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PREPARED TESTIMONY
of the
American Gastroenterological Association
Before the
Subcommittee on Health
Committee on Ways and Means
United States House of Representatives

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Chairman Herger, Ranking Member Stark and Distinguished Members of the Subcommittee, thank you for inviting the American Gastroenterological Association to testify today regarding physician organization efforts to promote high quality care and how they can inform the Subcommittee's approach to Medicare physician payment reform. I am Michael Weinstein, and I am a practicing gastroenterologist in the Washington, DC metro area and serve as chair of the AGA Digestive Health Outcomes Registry® Executive Management Board.

The AGA is the largest society of gastroenterologists, representing more than 16,000 physicians and scientists who are involved in research, clinical practice and education on disorders of the digestive system. With other specialty societies, we founded the Alliance of Specialty Medicine, a 12-member coalition of medical specialty societies. The alliance wholly supports efforts to improve the quality and efficiency of health-care delivery, and continues to seek improvements in government-sponsored quality initiatives that are misaligned, lack sufficient flexibility to accommodate different specialties, and rely on measures that are inadequately risk-adjusted and have no demonstrated link to improved outcomes. I thank you and your Ways and Means colleagues for reaching out to the physician community to solicit our input as you craft a Medicare physician payment reform proposal to replace our unsustainable and broken system. AGA applauds your efforts to move physicians to a more viable system that rewards physicians for improving the quality of care that they provide to their patients.

Over the past decade, the AGA has made considerable investments in the development of quality outcomes measures, patient registries, collaborations with private payors and other quality improvement initiatives to provide gastroenterologists (GIs) with the tools necessary to improve patient outcomes and also prepare them for a changing health-care marketplace.

In 2005, we launched the AGA Center for Quality in Practice, with a mission to enhance quality and safety in the practice of gastroenterology through the following activities:

- Identifying key quality-of-care indicators in the treatment of digestive diseases and determining how the indicators will be measured.
- Developing resources to support quality management in GI practice, including information on quality improvement processes, evidence-based guidelines, performance measurement and customer satisfaction.

- Conducting a continuous review of emerging national quality and patient safety standards, as they might be applicable to GI diseases.
- Developing programs, tools and training programs for members to help them implement evidence-based guidelines and measure and report adherence to quality indicators.
- Developing patient education materials to ensure that patients have appropriate expectations regarding high quality, patient-centered, evidence-based care.

The following is a summary of our key initiatives:

STEPS TO MEASURING AND REWARDING QUALITY AND EFFICIENCY

AGA is committed to ensuring that Medicare and private payors measure physicians against standards that are scientifically valid, fair, realistic and linked as closely as possible to patient outcomes. We offer the following steps to achieving this goal, which sets a foundation for a payment system that rewards care based on science, avoids waste and inappropriate services, and identifies known opportunities for quality improvement.

STEP 1: Develop evidence-based clinical guidelines that identify gaps in care.

The AGA has a long history of developing evidence-based guidelines and medical position statements. In 2011, the AGA redesigned its medical position statement development process and adopted the Grading of Recommendations Assessment, Development and Evaluation (GRADE) system of rating guidelines, which has been adopted by a wide range of national and international professional medical societies, health-related branches of government and health-care regulatory bodies. We continue to refine the implementation of this rigorous process.

The AGA guideline development process aims to address specific clinical questions for the practicing gastroenterologist and other providers. We first analyze, compare and rank the scientific evidence to create a technical review paper. A multi-stakeholder group then develops recommendations based on the evidence. This process is scientific, evidence-based and rigorous, unlike a consensus statement process that relies on the expert opinion of a panel of physicians.

STEP 2: Create measures based on evidence-based guidelines.

The AGA supports the delivery of efficient quality GI care with a focus on improved health outcomes. To incorporate these elements into a payment system (Medicare or others), care outcomes need to be measurable and incorporated into a single set of performance measures. To this end, AGA is developing a Gastroenterology National Quality Measure Set, which currently includes 24 measures with several more pending.

We develop these measures through the AMA's Physician Consortium for Performance Improvement (PCPI) standard and independent measure development processes. Our

performance measures for adult and pediatric populations include the following conditions: hepatitis C, inflammatory bowel disease (IBD), gastroesophageal reflux disease (GERD), endoscopy and polyp surveillance, and colorectal cancer screening. Many of these measures have been included in the Centers for Medicare and Medicaid Services (CMS) Physician Quality Reporting Initiative (PQRI)/PQRS programs since 2007. The AGA often collaborates with patient advocacy organizations on the development of evidence-based guidelines and quality measures such as the Crohn's and Colitis Foundation of America, which helps make these processes transparent. We inform and educate gastroenterologists about measures, measure development and related CMS incentive programs through our various print, electronic and social-media communication vehicles.

As part of our commitment to measures development, the AGA will participate in the National Quality Forum (NQF) pilot of its two-staged endorsement process. To be endorsed, a measure submitted to NQF must satisfy four criteria — importance to measure and report (must pass), scientific acceptability of the measure properties (must pass), feasibility to implement, and usability of the measure results — and must be judged to be "best in class." Since measure developers are currently required to submit fully specified and tested measures for consideration, this leads to costly investments of developers' time and resources to specify and test a measure that does not achieve NQF endorsement.

In the redesign, the consensus development process would be conducted in two stages. Measure "concepts" would be evaluated against NQF's importance criterion (addresses a high impact area, gap in care, or opportunity for improvement exists, and evidence is sufficient to support the focus) in stage one. Potential related and competing measures would also be identified during this stage. All measures, regardless of their stage of development (e.g., concept, fully specified measure, fully specified measure with testing, undergoing maintenance review with NQF) would be required to undergo concept review. Once the importance threshold has been met, a measure or concept could move into the second stage. Stewards such as the AGA would have up to 18 months to complete testing and full specification of their measures and bring back the measure for stage two review. Stage two would evaluate fully specified and tested measures against the remaining three criteria: scientific acceptability, usability and feasibility. At the end of stage two, measures that are ratified by the board will receive NQF endorsement. The AGA has been selected by the NQF to submit our adult IBD measure set through this revised measure endorsement pilot.

STEP 3: Facilitate collection of data related to quality measures through Web-based, manual and electronic means so that all physicians can participate.

There is variation among practices in the ability to collect data, e.g., rural providers vs. large integrated delivery systems with advanced electronic medical record (EMR) systems. Reliable electronic infrastructure will facilitate efficient and accurate communication, data exchange and translation of documented quality actions (patient care) so that financial incentive programs can be implemented.

To help gastroenterologists collect data, the AGA created the AGA Digestive Health Outcomes Registry® (AGA Registry), which is a national outcomes-driven registry with the mission to improve patient health outcomes and the cost effectiveness of digestive care. It uses scientifically valid methods to collect, analyze and report clinically relevant data, empowering the health-care community to optimize quality of care. Through the AGA Registry, gastroenterologists can monitor and improve the care they provide to their patients while also generating data to compare the efficacy of treatments.

The AGA Registry launched in May 2010, with an initial focus on guidelines-driven management of IBD and effective strategies for colorectal cancer prevention. The AGA Registry is certified by CMS to submit PQRS data on behalf of providers reporting the hepatitis C measures group. The AGA Registry is designed to interface with practices that have a robust health information technology infrastructure (such as gMed) who wish to have a comprehensive program for quality measurement and improvement and have already made a substantial commitment to demonstrating value. To date, 369 clinicians have enrolled in the AGA Registry. With our collaboration with UnitedHealthcare and other payors, we anticipate that the number of reporting physicians will increase to more than 1,000 by early 2013.

The AGA Registry provides participants with:

- Tools that fit into practice workflow and enable efficiencies in the delivery of care.
- Access to quality and performance indicators.
- National and in-practice comparative benchmarking.
- Online and in-person educational and professional development opportunities.
- Integration with existing health-care software systems.
- Professional networking and knowledge sharing.

The AGA Registry accepts direct submission from EHRs. The AGA Registry offers two paths to system integration:

- The registry is integrated into gMed's gGastro v4, the most common Certification Commission for Health Information Technology (CCHIT) certified EMR utilized in community-based gastroenterology practices, which allows users of this EHR to participate in the registry using their existing platform and clinical workflows.
- The AGA partnered with FIGMD, a company that specializes in integrating clinical systems regardless of their platform, version or specialty, to provide a low-cost solution for integrating a practice's EHR with the AGA Registry.

In addition, the AGA gathered the step-by-step advice of gastroenterologists with informatics expertise in its *EMR Field Guide for Gastroenterology.* Published in 2009, this guide provides physicians with the information needed about the essential clinical and functional elements of EMR systems that will meet the specialized needs of a gastroenterology practice.

STEP 4: Develop financial incentive programs based on evidence-based measures that translate into improved patient outcomes.

AGA has developed partnerships with private entities that may be instructive:

- In April, the AGA entered into an agreement with UnitedHealthcare to incorporate GI physician data from the AGA Registry into its physician performance measurement program. This program allows the comparison of individual treatment practices with regional and national treatment recommendations created by gastroenterologists. Data from the AGA Registry will support UnitedHealthcare's expanding portfolio of physician incentive programs that reward medical groups and physicians who demonstrate high quality, cost-effective, and improved patient care and outcomes.

- In May, Blue Cross Blue Shield of North Carolina recognized the AGA Registry as an approved mechanism for gastroenterologists to demonstrate their commitment to quality. The AGA is actively engaged in discussions with a number of other regional and local payors to incorporate data from the AGA Registry into their physician performance measurement programs.

- In mid July, the AGA launched the Digestive Health Recognition Program (DHRP), in partnership with the Healthcare Incentives Improvement Institute (HCI3). The DHRP, which is simple to access and use, will allow physicians to report clinical data, which is then assessed by an independent third party, and scored based on quality performance. Physicians who meet scoring requirements are recognized as quality providers of GI care by the AGA and the Bridges to Excellence (BTE) program administered by HCI3.

  BTE has been adopted by numerous health payors as a model for assessing quality of care and determining reward and recognition status for providers. The program was built to allow practices to easily look back on 25 to 30 consecutive patients and provides an opportunity to achieve a two-year recognition of excellence. The DHRP will begin with a program measuring quality in the treatment and management of inflammatory bowel disease (IBD) and will expand to include other clinical domains, such as hepatitis C, in the future. The IBD module will allow academic medical centers, which have been shut out of most pay-for-performance programs, and the AGA Registry to participate in this program. The DHRP measure set for IBD is the same set approved for reporting 2012 PQRS data to CMS, allowing providers to meet requirements for both quality-reporting programs through a single mechanism.

CLINICAL IMPROVEMENT ACTIVITIES

Supporting the steps to measuring and rewarding clinical efficiency and quality are clinical improvement activities. I will provide an overview of some of AGA's key activities in this area.

The AGA developed a Procedural Sedation/Patient Safety Practice Improvement Module (PIM), which has received approval from the American Board of Internal Medicine (ABIM) to be part of ABIM's Approved Quality Improvement (AQI) Pathway.

The AGA Procedural Sedation/Patient Safety PIM is the first independently developed PIM in the field of gastroenterology to be approved by the ABIM for Maintenance of Certification (MOC) for points toward the self-evaluation of practice performance requirement. These programs have been built to coordinate with licensure requirements and each cross-fertilizes the other.

The AGA's Procedural Sedation/Patient Safety PIM is an online portal that guides physicians through a chart abstraction of de-identified patient data, compiling this information to help physicians identify patterns and select changes or interventions that should improve performance. Participating physicians then implement an improvement plan, followed by another chart extraction several months later. The PIM generates a report comparing the two sets of charts, allowing physicians to easily assess the impact of their improvement plan and recognize opportunities for ongoing improvement in practice.

The sedation PIM focuses on practice-based evaluation of five quality indicators: risk assessment, informed consent, depth of sedation, patient safety (managing medication) and patient satisfaction.

In April 2012, the AGA collaborated with other specialty societies to launch a major education campaign focused on curbing overuse or misuse of tests and procedures.

Our list of "Five Things Physicians and Patients Should Question" is part of the prominent Choosing Wisely® campaign, which is an initiative of the ABIM Foundation. The list identifies five targeted, evidence-based recommendations that can support wise choices by physicians and patients. AGA's list makes the following recommendations:

- For pharmacological treatment of patients with gastroesophageal reflux disease (GERD), long-term acid suppression therapy (proton pump inhibitors or histamine2 receptor antagonists) should be titrated to the lowest effective dose needed to achieve therapeutic goals.
- Do not repeat colorectal cancer screening (by any method) for 10 years after a high-quality colonoscopy is negative in average-risk individuals.
- Do not repeat colonoscopy for at least five years for patients who have one or two small (< 1 cm) adenomatous polyps, without high-grade dysplasia, completely removed via a high-quality colonoscopy.
- For a patient who is diagnosed with Barrett's esophagus, who has undergone a second endoscopy that confirms the absence of dysplasia on biopsy, a follow-up surveillance examination should not be performed in less than three years, as per published guidelines.

- For a patient with functional abdominal pain syndrome (as per ROME III criteria) computed tomography (CT) scans should not be repeated unless there is a major change in clinical findings or symptoms.

The medical profession is in the midst of major changes to the manner in which it is reimbursed for its services. It is the AGA's intention to lead this discussion instead of having to react to changes implemented by outside forces. The immediate focus for the practicing gastroenterologist is to initiate a dialogue with patients when these five topics arise. These statements allow primary care and GI providers to discuss the best course of care given a patient's situation.

For example, the statement "Do not repeat colorectal cancer screening (by any method) for 10 years after a high-quality colonoscopy is negative in average-risk individuals," invites a discussion regarding a patient's risk. By facilitating the discussion of individualized risk, available science can be used as a basis for informed decision-making between providers and their patients. While the statement is based on the best evidence supporting quality health care, it is not intended to replace clinical judgment, since patient risk and colonoscopy quality may be difficult to precisely quantify.

The Choosing Wisely statements are designed to help patients and their clinicians understand which common procedures, tests and treatments are appropriate given their current health circumstances. It is hoped that by reducing overuse of common, high-volume resources, we may be able to "bend the cost curve" and ensure that resources remain available to provide the care we know will be beneficial to our patients.

The AGA is also developing Clinical Service Lines.

These are a collection of resources, combined with a "how to" manual, to help put all the pieces together so that a practice can provide the highest quality of care to its patients. These service lines will be built into an EMR for the purpose of coordinated information management and will be accessed through a single portal for the AGA Registry, our Digestive Health Recognition Program, PQRS and others as they become available. The initial clinical service line is for treatment of hepatitis C and this will be interfaced with gMed.

ALTERNATE PAYMENT MODELS

Developing a colonoscopy bundle fee is an integral component of AGA's Roadmap to the Future of GI Practice initiative. Recently, AGA was approached by a claims logic company used by most major private payors and a health plan to provide the objective clinical and scientific expertise for developing the bundles, including length of time of the bundle, complications and associated "carve outs." We have heard from members that entities in Minnesota and other payors, including Wellpoint, have approached GI groups regarding development of a colonoscopy bundle.

The project is proceeding with AGA bringing all parties to the table. AGA physicians are developing the content (e.g., screening colonoscopy, diagnostic colonoscopy and therapeutic and carve outs) of the bundles.

ADMINISTRATIVE AND REGULATORY BURDENS

Administrative and regulatory burdens continue to threaten the viability of physician practices, especially small practices and ambulatory surgery centers (ASCs). The AGA, along with organized medicine, has long advocated for administrative simplification for billing and patient information. This could save time and money for practices. Additionally, harmonization of PQRS, EHR Meaningful Use, and e-Prescribing reporting requirements could also provide a more streamlined process as physician practices comply with many of the new mandates from Medicare. It should also be noted that ASCs do not have an EHR incentive program. Most GIs perform services in the ASC setting and do not receive credit for the EHR use in this setting.

CONCLUSION

The AGA appreciates the opportunity to share our experience with quality and efficiency programs with both Medicare and private payors and believes many of these approaches can be expanded to a wider population base. Again, we share your vision to create a new payment system that rewards physicians for quality improvement and moves the Medicare system toward a more stable and viable path.

AGA's quality portfolio is intended to provide practices with multiple tools and resources to demonstrate improved patient outcomes and high quality and efficient care. We share the subcommittee's interest in developing and implementing policies and initiatives that meet these goals. Thank you, again, for the opportunity to share AGA's many programs and experiences with you and know that we stand ready to continue this dialogue.