvement over time and later transitioning to relative rankings. The goal should be to foster overall improvements in patient care and not to create a competitive environment that pits one physician against another, creating perverse incentives that detract from doing what it truly best for the patient. When it is appropriate to transition to relative rankings, it is critical that comparisons be made amongst similar physician

specialties and even sub-specialty peer groups in order to ensure the most accurate analyses. Performance comparisons also should initially focus only on outliers.

Overall, reforms should remain voluntary and flexible until more concrete evidence about their effectiveness is established.

Positive Incentives

Value-based payment reforms should rely on incentives for meaningful quality improvement, rather than penalties for arbitrary indicators of performance. Positive incentives are critical for gaining physician trust and encouraging ongoing engagement. Positive incentives also help to ensure that physicians are reimbursed at a level that will allow them to invest in infrastructure and care processes to continually improve the quality of patient care.

Minimal Reporting Burden

Value-based payment reforms should pose a minimal burden on practicing physicians. Current programs have overlapping, duplicative, and time-consuming administrative requirements that breed frustration among practicing physicians and detract from time spent with patients. Physicians should be able to choose the quality improvement activity that is most appropriate and convenient for his/her practice. Reporting should not interfere with, but instead encourage, higher quality care.

Greater Emphasis on Quality vs. Cost

While higher value healthcare is a reasonable goal, the primary focus of health system reform should be the quality of a patient's care rather than economic considerations. If carried out properly, quality-focused efforts will shed light on under-utilized, mis-utilized, and over-utilized care, which will naturally target inappropriate spending. For example, data collection through registries and other robust databases can shed light on the appropriateness of care and utilization patterns, and impart lessons on how best to achieve more efficient outcomes.

Both public and private payers continue to struggle with how to accurately define and measure appropriate resource utilization in health care and very few trustworthy risk-adjustment mechanisms exist. In fact, the RAND Corporation published a series of studies that questioned the reliability of cost profiling. One study found that physician ratings based on cost of care can be incorrect up to two-thirds of the time for some specialties and that even under the best-case scenarios, they misclassify one-fourth of all physicians. RAND ultimately concluded that "current methods of physician cost profiling are not ready for prime time" and that "current cost profiling approaches need to be improved, or new approaches need to be developed."
Questions also remain about how to most effectively report cost data (e.g., reporting on the cost of a single procedure or diagnostic test versus reporting on the cost of an entire episode). While some formats may be more personalized and easier to calculate, others may be more comprehensible and actionable.

It also remains unclear to what extent patients value and rely on cost information for healthcare decision-making. Patient education is a critical component of cost measurement. Patients must fully understand the factors that influence cost variations and not automatically assume that there is a consistently direct (or even indirect) relationship between cost and quality.

Finally, federal reforms must account for the fact that cost comparisons are more appropriate under certain circumstances, such as elective procedures and conditions that are not life-threatening. Cost measurement should focus first on more predictable circumstances and patient populations, rather than more complex clinical scenarios. Adequate time is also needed to fine tune risk adjustment and attribution methodologies so that they produce accurate and meaningful results across specialties and different practice types.

Timely Feedback

Meaningful and timely feedback is the foundation of any successful quality improvement initiative. The current time lag between measurement and payment adjustments is not only confusing, but discouraging. For performance-based feedback and incentives to result in sustained improvements, value-based payments should fall closer to when the care was actually provided.

Fair Appeals Processes

Payment reforms that hold physicians accountable for quality and cost performance must include a clear and fair appeals process. Since the goal is ongoing improvement and education, physicians should be given the opportunity to review data and to make care adjustments based on feedback prior to being held accountable for performance. In addition, protections should be in place to ensure that any performance data is not subject to discovery or admission as evidence in judicial or administrative proceedings without the consent of the physician.

Health Information Technology Infrastructure that Supports Quality Improvement

Currently, physicians are being held accountable for the meaningful use of certain HIT functionalities to improve patient care when those functionalities simply do not exist. National certification criteria and, more importantly, mechanisms to ensure that vendors adhere to those criteria, must be in place and the functionalities well tested before physicians can be held accountable for using HIT to satisfy specific clinical objectives. Despite federal incentives, specialists still question the value of investing in systems that remain largely irrelevant to their practice. Lack of standardization and interoperability between these systems also remains a major challenge that must be addressed before true evidence-based quality improvements can be effectively incorporated into practice.

Fundamental Elements for Value-Based Delivery and Payment Models

The following fundamental elements should be featured across all value-based payment models, regardless of specialty or practice type. To promote meaningful engagement, physicians should be given the flexibility to choose the most appropriate manner in which to fulfill each of these common elements based on their practice type and patient populations.

- **Quality Measurement** – Measures of clinical quality that meet minimum standards and are developed by relevant clinical experts should be a fundamental component of any value-based payment reform. It is critical that measures are continually evaluated and updated based on the clinical evidence and that physicians can choose from a wide selection of measures that are most meaningful and relevant to their practice.
- **Continuous Data Collection** –Physicians should be able to demonstrate engagement in continuous clinical data collection through the use of a qualified registry, database, or other health information technology.

Continuous data collection is critical to identifying the most appropriate practice patterns and linking processes to better outcomes. This is particularly important for managing chronic diseases or other conditions without well-defined beginnings and ends. Payment reforms should incentivize ongoing data collection and promote an infrastructure where public and private claims data is more easily accessible and can be linked to clinical data to provide a more complete understanding of the relationship between quality and cost.

- **Shared Decision-Making (SDM)** – Physicians should be able to demonstrate engagement in collaborative processes that assist patients with making individualized treatment decisions by taking into account the best scientific evidence, as well as the patient's values and preferences.
- **Care Coordination** – Physicians should be able to demonstrate strategies to ensure seamless transitions of care between providers and care settings, when appropriate, including effective communication during referrals and consultations, systematic processes for tracking follow-up tests and treatments, and patient education and support for self-management.
- **Patient Reported Outcomes (PROs) and Care Experiences** – Physicians should be able to demonstrate that they are collecting data on both patient reported care experiences and patient reported health outcomes (e.g., pain, physical function, depression, social function, and other quality of life domains) using validated instruments such as CAHPS, PROMIS, and the Oswestry Disability Index.

Providing Legal Protections

Most Americans agree that the current medical-legal system is broken and in dire need of reform. 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. 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 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 guidance on the other.