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IDSA
Infectious Diseases Society of America

April 12, 2013

The Honorable Dave Camp, Chairman
Ways & Means Committee
U.S. House of Representatives
Washington, DC 20515

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

Submitted via: sgrcomments@mail.house.gov

Re: Second Draft of SGR Repeal and Reform Proposal

Dear Chairmen Camp and Upton:

On behalf of the Infectious Diseases Society of America (IDSA), which represents more than 10,000 infectious diseases physicians and scientists devoted to high quality patient care, we thank you for the opportunity to provide feedback on the House leadership's revised proposal to replace Medicare's sustainable growth rate (SGR) physician payment formula with more predictable payment rates that reward physicians for delivering high quality and efficient care. We appreciate that the revised proposal emphasizes the need for a period of stable fee-for-service (FFS) payments while new payment models and performance measures are developed; that it aims to give physicians the flexibility to participate in the payment and delivery model that best fits their practice, whether FFS or an alternative model; and that it emphasizes the importance of evidence-based, yet flexible, physician-driven and specialty-specific quality and efficiency measurement. Gradual implementation and recognition of more diverse and meaningful approaches to quality improvement are critical elements of any value-based payment system, and the IDSA is pleased to see these features as the hallmark of your proposal.

IDSA also supports the aspects of the proposal that aim to reduce administrative burden so that physicians can focus more of their time on direct patient care rather than reporting. IDSA is encouraged to see this proposal calling for a system in which cost-based adjustments remain *voluntary* and only rely on positive incentives, rather than penalties. Furthermore, we thank the committees for recognizing the need for more reasonable timeframes for measure development, more timely performance feedback, and giving physicians the opportunity to make improvements in care before payments are adjusted.

Although the IDSA supports many aspects of this proposal, we have outstanding concerns and questions, which are discussed below.

Phase II. Portion of Payment Based on Quality through Update Incentive Program (UIP)

Is it appropriate to reward improvement in quality over time in addition to quality compared to peers?

Following repeal of the SGR and a period of stable fee schedule updates, the second phase of the proposal would tie a portion of physician payment to quality performance. Providers would have three ways to receive credit that will determine their variable performance-based rate: 1) score on quality measures relative to their peers; 2) significant improvement in their own quality score from the previous year; and 3) executing clinical improvement activities. It is unclear if the intent of the proposal is to a) immediately consider all three factors simultaneously, b) use a phased-in approach to gradually consider all three factors over time, or c) allow physicians to select which *one* of the three performance attributors is most relevant and meaningful to their practice. Ideally, IDSA would favor a system in which the variable portion of payment is based on only one of these factors, chosen by the physician. If the intent is to evaluate all three of these factors, we recommend a phased-in approach that begins with rewards for clinical improvement activities, transitions to rewards based on individual improvement over time, and only when mechanisms are in place to ensure accuracy and feasibility, progresses to relative rankings among clinically similar peers. This last stage raises many additional questions which must be carefully considered prior to widespread implementation. For example, will payment adjustments be based simply on whether a physician outperformed his/her peer or will they vary depending on the extent to which he/she exceeded the performance of peers?

How should the Secretary address specialties that have not established sufficient quality measures?

A critical element of the proposal's second phase is the decision to consider "clinical improvement activities" when calculating the performance-based payment rate. The proposal sets forth a defined menu of broadly applicable clinical improvement activities from which providers could choose from, including provision of care consistent with specialty-specific evidence-based guidelines, improved care coordination and delivery, and targeted utilization of patient registries for chronic conditions. Recognition of these alternative, yet highly effective, quality improvement activities helps address many of the challenges that specialties currently face related to measure development, testing and implementation. The current measure endorsement process is often cost prohibitive and too time consuming to keep up with the evolving science of medicine, and too restrictive to recognize "outside-of-the-box" approaches to quality. As a result, important quality improvement interventions often go unrecognized by federal reporting programs.

The IDSA recommends that the definition of "clinical improvement activities" also include "board-sponsored quality improvement initiatives." The primary goal of the American Board of Internal Medicine (ABIM), for example, is to promote continuous learning and improvement of a professional's clinical judgment in an effort to improve patient care. As part of maintaining continuous certification, professionals must engage in systematic practice performance measurement and demonstrate improvements in patient care, including continuous monitoring of performance feedback, comparing individual performance to clinical guidelines and comparable

peers in the field, identifying improvement goals, and demonstrating actions to improve upon practice and to assess the impact of such improvements. These last two actions, in particular, go beyond current federal quality reporting requirements and are an extremely valuable element for ensuring meaningful use of performance data to improve patient care. Furthermore, practice performance is measured against professionals treating similar patient populations in comparable care settings.

In addition to defining clinical improvement activities, Phase II of the proposal also lays out criteria that the Secretary will use to select quality measures for inclusion in the UIP. These include NQF endorsed measures, as well as non-NQF endorsed measures that either meaningfully differentiate performance, address at least one of four domains (clinical care, safety, care coordination, and patient experience), or fill measure gaps. The IDSA questions how this proposal would address our concerns with the current measure endorsement process. Would it set a lower bar in order to recognize more unconventional measures or measures that are clinically important, but do not yet have the required testing data or evidence base? And what criteria would be used to identify measures that meaningfully differentiate performance?

Are there sufficient clinical practice improvement activities relevant to your specialty?

See previous response. The IDSA strongly urges the committee to include "board-sponsored quality improvement initiatives" under its definition of clinical practice improvement activities.

Phase III. Reward for Efficient Resource Use

How much time is needed to refine the methodology for determining and attributing efficient use of health care resources?

While we are unable to propose a specific timeframe, we cannot overstate the need to carefully evaluate efficiency measures and methodologies that are most appropriate for a range of practice types and patient populations before widespread implementation. Public and private payers continue to struggle with how to accurately measure physician resource use. Risk-adjustment and attribution methodologies are still woefully unrefined and resource-use feedback reports distributed to physicians to date have proven to be of little value. These issues must be resolved before cost data can be used to influence payment decisions. If there is one lesson to be learned from the last few years it is that rushed timelines only result in confusion and mistrust among physicians, and deter meaningful participation and progress.

Is it preferable to only have a payment implication based on efficiency for providers that meet a minimum quality threshold?

Yes, quality should be the chief determinant of variable payment rates. 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 can shed light on under-utilized, mis-utilized, and over-utilized care, which will naturally target inappropriate spending. As mentioned earlier, we support delaying the transition to efficiency based payment adjustments until methodologies are further refined to ensure more accurate and meaningful evaluations of physician resource use.

Provider Opt Out for Alternate Payment Model (APM) Adoption

What do you believe will be necessary to support provider participation in new payment models?
What is a reasonable time frame for CMS to approve and adopt APMs?
Should providers be able to participate in more than one payment model?

Flexibility is key to ensuring physician buy-in. In line with the approach taken in earlier phases of this proposal, the IDSA recommends that physicians be given the opportunity to choose from a variety of payment model(s) that best fits the needs of their practice setting and patient population. Allowing participation in more than one payment model could help physicians determine which is most suitable and applicable to their practice and shed additional light on the effectiveness of each model for future policymaking purposes. We again highlight the importance of gradual and careful implementation with ongoing evaluations of potential unintended consequences.

Improvements Upon Current Law

What improvements upon current law:

a. **Do you believe will be required to support alternate payment model adoption?**
b. **Will help ease the adminstrative burden upon medical providers?**
c. **Would support the provision of quality health care delivery for Medicare beneficiaries?**

Simultaneous implementation of multiple programs created under separate laws has resulted in overlapping requirements and misaligned incentives, which creates extraordinary financial and administrative burdens for physicians and diverts attention away from true quality improvement. We appreciate efforts made to date, however more must be done to align these quality improvement programs to reduce confusion and encourage participation.

The IDSA also believes that investments should be made in key infrastructure so that physicians have the tools to seamlessly integrate new workflows and information technology into practice prior to being held accountable for these significant reforms. For example, despite federal incentives to adopt electronic health records, many physicians continue to question the value of investing in systems that remain largely irrelevant to their practice. Lack of standardization and interoperability between these systems remains a major challenge that must be addressed before true evidence-based quality improvements can be effectively incorporated into practice.

We thank the committee leadership for continuing to engage the physician community as it seeks to reform and improve the current physician reimbursement system. Should you have any questions, please contact Amanda Jezek at 703-740-4790 or ajezek@idsociety.org.

Sincerely,

Mark A. Leasure
Chief Executive Officer