AMERICAN ACADEMY OF AUDIOLOGY

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The Honorable Frederick Stephen "Fred" Upton
Chairman
Committee on Energy and Commerce
United States House of Representatives
Washington, DC 20515

Dear Chairman Upton:

The American Academy of Audiology (the "Academy") is the world's largest professional organization of, by, and for audiologists. The Academy promotes quality hearing and balance care by advancing the profession of audiology through leadership, advocacy, education, public awareness, and support of research. On behalf of nearly 12,000 members, the Academy writes to thank you for your efforts in repealing the Sustainable Growth Rate (SGR) and pursuing meaningful payment reform.

We are appreciative of the professional staff of the Energy and Commerce Committee for the information and materials afforded to representatives in attendance at the May 28, 2013 briefing. This letter serves to provide the feedback solicited from that discussion.

Questions for Comment on Phase I

1. What is an appropriate period of payment stability in order to develop and vet measures and build the necessary quality infrastructure?

Based on the previous proposals issued by the Committee and the policy which the discussion draft legislation seeks to amend, it does not appear that non-physician providers would be included, at least initially, in the Update Incentive Program (UIP). However, when these provider groups are added to the UIP, the Academy recommends consideration of a phase-in process for the period of payment stability. Of the professions that can independently bill Medicare, audiology was among the last to be added to the Physician Quality Reporting System (PQRS). Since 2009, we have not received sufficient opportunity from the Centers for Medicare and Medicaid Services (CMS) to adequately participate in PQRS, nor to ultimately obtain National Quality Forum (NQF) endorsement of our measures. For example, as recently as last year, two of the four PQRS audiology measures were retired from the program, resulting in audiologists having very few measures on which to report. Further, a 2013 NQF report recommendation suggests that a third audiology-specific measure will be retired in 2014. As our profession, like others, will require more time to develop and vet an adequate number of measures to construct the foundation envisioned in this proposal, we would ask that you permit the Secretary to provide additional time for those smaller specialties and/or non-physician specialties, like audiology, to build the necessary quality infrastructure.

2. Considering the different levels of provider readiness, how do we balance the needs for a stable period enabling providers to build and test the necessary quality infrastructure, while still incentivizing early innovators to move to Phase II, with opportunities for quality-based payment updates?

We would reiterate our comments to question #1 above. Additionally, the Committee might also consider requiring the Secretary to render CMS contractors available to provider groups that are less ready for the implementation of the UIP. These contractors could assist those who need greater support by providing the quality measure development and testing expertise needed, providing recommendations related to achieving NQF endorsement (if NQF becomes a recognized entity for the UIP) and ensuring that relevant research is consistent with best practice standards. By having the Agency provide assistance to those provider groups that need support, providers could potentially finalize measures more quickly to enter into the framework of the UIP.

3. What does a meaningful, timely feedback process look like for providers? What are adequate performance feedback intervals?

Ongoing feedback with respect to one's performance compared to their peers would be most meaningful to providers. This would afford opportunities to modify behavior when appropriate and avoid excessive penalties. Ideally, if a national registry is developed, providers could constantly monitor their own individual performance relative to their peers while externally receiving feedback at regular intervals, perhaps quarterly.

4. How should Peer Provider Cohorts be defined to ensure adequate specificity while preserving adequate comparison group size and ability to develop appropriate measurement sets? For example, is using the American Board of Medical Specialties (ABMS) list appropriate?

This question is seemingly not applicable to non-physician provider groups such as audiology. The population of licensed audiologists would provide an adequately defined Peer Provider Cohort.

5. Should the list of Peer Provider Cohorts also include patient, procedural, or disease-specific cohorts in addition to the traditionally-defined specialty groupings? Pros of this approach are that it would offer a more relevant basis for measure development and comparison between physicians, since many physicians perform outside of a narrow range of "stereotype" description of their primary specialty. Cons are that it may create too vast an array of cohorts. This may dilute the ability to develop meaningful quality measurement sets and comparison groups and impose excessive financial and administrative burden on the physician group as well as upon CMS. In addition to answering, please provide rationale.

Again, this question is seemingly not applicable to non-physician provider groups such as audiologists. Depending on how Peer Provider Cohorts are defined, audiology is likely too small

of a profession (there are approximately 12,060 practicing audiologists in the United States)[1] to develop additional sub-disciplinary cohorts. While physicians are trained to treat the whole body, and specialize narrowly, this is not typically true for audiologists. Although there are those within the profession who focus on vestibular, tinnitus, or cochlear implant services, this does not represent the majority of practitioners. As such, it would likely be of excessive financial and administrative burden to the Academy and the Audiology Quality Consortium (AQC)[2] to include subgroupings for vestibular, tinnitus, or cochlear implant services cohorts or related cohorts, when the needs of professionals practicing in these "specialty areas" could be adequately addressed by developing a relevant number of measures applicable to those groups.

6. Under the proposed revision of SGR which emphasizes best quality practices, non-physician providers who are currently paid under the Medicare payment system are also expected to be rated on quality measures. Do these non-physician providers need unique measurement sets compared to physician providers?

Non-physician providers, such as audiologists, need unique measurement sets akin to those that have been created under PQRS. However, other professions could also report on some or all of the applicable measures and vice versa. In theory, specific measures could continue to be utilized among physician and non-physician practitioners. For example, audiologists perform several of the same procedures that otolaryngologists (ear, nose, and throat physicians) perform and therefore bill the same procedure codes. If both providers bill the same codes and perform the same actions, which is consistent with the very intent of the initiative, this may lead to enhanced quality outcomes for patients. This behavior also enhances inter and intra –professional consistency with respect to best practices and patient-centered care. The Academy believes that cross-disciplinary measures are integral to this process and that all eligible providers (physicians and non-physicians) should be permitted to report on any applicable measure and obtain the corresponding update incentive payment.

<u>Questions for Comment on Phase II</u>

1. Understanding that the proposed payment system relies on reporting, how should existing programs, such as, but not limited to PQRS, EHR/Meaningful Use, VBM be transitioned into the new system? Are there aspects of the current systems that should be retained, modified, or discarded?

The Academy believes that aspects of the PQRS system should be maintained under the new UIP. Significant educational resources provided by CMS, and in turn by the Academy and AQC, have been expended in instructing audiologists about PQRS reporting by which providers submit claims to Medicare for PQRS measures using G codes on the CMS 1500 claim form. In addition, new G codes have been created specifically for use in the PQRS program and have become recognized by audiologists as being associated with specific measures. Audiology does not currently have a nationally-recognized registry or related data reporting system and such a system will require time, expertise, and resources to be developed. Additionally, audiologists are currently not among the list of eligible providers who may qualify for the electronic health

[1] U.S. Bureau of Labor Statistics, Occupational Employment and Wages (May 2012)
[2] A coalition of 10 audiology-related organizations that develops quality measures

records (EHR) incentive, therefore EHR adoption among audiologists is not yet widespread and would prove to be a financial hardship for most independent practices. Given these factors, changes to the current reporting mechanism would compromise our efforts to date and present significant challenges for timely adoption for those professions, like audiology, that still rely on claims-based reporting.

2. How do we align and integrate quality measurement and reporting with existing and developing specialty registries? How can registries support provider feedback and streamline provider reporting burden?

As noted in question #1 above, audiology does not currently have a nationally-recognized data reporting or collection system, nor do we have a registry under which to report. However, the Academy believes that registries, when properly constructed, can serve to streamline and ease the burden of reporting quality measures. They can be directly integrated with Electronic Medical Records (EMR), billing and coding systems, etc., and can also serve as an internal monitoring mechanism for providers to track the quality of their outcomes on an ongoing basis as compared their peers (as opposed to waiting on external feedback).

3. What Clinical Improvement Activities best promote high quality clinical care and should those activities be required as an integral part of a quality-based payment system?

The Academy maintains some concerns with regard to certain aspects of the definition of a "clinical practice improvement activity" because, as noted above, audiology does not currently have a nationally-recognized registry or data reporting system. Additionally, most audiology practices have not yet adopted EHR. The financial and resource burden to meet the clinical improvement activities criteria will be significant for the profession for audiology. As such, any proposal should take into account the need for assistance from the Secretary for smaller professional groups who serve Medicare beneficiaries to become familiar with clinical practice improvement activities to include support in the development of national database registries.

4. What process or processes could be enacted that would ensure quality measures/measurement sets maintain currency and relevance with regard to the latest evidence-based clinical practices and care delivery systems? How would these processes ensure that quality measures evolve with data accumulation and advancement in measure development science, and appropriately account for the relative value of measures as they relate to best possible patient care?

The Academy suggests that the Secretary require an annual review of quality measures, with input from the professions, as well as offering longer periods in which to submit measures. Further, we would recommend that a designated CMS staff member or CMS contractor serve as a liaison to each profession in the event that changes in clinical practices or reporting methods change outside of the annual review. Additionally, we would advocate that an exceptions process be in place in the event that there is urgent need for measure revisions outside of the yearly evaluations. Annual reviews should include an updated scientific literature review and vetting by all representative professional organizations.

5. Quality measures are categorized into process, structural, and outcome measures. Should these measures be differentially weighted in a quality scoring system? If so, how?

The Academy would support considering a tiered reporting system with different weights applied based on the particular measure category. Process measures, for example, are reflective of best practice and may not always contribute to quality improvement. Outcomes measures serve to ensure the quality and efficiency of the care a patient receives. Since they are often more comprehensive in nature, a greater score could be placed on the successful reporting of those more complicated measures.

6. From a variety of backgrounds, providers newly enter (or re-enter) the Medicare system throughout the year. Since these providers have no reference baseline with regard to quality reporting in the Medicare system, how should the system account for their payment during their "observation" year?

Audiologists are not currently among those professions eligible to opt-out of the Medicare program. As such, there would be no observation year and payment could begin the month following assignment of their Provider Transaction Access Number (PTAN).

7. Should public and multi-stakeholder input be used during the measure development and selection processes? If so, are there current CMS or non-CMS mechanisms that could be applied?

We support multi-stakeholder measure development and we would echo the comments above in question #1 with regard to Phase I. The Academy is unaware of a CMS or non-CMS process that could be applied. It has been challenging for the profession of audiology to gather educational information or learn about relevant hearing and balance related clinical workgroups from the NQF organization, despite great efforts to make contacts within that entity. Even as a provider organization that has joined NQF as a member and pays the substantial dues, the Academy has found it exceedingly difficult to obtain consistent, ongoing support with regard to measure development and education. The American Medical Association's Physician Consortium for Performance Improvement (PCPI) is a possible alternative. However, the Academy (a non-physician membership organization) maintains reservations given that the entity is run by a professional association that may have competing or conflicting interests in the process. We would urge the Committee to consider creation of a CMS-administered entity or external body with a standardized education and development process that is not unduly influenced by the interests of any one provider type or group.

8. In the interest of transparency, a public comment opportunity is vital to the quality measure development and approval process. Are there current mechanisms that are both substantive and nimble enough to meet the policy framework in the discussion draft of the legislative language?

The Academy can envision two potential mechanisms for public comment opportunity of quality measure development and approval. First, notice of measures in the Federal Register, which would afford widespread review and is publicly available. Second, should a CMS-administered entity which reviews, develops and recommends quality measure be created, this entity could regularly make available measures under development for public comment via the entity's website or through monthly or biweekly e-notices.

9. Methods linking quality performance to payment incentives must be fair to providers and faithful to the goals of a value-based payment system. Many strategies have been proposed; examples include comparing providers to each other versus benchmarks. Please suggest method(s) of quality-based payment which meet the goals of fairness and fidelity, and one that promotes provider collaboration and sharing of best practices to achieve a learning healthcare system.

Perhaps the two most conventional models in performance-based reimbursement are 1) measuring providers against their peers and 2) measuring providers against pre-determined benchmarks. The Academy would be supportive of either of these models assuming that provider groups are afforded adequate opportunity to provide input into the construction and adoption of the model and that appropriate consideration is given to the unique implementation challenges that many of the smaller, non-physician provider groups face as outlined throughout these remarks.

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The Academy appreciates the efforts by the members of the Energy and Commerce Committee to ensure high quality and efficient care through a transformation of the Medicare payment process and we appreciate the opportunity to offer input. Should you need clarification on any of our comments or further information, please contact Melissa Sinden, Senior Director of Government Relations at (202)544-9335 or by email at msinden@audiology.org. Thank you for your review and consideration of our comments.

Sincerely,

Deborah L. Carlson, PhD

President