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July 26, 2012

Comments for the Hearing Record: *"Physician Organization Efforts to Promote High Quality Care and Implications for Medicare Physician Payment Reform"*

Dear Chairman Herger and Ranking Member Stark,

The American College of Gastroenterology (ACG) appreciates the opportunity to offer comments and recommendations in response to the Health Subcommittee's hearing entitled *"Physician Organization Efforts to Promote High Quality Care and Implications for Medicare Physician Payment Reform"* held on July 24, 2012. ACG also expresses its thanks for holding a hearing on an issue that is so important to our membership.

ACG is a physician organization representing gastroenterologists and other gastrointestinal specialists. Founded in 1932, our organization currently numbers over 12,000 physicians among its membership of health care providers of gastroenterology specialty care and we focus on the issues confronting the gastrointestinal specialist in treatment of patients. The primary activities of ACG have been, and continue to be, promoting evidence-based medicine and optimizing quality of patient care.

As Congress seeks a permanent solution to the flawed price controls inherent in Medicare's Sustainable Growth Rate (SGR) formula, and moves forward with reforms to the structure of Medicare Fee-for-Service (FFS) physician reimbursement, it will be critical to ensure that a commitment to preventive services is maintained and new payment systems are tied to performance on quality metrics that are supported by physician specialty societies and a wide cadre of providers. Congressional efforts to reform and improve Medicare FFS reimbursement for physicians should recognize the importance of designing a Medicare payment model based in part from the input of medical organizations and specialty societies—and the Committee has taken an appropriate, thoughtful path in seeking recommendations from physician organizations during its deliberations on possible alternatives and improvements to the current Medicare physician reimbursement model.

ACG would like to stress to the Committee that the SGR formula is based on a flawed presumption that Medicare providers actually have substantial influence over the various components in the formula itself, including: the estimated changes in reimbursement for physician services (determined by Medicare or other *payers* of health care services), the estimated change in beneficiaries enrolled in the Medicare FFS program, the estimated per capita growth in the U.S. gross domestic product (GDP), and the estimated change in expenditures due to any revision in federal law or regulation. Yet, physicians are scheduled to receive devastating cuts in Medicare reimbursement rates as a result of the SGR formula—a 27% reduction for services provided after January 1, 2013.

ACG stands ready to work with the Committee on Ways & Means, and other Members of Congress, in developing a Medicare physician payment structure that more appropriately rewards quality care and outcomes, and moves away from a purely volume-driven payment structure – but that also provides stability and certainty to physicians and Medicare patients.

Quality Measurement

A wide range of experts, including the Medicare Payment Advisory Commission (MedPAC), the Institute of Medicine (IOM), and the Government Accountability Office (GAO), have urged Congress and the Centers for Medicare and Medicaid Services (CMS) to adopt Medicare provider payment policies that more adequately link payment levels to performance on a range of quality measures. ACG agrees on this point. Adherence to best practices and physician cognizance of quality indicators are improved through quality measurement and tying physician payment levels to the quality of care provided. By fostering this connection between payment and quality of care, patient outcomes can improve as a result—which should help lower the growth rate of Medicare expenditures over the long-term. The continued improvement and development of both the Physician Quality Reporting System (PQRS) and the value-based payment modifier within the Medicare Physician Fee Schedule (PFS) represent important first steps in a move towards payment for quality. However, both of these physician payment components should fully encompass the specific best practices and quality measures that can be applied to specific physician specialty services.

Quality Improvement Registry: GIQuIC

As an organization, ACG also uses these evidence-based guidelines in its own programs. An example of this is the GI Quality Improvement Consortium or "GIQuIC" which is the largest clinical quality improvement registry in gastroenterology. The project was developed as a non-profit educational and scientific partnership between ACG and the American Society for Gastrointestinal Endoscopy (ASGE). The GIQuIC registry was developed to capture quality indicators for GI procedures and disease management.

These indicators are outcome-based measures pertinent to clinical gastroenterology and help ensure the patient receives the most accurate and cost-effective colorectal cancer screening exam. GIQuIC started with colonoscopy measures as colonoscopy is by far the most common procedure performed by gastroenterologists generally and Medicare in particular. Other key procedures such as upper endoscopy and disease management issues such as inflammatory bowel disease (IBD) and Hepatitis C will also be added to the registry shortly.

GIQuIC participants volunteer their time at a substantial financial cost to their practice in order to improve patient care. Participants upload blinded patient data to the registry, and in return, receive access to reports on their own performance as well as the ability to compare themselves to national standards and other participants in the registry – *all on a real time basis*. These comparisons include provider type, facility type, geographic regions, and a myriad of other data points.

The GIQuIC registry was also developed to be easily incorporated into the electronic health records commonly used by gastroenterologists called endoscopy writers or "endowriters" as well as other electronic health records. This ability to electronically transmit all patient records for key physician/patient interactions has been a critical element to easing integration of registry participation into clinical practices. It also allows all cases to be included, thus avoiding the cherry-picking of cases to report, as well as other data reliability problems that are often associated with claims based data collections.

Congress and CMS could establish a quality-based payment system with quality measures that distinctly apply to different areas of the practice of medicine by partnering with clinically–focused physician organizations that develop specialty-specific quality improvement measures. This improved specificity in quality measurement would allow the payment system to more accurately assess the quality of care provided within each specialty practice area, and more appropriately reward physicians based on quality performance. Physician and medical societies' input is essential to assessing and defining "high quality of care."

Additional Benefits of Registries

It is important to note the utility of the data that registries could provide Medicare and Congress when assessing programmatic costs. As an example in our specialty, according to CMS statistics, more than 250,000 screening colonoscopies for average-risk Medicare beneficiaries (not at high-risk for colorectal cancer) were performed in 2010 and totaling over $50.6 million in Medicare reimbursement to providers.[1] However, a study published in May 2011 looked at a sample of 24,000 screening colonoscopies in Medicare from 2001-2003. The authors found that over 20% of this sample had repeat screenings before recommended guidelines (10 years for the average-risk patient) with no justifying explanation.[2] While there may be legitimate clinical reasons for these repeat examinations, registries capturing this information provide Medicare with helpful data to assess the issue and be a good steward of taxpayer dollars while also helping to make well-meaning physicians and their practices more aware of practice patterns that can get lost in the midst of a high pressure, busy practice environment. Registries like GIQuIC can also assist in identifying gaps among beneficiaries who may not be receiving the preventive care for their own benefit as well as to the benefit of the Medicare program by mitigating the growth of extremely high cost drivers, such as cancer treatment and end of life costs.

Alternative Payment Models

Accountable Care: Maintaining Independent Clinical Judgment

If Congress moves forward with a transition away from traditional Medicare FFS reimbursement, the new value-based payment model must ensure that quality is not sacrificed in the name of cost control. ACG holds concerns that under the accountable care organization (ACO) payment model, "cost control" may eclipse "improving quality" as the primary objective of care. Global expenditure limits per beneficiary can foster dangerous, large institutional cost control pressures that could impede a physician's clinical judgment in certain instances, when deciding what is best for the patient. The maintenance of independent clinical judgment is paramount.

Payment Bundling: Options for Savings

Additionally, while there has been some enthusiasm regarding the development of "bundled payments" across care settings for Medicare services related to a particular "episode of care," payment bundling is not a panacea to Medicare's cost-growth problem. Episode-based payment bundling for hospital services—under Medicare Part A's diagnosis related group (DRG) payment structure—has not curbed cost-growth for hospital services, and this payment system can have a negative impact on care quality. Also, unlike the inpatient hospital setting where the care is performed under one roof or campus, payment bundling in Medicare Part B may prove difficult especially when an "episode" of care is extended across multiple independent practices or over an extended period of time. However, there may be an opportunity to find savings in Medicare Part B via payment bundling depending upon the definition of the outpatient "episode." For example, by bundling a payment for colonoscopy to include the fee for the underlying procedure, as well as the anesthesia or related services that are currently billed separately by others, our members may help to control costs and save the Medicare system money.

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[1] CMS Medicare Part B Summary File; 2010 Payment Claims. http://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/NonIdentifiableDataFiles/PartBNationalSummaryDataFile.html

[2] James S. Goodwin, MD; Amanpal Singh, MD, MS; Nischita Reddy, MD; Taylor S. Riall, MD, PhD; Yong-Fang Kuo, PhD Arch Intern Med. Published online May 9, 2011. doi:10.1001/archinternmed.2011.212

Focus on Proven Prevention

Any new payment structure will need to retain reimbursement incentives for physicians to provide clinically proven preventive services, as proper utilization of these services provide us with the best chance to reduce the prevalence of chronic conditions and prevent or limit the severity of certain deadly diseases, including colorectal cancer, over the long-term.

The *Supporting ColoRectal Examination and Education Now" (SCREEN) Act* (H.R. 3198), as introduced by Ways and Means Committee Member Rep. Richard Neal (D-MA), would foster increased adoption of best practices and quality care in common colorectal cancer screening procedures and make an important commitment to outcomes-based Medicare reimbursement for colorectal screenings contingent upon a provider's participation in a nationally recognized quality improvement registry measuring the physician's performance based on well-developed colorectal cancer screening quality metrics, H.R. 3198 would adjust payment policy for common colorectal cancer screening procedures, like colonoscopies.

H.R. 3198 is an example of moving the Medicare reimbursement system to a more value-based purchasing model that not only ensures providers are demonstrating a high quality of care, but Medicare providers also are rewarded for taking the initiative to improve the quality of their clinical work in performing screening procedures. Finally, without proper incentives for patients to seek out appropriate and high quality health care services, especially proven preventive services, there is little incentive to help slow the cost curve of Medicare spending.

A Role for Patients/Beneficiaries

Of course, a critical element in any prevention effort within fundamental delivery reform is patient responsibility. This cannot be overemphasized. There is no one more important to the health and well-being of patient and taxpayer than themselves. However, without proper incentives for patients to seek out appropriate and high quality health care services, especially proven preventive services, there is little incentive to help slow the cost curve of Medicare spending. This is especially important should Congress decide to move toward more care-coordination or shared-savings models. Even the most efficient care-coordination model has little control over a Medicare beneficiary's health care services if the beneficiary is neither price-sensitive nor willing to stay within the system. While ACG recognizes the difficulty in convincing constituents that there is a trade-off between cost and choice in these models, ACG urges the Committee to consider patient responsibility reforms if it intends to further develop more care-coordination or accountable care initiatives.

A beneficiary that has easily accessible, patient-friendly information on quality and services is better educated and more cost-conscious. One tactic employed in association with the GIQuIC registry is to allow participating physicians and their practices to publicize their participation in the quality registry in the various ways that our physician members interact with their patients, prospective patients, and referring physicians. In previous comments to CMS regarding the Medicare "physician compare" website, ACG has recommended that CMS include on the "physician compare" website useful information pertinent that the provider's scope of practice such as participation in a quality improvement registry and other types of credentials or awards that the beneficiary may find useful when seeking health care services.

The Path Forward

While the Congress faces significant challenges in developing Medicare physician payment reform models that balance the goals of moving toward value-based payment with the need to provide equitable reimbursement, the Committee's broad approach to gather input from physician stakeholders is a critically important first step. Congress must eliminate the SGR formula and its draconian reductions in Medicare physician reimbursement, in

order to ensure certainty to physicians participating in the Medicare program and to provide continued access to physician care for Medicare beneficiaries.

Over the longer term, the establishment of an alternative Medicare physician payment model should avoid repeating the mistakes of the SGR, and resist temptations to apply global caps on per beneficiary expenditure levels. Instead, lawmakers should build on the development of quality measurement systems and quality-linked payment adjustments in the Medicare system, while also encouraging the utilization of proven preventive services via coordinated approaches to incentivize preventive care through physician payment rates and through reductions in beneficiary cost-sharing.

ACG appreciates the Committee's thoughtful requests for physician input during these important deliberations and is eager to assist the Committee in any way. If you have any questions or would like to discuss further, please contact Brad Conway, Vice President of Public Policy, Coverage & Reimbursement at 301.263.9000 or bconway@gi.org.

Sincerely,

Lawrence R. Schiller, MD, FACG
President
American College of Gastroenterology