November 12, 2013

The Honorable Max Baucus
Chairman
Senate Finance Committee
Washington, D.C. 20510

The Honorable Orrin Hatch
Ranking Member
Senate Finance Committee
Washington, D.C. 20510

The Honorable Dave Camp
Chairman
House Ways & Means Committee
Washington, D.C. 20515

The Honorable Sander M. Levin
Ranking Member
House Ways & Means Committee
Washington, D.C. 20515

Dear Senator Baucus, Senator Hatch, Representative Camp and Representative Levin:

The American Association of Clinical Endocrinologists (AACE) welcomes the opportunity to provide comments on the Sustainable Growth Rate (SGR) repeal and Medicare physician payment reform proposal. We commend your continued efforts to repeal the SGR formula once and for all and to enact meaningful and sustainable physician payment reform.

AACE represents over 5,000 endocrinologists in the United States alone and is the largest association of clinical endocrinologists in the world. The majority of AACE members are certified in Endocrinology and Metabolism and concentrate their work on the treatment of patients with endocrine and metabolic disorders including diabetes, thyroid disorders, osteoporosis, growth hormone deficiency, cholesterol disorders, hypertension and obesity. AACE members are committed to providing the highest quality of care to the patients they serve.

Our comments below are structured to address each of the eight sections contained in the discussion draft.

1. **SGR Repeal and Annual Updates**

AACE has long supported repeal of the SGR formula and we applaud the Committees for permanently repealing the flawed SGR formula in the proposal. We are disappointed, however, at the lack of recognition or appreciation for the increasing costs of providing medical services and the burden of investing in infrastructure to comply with new quality and reporting requirements at a time when many practices are barely able to keep afloat. A ten-year freeze in payments in reality represents compounded payment cuts, which will further erode the viability of the physician practice. We understand the importance of controlling the cost of the legislation but we are concerned that a freeze in payment coupled with new administrative burdens related to compliance with the Value-Based Performance Payment Program discussed below, will cause physicians to leave the Medicare program in numbers not previously seen or, at the very least, refuse to see new Medicare patients at a time of record-breaking Medicare enrollment.

The proposal provides a 5% bonus to professionals who have a significant share of their revenues in Alternative Payment Models (APMs) that involve two-sided financial risk and a quality measurement component from 2016 - 2021, however, current APMs provide limited opportunity for integration of the subspecialist, such as the endocrinologist, who is in a solo or small group practice. For this pathway to provide a meaningful opportunity for subspecialists to earn bonus payments there must be more APM opportunities for subspecialists than what currently exists. AACE supports a period of stability during which physicians receive payment updates that keep pace with the growth in medical practice costs, based on the Medicare Economic Index (MEI). Direct financing and technical assistance should also be made available so
physicians can acquire the necessary infrastructure enhancements to develop and test APMs and achieve integration with quality improvement initiatives.

2. Value-Based Performance (VBP) Payment Program

AACE commends the Committees for sunsetting the penalties associated with the Physician Quality Reporting System (PQRS), the Value-Based Payment Modifier (VBM) and the Electronic Health Records (EHR) meaningful use program in an effort to create a streamlined program aimed at incentivizing quality and reducing cost. We strongly encourage you to eliminate the penalty phase of these programs that begin with the 2013 performance year, resulting in reduced payments in 2015, instead of continuing the penalty phase of these programs for two years through the end of 2016. Why should two years of payment penalties be imposed as a result of programs that the Committees’ are recommending for sunset? To do otherwise reflects an arbitrary and simple way of addressing the Medicare funding crisis on the backs of physicians.

We look forward to seeing more details about the implementation of the proposed Value-Based Performance (VBP) payment program, however, we raise the following concerns based on discussion draft description of this program.

- **Quality Measures**: AACE reiterates support for overriding the current ineffective CMS quality measurement programs and replacing them with quality metrics developed by physicians, in-conjunction with medical specialty societies, based on evidence-based medical guidelines, position statements and other clinical tools that provide much more accurate delineation of the physician-delivered quality of care. We maintain that the PQRS measures do not provide an accurate and reliable method for evaluating the quality or value of the highly-skilled, labor intensive cognitive care provided by an endocrinologist acting as a consultant to treat patients with complex and difficult endocrine diseases and disorders. The metrics against which physicians will be judged need to be metrics that are under the control of, or are mostly under the control of, the physician. For example, a disease such as Type 2 Diabetes requires multiple daily choices made by the patient in order to achieve a good outcome. If the patient fails to monitor his/her blood sugar, misses doses of medication, can't afford the proper foods that are in his/her meal plan, and will not exercise, then a metric like the A1c will not be a measure of the physician's quality of care, but will be a measure of the patient's compliance (influenced not only by the physician, but by the patient's education status, ability to adhere to a medication regimen, ability to afford the right foods, ability to have the time or a safe place to exercise, etc.). The physician should instead be measured by whether an A1c test was ordered as needed and if it was not at target, whether or not an appropriate intervention was recommended by the physician.

- **Resource Use**: We are concerned about having physician payment based on efficient use of resources without knowing what risk adjustment methodologies will be in place to preserve access to care for the sickest patients and those with chronic disease. The budget neutral payment approach to the VBP program providing bonuses to the top performers being paid for by penalties imposed on the bottom performers provides a significant disincentive to physicians to provide care for patients with hard to treat chronic medical conditions. In those circumstances, even those who are providing high quality care may be penalized if others score better. Moreover, efficiency, or efficient care, does not always result in effective care, and risks creating the unintended consequence of reducing quality of care. Efficiency measures can also be largely dependent on patient behavior/compliance, which further reduces their reliability as an indicator of physician actions. It would be beneficial to delay or eliminate this performance assessment category until accurate and proven risk adjustment methodologies are developed. We also urge a transparent process be established for review and comment on the risk adjustment methodology.

- **Clinical Practice Improvement Activities**: The ability to engage in the categories of clinical practice improvement activities listed in the discussion draft will vary by physician specialty. Some of the activities listed, e.g. care coordination, such as timely communication of clinical information and use of remote monitoring or telehealth, will require a significant investment in infrastructure that payment freezes or reduced payments due to poor compliance with current reporting programs simply do not permit. While all of the activities listed are laudable
objectives, any one of them will be difficult for many physicians, particularly those in solo or small group practice, to achieve without additional resources being made available.

- **EHR Meaningful Use**: If our understanding of the discussion draft is correct, the current EHR meaningful use requirements will comprise one of the four VBP assessment categories, for which the Committees assume a "modest" physician failure rate of 30-40%. If the goal of the VBP program continues to be the improvement of patient care and outcomes, then why maintain an assessment category under the VBP program that is so hard for a large percentage of physicians to implement? Incorporating requirements in a new program that set physicians up for failure in order to control overall program costs is a huge disincentive for physicians to participate and undermines the integrity of the Medicare program.

- **Assistance to Small Practices**: We support the proposed assistance to small practices of ten or fewer eligible professionals located in Health Professional Shortage Areas or rural areas to help them improve performance and to facilitate participation in advanced APMs. However, we believe that small practices beyond those in HPSAs and rural areas will need financial support and technical assistance to engage in clinical improvement activities and participate in APMs. We strongly urge additional resources be provided for this purpose.

- **Performance Assessment on Budget Neutral Basis**: The budget neutral payment approach with bonuses to those physicians that perform at the highest composite score level funded by penalty reductions to those at the bottom of the composite score range will preclude recognition of the attainment of quality standards under the VBP program by most if not all providers. In this scenario even those physicians who are providing high quality care may receive payment reductions if the composite scores of others are higher. Structuring the VBP in a manner that penalizes progress towards or achievement of a stated reform objective is both unfair and unacceptable. Additionally, making the assumption that all physicians who practice in a certified medical home would receive the highest possible score for this category without having their particular performance measured with a composite score reduces the funding available and the ability of more physicians who are not part of a medical home to be judged as high performers and receive bonus payments.

- **Timeline**: We believe it is unrealistic to assume that physicians will be able to adopt and optimize a new VBP program by 2016 that has not been fully developed and enacted or has gone through the rulemaking process.

3. **Encouraging Alternative Payment Model Participation**

- We encourage the Committees to take the approach adopted by the House Energy & Commerce (E&C) Committee providing a streamlined process to submit and test alternative payment models outside of the Centers for Medicare and Medicaid Services Innovation Center to create more opportunities for specialists and subspecialists to engage in APMs. Access to Medicare claims data will be critical for physicians, specialty organizations, healthcare provider organizations and other entities to develop APMs and to assure accuracy in modeling and projections. We also support the E&C Committee’s transparency provisions requiring that the Secretary of Health and Human Services make publicly available an explanation of the reasons why a proposed APM is not recommended by the APM contracting authority for evaluation through a demonstration program.

- We are disappointed that all of the SGR repeal and physician payment reform proposals pending before Congress to do not include the ability of physicians and patients to enter into private contracts. AACE believes private contracting without penalty is critical to achieving cost-effective and sustainable physician payment reform and strengthening the patient-physician relationship. Beneficiaries should have the right to negotiate fee arrangements with the doctor of their choice without penalty to the patient or the doctor. As more and more physicians are entering concierge medicine due to the unpredictability of the current system, they currently must "opt-out" of Medicare for two years if they intend to enter into a private contract with only one beneficiary. Private contracting without penalty will increase beneficiary access to physicians and is an important payment reform that will limit federal Medicare spending instead of increasing it. At the very least we urge you to enact the necessary provisions that will permit private contracting to be tested as an APM.
4. **Encouraging Care Coordination for Individuals with Complex Chronic Care Needs**

- Certain physician services that facilitate improved communication and coordination of care that are currently uncompensated should be paid for under a reformed payment system in order to maximize care. The policy of no longer paying for the consultation codes under the Medicare Physician Fee Schedule (MPFS) has significantly reduced the communication and coordination of care between the patient's primary care physician and the specialist consultant. We are concerned, however, that the Committees’ proposal intends to pay for certain codes for the management of complex chronic care in a budget neutral manner.

- We recommend exploring an alternative episode of care model based on time providing care for patients with complex chronic diseases. Under this scenario physicians could be paid via bundled units of care based on time spent providing non-face-to-face patient care. Specifically, any time spent communicating results, formulating a care plan, speaking to other physicians about the patient’s status or speaking indirectly to the patient between face-to-face office visits should be coded and billed under the innovative new option. Documentation of time could easily be accounted for, such as in EHR products, in the context of the “documentation only encounter”, making billing simple. Codes would be standardized to specifically agreed-upon time intervals. Such a system for coding non-face-to-face care could serve as a “beta test” for converting all cognitive care codes in the Medicare System into time-based codes. The complicated “bullet coding system” presently in use has done little to improve care and, quite frankly, has actually encouraged the computer-based upcoding issues that CMS is now facing. We envision a future in which all procedural care will be coded by CPT and all cognitive, patient interactive care will be coded by time interval codes. The place to start this coding revolution is in the intervals between face-to-face visits where we need increased ability to improve coordination of care and patient safety. We encourage CMS and Congress to consider this proposal carefully.

5. **Ensuring Accurate Valuation of Services Under the Physician Fee Schedule**

- Accurate valuation of services is another area where there is a real possibility that funds would be taken out of the physician payment pool. Under this proposal, if the “target” (unknown amount) is not met the difference would be taken out of the physician pool. This could lead to a serious decrease in the fee schedule pool of funds. A detailed explanation of how the target will be calculated and applied is required. The financial disincentive of this part should be removed. Instead Part B should be broken up into two parts; B1 would include office visits, which are undervalued, and care coordination, much of which is still uncompensated; and B2 would include all procedural codes. Under this scenario the valuation of services, application of targets for misvalued services and the redistribution or reduction of funds within the two fee schedules would be more appropriate and accurate way to achieve the objectives of the service valuation proposal.

- We support the proposal to compensate physicians for providing information to assist the accurate valuation of services under the fee schedule; however, to penalize a physician for not providing this information by applying a 10% reduction for all services in the subsequent year is unreasonable if not outrageous. This requirement will pose a burden for those practices that are still struggling with obtaining the necessary infrastructure and EHRs for quality reporting programs. Additionally, only obtaining data from groups of 10 or more will not account for variations in the provisions of specific services that occur in smaller practice settings.

6. **Recognizing Appropriate Use Criteria**

- The proposed implementation of new appropriate use criteria is going to be very burdensome and costly to most practices. As it is now many physicians are not required to demonstrate they have consulted with appropriate use criteria or seek prior authorization to perform a test they believe is required based on their best clinical judgment. If this proposal is implemented, patient access to any advanced radiologic or electrocardiogram procedure will be severely limited while this proposal is operationalized, and many physicians will simply elect not to treat patients who need these procedures. A single patient record would decrease unneeded, duplicative, and expensive testing more than demonstrating necessity to the Secretary or seeking prior authorization. A patient record would also enhance the coordination of care among health professionals.
treatment of a specific patient. It would make more sense for Medicare to keep a single protected patient record
that all physicians treating that patient could access. This could be accomplished with computerized records
transmitted into a single database held by Medicare. Similar databases could be implemented by private
insurance companies.

7. **Expanding the Use of Medicare Data for Performance Improvement**

- No comment on this section

8. **Transparency of Physician Medicare Data**

- Publishing data is a laudable objective, but there needs to be processes identified to ensure accuracy, the right
  of the physician to review the data and dispute and correct any inaccuracies. Decisions about appropriate and
  useful criteria to publish should be made in consultation with physicians and the medical specialty societies that
  represent them.

On behalf of AACE, I offer whatever assistance we can provide to assist you as you pursue enactment of Medicare
physician payment reform. Please feel free to contact me or Sara Milo, AACE Director of Legislation and Governmental
Affairs, at 904-353-7878 or smilo@aace.com if we can be of help.

We look forward to continuing to work with you on physician payment reform in the weeks and months ahead.

Sincerely,

Jeffrey I. Mechanick, MD, FACP, FACE FACN, ECNU
President