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February 25, 2013

Brett Baker
Professional Staff
House Ways and Means Committee, Subcommittee on Health
1102 Longworth House Office Building
Washington D.C. 20515

Subj: SGR Repeal and Reform Proposal

Dear Mr. Baker,

The American Urological Association (AUA), a leading advocate for the specialty of urology, fully supports the main principles behind the House Ways and Means and Energy and Commerce Committees' Sustainable Growth Rate (SGR) repeal and reform proposal and applauds the physician-friendly concepts outlined in the proposal. We are especially pleased that your proposal acknowledges many of the concepts discussed with specialty societies. In particular, the AUA encourages recognition of quality activities that are meaningful and relevant to all specialties, the use of achievable improvements that are based on physician-endorsed measures and the emphasis of quality over volume.

The AUA strongly believes that the Medicare payment system must be updated to reflect current practices, healthcare settings and realities. The proposal focuses on permitting physicians to make healthcare decisions, based on their expertise, that are most applicable to their specific patient populations. As such, physicians should be empowered to determine quality measures that are clinically meaningful to their patients and rewarded for providing high quality and efficient care.
However, the AUA is concerned about the details involved in implementing this framework. For example, the financial considerations could be more fully spelled out, including information on how these reforms will be financed. In addition, incentives for participation could be more clearly delineated.

Our specific comments focus on Phase 2: Reform Medicare's FFS payment system to better reflect the quality of care provided.

The AUA fully supports Phase 2 efforts to base performance assessment on physician-endorsed quality measures, as well as participation in clinical registries and the use of tools to engage patients. However, Congress should keep in mind that the current evaluation and endorsement process for measures used under federal reporting programs is resource-intensive. Physician specialty societies often do not have the staff, technical capacity or finances to devote to such rigorous and time-consuming objectives.

For example, the AUA developed a measure set on prostate cancer several years ago. Created under the auspices of the Physician Consortium for Performance Improvement (PCPI), this measure set was submitted to the National Quality Forum (NQF), but only a subset of the measures was ultimately endorsed by the NQF Board of Directors. In addition, the AUA recently devoted more than 2 years' effort to the development of its female stress urinary incontinence measures. These measures were developed under the independent measure development process of PCPI and relied on the expertise of a multi-disciplinary workgroup that included the specialties of urology, urogynecology, geriatrics, family medicine, nursing and federal organizations. Despite this rigorous and inclusive process and a tremendous investment of resources, only one of the five measure concepts was approved by NQF for further development. Furthermore, measures still have to be tested and e-specified (for inclusion in electronic health records), which requires additional time, expertise and resources beyond the capacity of many small specialty societies.

Additionally, the current measure endorsement process provides limited opportunity for specialties due to NQF's interest in certain "priority" populations and conditions; for example, many urological conditions of importance to urologists and their patients may not be a high priority for NQF. NQF may not be interested in non-cancer urologic topics despite their impact on the quality of life of urologic patients. Finally, the current process is multi-layered and requires several committee approvals before measures are endorsed and, ultimately, accepted into a federal quality program.

Unfortunately, AUA's experience with the current measure endorsement process has been frustrating, yet not unique. Many specialty societies are hesitant to invest significant resources in measure development, only to have their measures rejected by NQF and effectively prohibited from inclusion in any federal quality program. The Centers for Medicare & Medicaid Services (CMS) must recognize more clinically meaningful and scientifically sound measures developed by specialty societies for their members to report on in quality programs. Specialty societies have the expertise to develop meaningful measures that will directly impact the practicing physician and, ultimately, the patient. The AUA welcomes the opportunity to develop measures for our members derived from our robust clinical practice guidelines. The AUA has been developing rigorous guidelines for more than 15 years, and the next logical steps are the development of measures and their inclusion in federal quality reporting programs to enable AUA members to participate in programs that are meaningful to the practice of urology today.

The AUA is considering the development of a clinical registry that, if deemed by CMS, would simplify measure reporting. However, this undertaking also is a significant financial commitment over several years, and smaller specialty societies simply may not have the resources to develop such a registry for their members. CMS funding for registry development as well as ongoing technical assistance to those maintaining and launching registries would be extremely beneficial to specialty societies, and the AUA would welcome working with the federal government and other physician organizations on registry development. Additionally, there may be multiple registries available to providers, and we must be cognizant of the need to reduce physician reporting burden. Therefore, the AUA looks to CMS to allow physicians the flexibility to report to the registry that is most applicable to their practice, thus reducing unnecessary duplicative data entry and reporting.

As outlined in the proposal, clinical improvement activities, such as shared decision-making tools, should be recognized. The AUA has long been a supporter of shared decision-making tools, such as the Benign Prostatic Hyperplasia (BPH) Symptom Score and patient counseling and engagement, which are critical to prostate cancer testing and treatment, as well as to non-life-threatening conditions that significantly impact quality of life, such as incontinence.

The AUA has concerns about inaccurate performance comparison and emphasizes that risk adjustment is critical in ensuring accurate comparisons and the opportunity for improvement in quality. If providers who treat patients with co-morbidities are benchmarked against providers with healthier patient populations, the results will be skewed. The provider with sicker patients will reflect poorer outcomes. A validated risk adjustment model should be an important part of this proposal as it allows for accurate comparisons of outcomes.

The proposal acknowledges the importance of timely feedback in altering behavior and impacting patient care. We applaud recognition of the value of timely and accurate feedback. Currently, AUA members do not receive feedback from federal quality programs in a timely manner and, therefore, cannot modify behavior to improve care when it is most needed. One form of feedback to the physician, the incentive, has been quite delayed. CMS has been issuing checks 7-9 months after the end of the Physician Quality Reporting System (PQRS) reporting year, which may be up to 18 months after the actual date of service provided. This is a disservice to our patients. Physicians who are truly committed to improving care welcome feedback results in a timeframe that allows for identifying best practices and changing practice patterns to improve quality.

The proposal to align Medicare payment initiatives with private payer initiatives would be most welcome. Physicians are already so overburdened with reporting requirements; reducing time spent collecting data is critically important in ensuring widespread participation in the program. Moreover, data entry should be minimized so that reporting for one initiative qualifies for all quality programs and eliminates the need for multiple reporting.

While there is much to applaud in this proposal, the AUA does have some reservations because the proposal's good intentions could ultimately lead to patient access problems. To begin, will the programs and activities utilized in the proposed new system replace or be in addition to current initiatives, such as PQRS? Would physicians who are long-term participants be favored over those new to the program? This may discourage new providers from participating in the program because they do not have a track record that would allow them to achieve better scores and, thus, greater success.

The AUA also has questions regarding measure development. What happens if physician specialty societies are not able to develop measures for their members? As we mentioned earlier, measure creation, testing and implementation is a long, onerous and expensive endeavor, and many societies may not have the resources for such an undertaking. It would be unfair for certain specialists to be penalized just because they are part of a smaller specialty whose society or board cannot oversee such an undertaking.

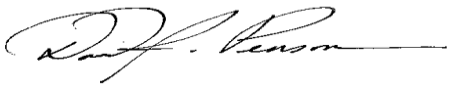
In addition, the program aims to reduce the reporting burden faced by physicians. Again, the AUA applauds this effort. However, we must note that many current programs also include this goal, and yet, adopting new, simplified reporting tools remains out of reach for many physicians

because they simply do not have the time, resources and/or staff to implement such tools. In addition, standardizing data collection/nomenclature in electronic health records (EHRs) presents a challenge. The current availability of structured data is largely dependent on the quality and prevalence of vendor-developed templates. Providers may find a suitable template that can capture information in structured fields with one EHR product but may have to input this data by free-text in another due to lack of available structured fields. Furthermore, existing templates that facilitate structured data capture may have poor usability, so providers may elect in certain circumstances to enter relevant data more quickly in narrative form. Poor interoperability between EHRs can lead to overuse as critical information may not be readily available to the practicing physician. One example of an efficient system that has achieved optimal interoperability is the Department of Veterans Affairs system; this is a single platform in which patient records can be accessed at thousands of locations nationwide, facilitating timely, appropriate and efficient patient care. In conclusion, standardization of EHR language is absolutely necessary to facilitate data analysis and accurately assess physician performance. Therefore, CMS must require standard platforms for EHR vendors.

A physician's most likely alternative to all of the difficulties mentioned would be to opt out of Medicare, which could lead to a serious patient access problem. Often physicians in these circumstances practice in small towns or rural areas where access to a specialist is already limited. Restricting the pool of specialists even further would only compound the problem. Therefore, we urge you to devote significant resources to these challenges to prevent such obstacles. Last, we support the proposal's inclusion of medical liability reform, repeal of the Independent Payment Advisory Board, and private contracting in the Medicare payment system. Again, the AUA appreciates the opportunity to provide input on this proposal. The involvement of the physician specialty societies is critical to the feasibility of this framework, and the proposed elements emphasize the importance of the physician role. Furthermore, the emphasis on clinically meaningful measures cannot be understated.

The AUA looks forward to additional details as the House Ways and Means and Energy and Commerce Committees further develop these concepts and welcomes opportunities to work with CMS and other physician organizations in measure implementation, registry development and outcomes assessment. Thank you for considering the AUA's input. If you have any questions about our comments, please contact Sandie Preiss at (443) 805-5460 or spreiss@auanet.org.

Sincerely,



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