November 12, 2013

The Honorable Max Baucus
Chairman
Finance Committee
U.S. Senate
Washington, DC 20510

The Honorable Orrin Hatch
Ranking Member
Finance Committee
U.S. Senate
Washington, DC 20510

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

The Honorable Sander Levin
Ranking Member
Ways and Means Committee
U.S. House of Representatives
Washington, DC 20515

Delivered Electronically

RE: October 30, 2013 SGR Repeal and Medicare Physician Payment Reform Discussion Draft

Dear Chairman Baucus, Ranking Member Hatch, Chairman Camp and Ranking Member Levin:

On behalf of the Society of Gynecologic Oncology (SGO), I am pleased to submit our comments to the Senate Finance Committee and House Ways and Means Committee regarding your Sustainable Growth Rate (SGR) Repeal and Medicare Physician Payment Reform Discussion Draft. SGO appreciates the Committees' efforts on this proposal and your willingness to entertain our comments. SGO members are encouraged by your efforts and we look forward to working with you and your staff on incorporating the suggested additions and clarifications articulated in this comment letter into the final legislative product. We appreciate you providing sub-specialty organizations, such as SGO, with a seat at the policy table and we are committed to working with you and with your staff in a constructive manner.

SGO is an 1,800-member medical specialty society whose mission is to improve the care of women with gynecologic cancers by encouraging research, disseminating knowledge, raising standards of practice and collaborating with other organizations dedicated to women's health care, oncology and related fields. SGO has a diverse membership that consists primarily of gynecologic oncologists but also includes medical oncologists, pathologists, radiation oncologists, surgical oncologists, nurses, physician assistants, obstetrician-gynecologists, fellows-in-training and residents.

SGO is considered the premier medical specialty society for physicians trained in and dedicated to the comprehensive management of gynecologic cancers. SGO members provide longitudinal care for women from diagnosis, to surgery, to chemotherapy, through survivorship and palliative care at the end of life. SGO members are often involved in education and research that has a direct impact on patient care. Due to their extensive training in radical pelvic surgery, gynecologic oncologists in SGO are also

commonly asked to care for women with medically complex gynecologic or obstetric situations requiring difficult pelvic surgery for nonmalignant causes. SGO members practice in a variety of settings, including academic institutions and hospitals, major regional cancer centers and private practice.

Because members of the SGO are the only practitioners that have unique training in gynecologic oncology and that provide comprehensive multidisciplinary care to gynecologic cancer patients, their practices are clearly the best environment to incubate and test new ideas for our health care system as it relates to gynecologic cancers.

We would also remind your Committee that on January 30, 2013, the SGO released a report proposing new ways to deliver high quality, cost-effective care to women with gynecologic cancers. Entitled, "Creating a New Paradigm in Gynecologic Cancer Care: Policy Proposals for Delivery, Quality and Reimbursement," a copy of this report is attached to this letter and we believe some of the content would be helpful to this process and the ideas incorporated into legislation.

SGO's comments on the **SGR Repeal and Medicare Physician Payment Reform Discussion Draft** are as follows:

SGR Repeal and Annual Updates

SGO strongly supports the repeal of SGR and we do understand the current political challenges of increasing the cost of the overall SGR repeal and replace proposal above the current Congressional Budget Office score of more than $140 billion. However, we are very concerned about annual updates of zero percent through 2023. SGO believes this proposal should provide at least five years of stable payments, with annual positive updates. We are concerned that an abrupt transition will likely lead many providers to greatly limit or drop current Medicare patients to retain financial solvency. For our elder oncology patient population, a reduction in number of providers may lead to delays and gaps in their treatment and with dire consequences to their health.

During the five years of stable payments, the CMS would be required to facilitate the occurrence of the following activities:

- Research would be supported and performed by specialty societies regarding the appropriate risk-adjustment methodology for the diseases and patients treated by their members.
- Medical societies would demonstrate progress on the creation of unified patient registries that would track outcomes, improve quality and could be used by the Centers for Medicare and Medicaid Services to set quality benchmarks in Phase 2 of this proposal.
- CMS would make claims data available in a searchable format to medical societies to assist in the development of registries and the benchmarks they would create.
- CMS will assign IT and content professionals to interface with the medical societies in order to assist in the creation of benchmarks and the integration of claims data into registries.

- CMS would require medical societies to submit an annual report regarding their progress in the development of measures, including outcomes measures.

- CMS would require medical societies and electronic health records (EHR) companies to work together to integrate specialty endorsed clinical practice guidelines into EHR systems.

Value Based Performance Program

Timing –

SGO appreciates the interest in moving Medicare physician payment to a more value-based system and the Committee harmonizing and streamlining the various programs, such as Physician Quality Reporting System (PQRS), Meaningful Use, and Value-Based Modifier. However, there are no gynecologic cancer specific quality measures that have been endorsed through the National Quality Forum (NQF) process for use in the Value-Based Performance (VBP) Program. We believe 2017 is too ambitious as that would mean that CMS would have to begin collecting data for the 2017 VBP as of January 1, 2015. We believe a 2019 calendar year is a more realistic target.

Furthermore, NQF is only now starting a measure endorsement process for additional cost and resource use measures, and CMS has not been able on its own to develop a system of capturing relevant resource use such that anyone has confidence that the current Value-Based Modifier Program is an accurate measure of an individual physicians' value to the Medicare system. It would be very unfortunate to have to ask for a patch or delay in two years, since we have already been doing that for the last 10 years. Let's take the time and get it right, now.

SGO believes we need a program that is phased in with numerous deadlines for particular amounts of progress and activities that are achievable, based on annual reporting to CMS by medical societies on their progress to be ready for 2017 for a 2019 program year. This legislation needs to outline a process where it is easy to see what the expectation is and how CMS will become a partner with physicians to achieve those expectations.

Secretary of HHS Solicitation of Recommended Measures

SGO has been working with the National Cancer Database Program and the Quality Oncology Practice Initiative (QOPI) run by American Society of Clinical Oncology (ASCO) on the development of gynecologic cancer specific quality measures. However, NQF has not had a specific call for cancer measures recently and does not have it on their schedule for the next round of topic areas.

While CMS already has an annual process for medical societies and others to submit their recommended measures for the PQRS program, the current reality is that if the measure has not been endorsed by the NQF, it will not get approved for the PQRS program. This is creating a bottleneck in the measure system as the NQF only has the capacity of its current HHS contract and this leaves out numerous diseases and specialties many of which do not yet have measures.

Therefore, SGO would recommend this legislation contain the following process for additional measures to be approved:

- Secretary of HHS is directed to create a standing body whose role is to review and approve measures. This body would use the same criteria for approval as any other measure development activity that CMS funds. Appointments to the standing body would be for three years, in staggered terms, and the body would be transparent under Federal Advisory Committee Act (FACA).

- The Secretary of HHS is directed to accept measure applications, including testing forms, every six months and measures would have to be approved within six months of submission.

- The Secretary of HHS will seek to promote the submission of measures that were not being addressed under any other HHS funded measure development activities.

- The measure application, evidence requirements, and testing requirement will be those that are standardized under the previous SGO recommendations.

- Any measure that was submitted with the intent to be used in the VBP Program will have to be endorsed by the medical society for the area that the measure addressed.

- If a measure was rejected, the Secretary of HHS will be required to send a report to the measure developer stating the reasons for rejection and provide the opportunity to the measure developer for a meeting with CMS staff to receive technical assistance prior to any re-submission.

Funding for Development of Additional Measures

SGO greatly appreciates that funding will be made available under this proposal for the development of additional measures. We would also hope that this funding would be available for use in creating infrastructure that will be used to test measures, such as registries.

SGO would recommend this legislation contain the following process for allocation of this funding:

- The Secretary of HHS would publish an annual notice of the amount of funding available for medical societies to apply for in a given year. Medical societies should be given priority for this funding.

- Applications for the funding would ask for information regarding the measures that would be developed with the funding, including the level of evidence available that supports the measure and information on how this measure would address a gap in performance.

- The application would also ask for a plan of testing the measure(s).

- The application would ask for a budget and a timeline.

- Funding should be granted to the project based on the need for measures in that disease or specialty and funding should not be denied based on a competitive scoring system, but instead on need and feasibility of the plan leading to a measure being completed.

- Grants should be made directly to medical societies and should be at a level that would allow for many grants in a given funding cycle, i.e. $25 – 50K per measure including the cost of testing.

- CMS would be obligated to provide technical assistance in measure development to all grantees ensuring that a new measure is completed and submitted to a measure endorsement organization or directly to CMS for inclusion in the quality activities.

Resource Use

The challenge of attributing costs to an individual physician or even to a group of physicians for treating Medicare beneficiaries in a given timeframe is daunting. CMS is not able to do this now and it does not appear that progress is going to be made in the foreseeable future. Definitely, it is not realistic for a methodology to be used that has financial risk associated with it in 2015.

SGO has not been approached by CMS regarding working with them on any episodes of care for any of the diseases that our members treat, even though these are diseases of aging and ovarian cancer is a very resource intensive disease to treat. Over 80,000 women will be diagnosed with a new gynecologic cancer this year and will have high medical needs during the first year of diagnosis - surgery, imaging, hospital care and for many chemotherapy and or radiation therapy. We are intrigued regarding the proposal in summary to establish a process to involve physicians in furthering the measurement of their resource use through identifying episodes of care and their involvement. But, we are unsure that CMS has the capacity to do this type of work by 2015 and that it has the tools to work with every specialty on a standard methodology and then also test the results.

SGO has been working on a condition-based bundled payment model where we have been mapping out the episode of care for a non-complicated endometrial cancer patient. But we are not using a standardized system or any specific rules for this work and it still needs to be validated with claims data and with prospective testing.

We believe this is an area that needs future discussion with the medical society community regarding methodologies and readiness before legislation would be brought before your Committees for a mark-up.

Here are some of the areas that SGO recommends be addressed prior to consideration of this section of the legislation:

- Tools for identifying episodes of care, e.g., 1) What will be the standard methodology? 2) Will each specialty and subspecialty be given comment platforms to map out these episodes? 3) How will diseases involving multiple specialties be attributed and consistently mapped?

- Could each specialty start with the disease that represents the highest number of patients treated in a given year for members of that specialty and that could then be used as a proxy for their entire level of resource use in a given year, versus each specialty having to have episode of care maps initially completed for all the diseases they treat.

- Risk-adjustment for case-mix, including severity of illness, patient's economic status, co-morbidity factors and geographic variation.

- Good use of resources versus overuse of resource and acceptable patient outcome.

- Implementation while not also adding a new layer of bureaucracy to the system, taking the physician away from patient care to attribute their information. CMS needs to review and reform physician documentation requirements to move away from requirements such as number of exam points and instead change to a system of documentation requirements that focuses on the things that actually improve quality and patient satisfaction.

- Reminder system and appeals process, versus reducing payment.

- For hospital employed physicians where they have no ability to dictate hospital policy and manage their costs, how should this be addressed in the attribution process?

- How physician performance regarding various levels of resource use will be, "scored," for calculation of the VBP and how improvement will be taken into account.

- Address the infrastructure challenges for CMS' data system to be able to have 600,000 physicians report this type of information based on CMS approved episodes of care and providing at least quarterly feedback so physicians can assess their behavior in real-time.

While SGO does not yet have all the clinical improvement activities listed in your proposal available to its members, it is working on many of them now and is committed to their development. However, CMS needs to give us time, at least five years, and resources for creating and maintaining these types of activities. There also needs to be a process created for updating and re-certifying these activities. Otherwise, much of the activities listed in the proposal become unfunded mandates to the specialty society community. CMS needs to be transparent, making the rules well in advance, making them easier to understand, and more direct.

For example, regarding the collection of data for the measurement of patient satisfaction, will CMS provide the resources and services necessary for a physician to be able to fulfill this requirement?

Clinical Improvement Activities

Physicians should be able to select two - three clinical improvement activities that will prepare them for trying an alternative payment model and CMS needs be directed to work with each medical society, to

create a customized list that will provide an appropriate infrastructure that will lead to future participation in an Alternative Payment Model (APM).

SGO would be very interested in working with EMR companies to turn their clinical practice guidelines into decision support tools. However, there is currently no incentive for the EMR companies to work with specialties where the number of patients per year with a particular disease is small. CMS needs to be directed to facilitate the interaction that would make the creation of decision support tools for all specialties a reality. Regarding improved care coordination, CMS should create a program that allows for the acknowledgement of the gynecologic oncologist as the coordinator of care for women with a gynecologic cancer. Coordination of care activities, like operating as a "Team Captain," should be included as part of the quality of care benchmark.

Regarding participation in clinical improvement activities, SGO would recommend the following be added as examples in the legislation:

- Annual Maintenance of Certification for specialty
- Proof of annual CME requirements
- Participation in hospital-based Continued Performance Improvement Committees
- Participation in a registry sponsored or endorsed by the physician's primary specialty society
- Participation in cooperative group clinical trials and offering trials to patients
- Participation in tumor boards and other ongoing training
- Participation in self-critical and other activities where practices are required to review their annual data and respond
- Surgical Steering Committee participation and maintaining surgical credentials and privileges at hospitals through an annual review process.
- Documentation of adherence to clinical practice guidelines that are endorsed by the medical specialty society.

Electronic Health Record Meaningful Use

SGO would recommend that the following be considered in this section of the legislation:

- CMS would be directed to make available on a quarterly basis a list of all the electronic health record products that are certified as meeting the meaningful use criteria by medical specialty on their website. If CMS does not list any certified products for a given specialty, that specialty should be deemed as having achieved this category.

- Physicians who are employed by a hospital that has met the hospital meaningful use requirements would automatically be deemed to have achieved compliance in this category given that physicians who are employed by a hospital have no control over the electronic record purchase decisions.

Performance Assessment and Performance Pool Funding

SGO believes that comparison among peers for the purpose of determining a physician's level of Medicare payments is not a good way to compare quality, but instead it is a good way to compare how well physicians compete with one another. Also, using statistics or straight percentages to compare

individual physicians would be inadequate with complex care situations. How does the Centers for Medicare and Medicaid Services (CMS) compare peers if all are performing at 100 percent on the quality measures approved for treating those diseases in Medicare beneficiaries? Comparisons such as proposed in the summary are based on relatives, not comparison to a standard. The focus should be on meeting a certain benchmark of quality.

Also in the current PQRS and EHR programs, physicians receive a negative update based on whether or not they participate not on how well they participated. Most of the PQRS measures were created on a standard of did you or did you not do something. They do not have the ability to be used to relative weighting.

SGO believes it would be better to have smaller bonuses for all those that meet a benchmark than to have large update factors for only a small number of physicians. Those that would get no bonus under this proposed plan or little bonus under this plan would still be treating Medicare beneficiaries and we have done nothing to help their value. This could be seen as a penalty to those patients they treat, as well.

Instead of the proposed system, SGO recommends that Congress direct CMS to create a process whereby medical societies would work with CMS to use their registries and other peer-reviewed published evidence to set the quality benchmarks for their various quality measures for a series of three - five years, with a process of annual review and any needed update. Medical societies would actively participate in this process, and in the case of overlapping measures where various specialties treat the same disease or condition, work together to submit common and agreed to by all specialties involved, universal benchmarks.

Also, there is nothing in the performance assessment section regarding the need for risk-adjustment. Prior to such a program as the VBP stating, CMS needs to be directed to work on a methodology of Risk Adjustments that would be specialty and disease specific. A research and technical assistance venue needs to be created such that specialty societies could work one-on-one with CMS to create these necessary risk-adjustment methodologies specific to diseases and procedures. This "Risk-adjustment Research Center," needs to be created in the new law with a timeline that matches the period of stability and appropriately funded.

CMS also needs to be directed to work with the medical specialty societies on a methodology for measuring annual improvement in quality of care delivered so that physicians who are improving their quality scores are rewarded. And for those that are already at 100 percent on a quality measure, they could be measured on maintaining that level of quality.

We appreciate the flexibility to have physicians select whether to have their performance assessed at the Practice Group or Individual Physician level.

SGO would like the opportunity to work more with your Committees prior to consideration of this legislation on a more equitable way to measure and reward physicians for their value to the Medicare beneficiary and the Medicare system.

Assistance to Small Practices

SGO supports this assistance being available to all small practices regardless of geographic location.

Feedback for Performance Improvement

SGO believes that feedback must be provided at the individual physician level at a minimum on a quarterly basis.

Encouraging Alternative Payment Models

In June 2012, the SGO held a meeting called the "Practice Summit," which investigated quality, delivery, and payment regarding gynecologic cancer care. In putting together that white paper, SGO and its members learned more about various alternative payment models.

SGO is now in the process of mapping out a condition-based payment model for an uncomplicated endometrial cancer patient with an add-on payment to the bundle for a patient with a higher level of severity. This project is in its infancy and will not be ready for wide-spread use by SGO members till 2017, assuming we find a private insurance company to partner with for data and testing. Therefore, we believe that limiting qualified APMs only to those that involve two-sided risk will be a prohibitive barrier for physicians to try an APM by Jan. 1, 2016. We believe CMS should be directed to do various types of APMs where the amount of the bonus payment would be part of the APM construct to give the greatest flexibility for participation.

If the legislation were to continue with this current construct, SGO believes the thresholds for having been a successful participant in an APM should be based on the number of Medicare beneficiaries covered by the APM versus the amount of revenue. Tracking revenue is more complicated and for very expensive diseases or patients, revenue is not a good indicator of involvement.

To date, CMS has not provided a demonstration or validation opportunities for any APMs that are for specialists. To SGO, this section looks to favor those primary care physicians that operate medical homes and thus would leave all the specialists in the VBP with the possibility of being penalized. Also, this section does not contain any explicit mention of funding or technical assistance for those medical societies that are attempting to craft APMs for use by their members.

Therefore, the SGO would recommend the follow additions to this section regarding activities by CMS:

- CMS should be directed to create a technical assistance program for medical societies that are trying to develop APMs. This technical assistance program would include sample contracts and Memorandum of Understanding (MOUs) for physicians to use to develop Accountable Care Organization (ACO) agreements. This technical assistance program would contain templates for use in creating financial models from claims and other data and episode of care maps for the creation of bundled payment programs.

- CMS should be directed to create a "data hub," where medical societies and individual groups of physicians could submit a request for various sets of claims data for use in modeling their potential participation in APMs. This program could be modeled off of National Institutes of Health (NIH) research programs where scientists submit proposals for various resources, such as genomics or other materials, and in this case CMS would approve the request and release the file of data.

- CMS should offer technical assistance workshops that medical societies could send in a request and then the workshop could be offered as a fee post-graduate course at their annual meeting. The course would include a binder with tools, worksheets, excel model templates, etc.

- CMS working with the National Committee on Quality Assurance (NCQA) should be directed to create a program with medical specialty societies for certification of specialty care medical homes or "team captain," programs for specialists.

- CMS should be directed put out RFAs for testing of disease specific APMs where phase 1 of the RFA is the creation of the model and phase 2 is the testing and validation and phase 3 is the national implementation.

SGO is concerned that there is very little in this section as presented which will actually help or encourage SGO members to participate in APMs. We would like to work with your Committees in this regard prior to consideration of this legislation.

CMS also needs to be directed to motivate the hospitals to allow employed physicians to participate in AMPs.

Ensuring Accurate Valuation of Services under the Physician Fee Schedule

SGO is concerned regarding the target for identifying misvalued services as being a monetary target versus a number of services reviewed per year target. The Resource Update Committee of the AMA has already reviewed and reductions have been made in most of the procedures in the fee schedule over the last several years. It is unclear to SGO how this system will work to allow for $3 billion in changes to codes without a large reduction in payments for office visit procedure codes.

Also, how do the targets address new technology or the need for codes and payments for new procedures? This will cause a chilling effect on better treatments being available for patients.

SGO does not support penalizing physicians by 10 percent for not providing the Secretary with information requested related to the fee schedule. There are ways to collect information from physicians without disrupting their practices and penalizing them. Registries can be a help and medical societies, such as the SGO can help, if CMS is specific regarding the type of data they are looking for and then provides tools for collecting it.

Also, SGO is confused how if the goal is to move physicians to APMs, this section then directs the Secretary to review global payments for surgical procedures and the office visits in the global period. Global period surgical codes are a starting point for condition-based payment bundles and it is up to the surgeon to manage that money in the 90 day period. The current system is one based on using the element of an office visit code(s) as building blocks to create an overall payment for the 90 day period. Global periods should not be viewed as absolute costs or absolute activities.

To attack the global periods only pushes backward the movement toward condition-based alternative payment models. Instead of having this be an evaluation exercise, the Secretary should be directed to start an initiative on working with surgical societies of beginning with a 90-day global surgical procedure and building out an condition-based, bundled payment APM for a longer period of time for the condition being addressed.

Additional Improvements to Current Law

CMS needs to review and reform physician documentation requirements to move away from requirements such as number of exam points and instead change to a system of documentation requirements that focuses on the things that actually improve quality and patient satisfaction. For example: Are physicians asking about a patient's pain and addressing it? Has the physician documented

the treatment plan or amount of residual disease following a surgical procedure for a gynecologic cancer?

Documentation requirements need to be changed to something that is truly functional rather than something physicians do in support of a level of service that results in a certain level of payment.

Malpractice reform will be necessary if APMs are going to meet the expectation of producing savings in the healthcare system. Liability reform would make health care process improvement easier to implement and maintain. SGO urges Congress to enact medical liability reform as we believe it would contribute to the success and viability of APMs.

CMS needs to standardize the coverage of new drugs and medical technology by the local Medicare Administrative Contractors (MAC), so that these MAC-derived policies do not have a role in impacting the achievement of quality measures.

Various waivers of current Stark and anti-trust laws will continue to be necessary if APMs are to flourish.

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SGO applauds you and your staff for leadership regarding the need to repeal the SGR and move forward with physician payment reform. SGO looks forward to working with your Committees on incorporating our recommendations from this letter.

Sincerely,

Barbara A. Goff, MD
SGO President

Attachment: Creating a New Paradigm in Gynecologic Cancer Care: Policy Proposals for Delivery, Quality and Reimbursement