In this issue...

2 MOHS COLLEGE JOINS THE ALLIANCE

SPECIALTY SPOTLIGHTS

3 NASS: Our Patients Need Us--We Need to Make Our Voices Heard

5 Urology Workforce Shortage: Challenges Facing Academic Urology Training Programs

7 AANS/CNS Unveil Neurosurgery Blog: More Than Just Brain Surgery

6 ALLIANCE IN THE NEWS

8 UPCOMING ALLIANCE EVENTS

8 SPECIALTY DOCS BLAST NYT EDITORIAL ON IPAB

9 JOIN THE ALLIANCE OF SPECIALTY MEDICINE

CMS, ALLIANCE KICK-OFF VALUE MODIFIER “SUPER USERS” NETWORK

In a conference room at CMS’ headquarters in Baltimore early this past December, physician representatives from the Alliance of Specialty Medicine and CMS officials kicked off the first-ever Value-based Payment Modifier (VBM) Super Users Network training session. The idea for a network of “super users” was generated by the Alliance early last year following a discussion of the lack of awareness and education of the VBM and concerns raised by physicians who received early versions of quality and resource use reports (QRURs). Specifically, the Alliance asked CMS to provide a mechanism for interpretation of feedback reports and meaningful dialogue between physicians, specialty society staff and CMS.

CMS officials were immediately responsive to the suggestion for such a network and agreed to partner with the Alliance to carry the concept forward.

Through the “super users” network, physician representatives and staff from each Alliance member organization are provided in-depth education and training on the VBM and associated QRURs. The goal of this enhanced education and training is to create a pool of “super users” able to translate key aspects of the value modifier program for specialists through a variety of media, including local, regional and national specialty society events, webinars, audio conferences, newsletter articles, and other channels.
The network also serves as a means by which individual physician members of Alliance organizations can engage in a meaningful dialogue with knowledgeable colleagues in their own specialty. In addition, “super users” will regularly provide important feedback to the agency on ways to improve the value modifier program and QRURs as they are phased-in for all physicians, as well as enhancing education efforts and addressing other provider concerns from the field.

CMS tasked the “super users” with developing a list of frequently asked questions (FAQs), as well as new mechanisms by which CMS could evaluate and measure cost and quality for specialty physicians, along with appropriate attribution methodologies, in the value modifier program moving forward.

Takeaways from this inaugural training session were positive. Organizations that participated were encouraged by CMS’ willingness to collaborate with the Alliance and maintain an ongoing dialogue with the network. Alliance participants were impressed with CMS’ openness to suggestions and support for a number of ideas brought forward by the “super users.” The Alliance again encouraged CMS to reevaluate its earlier decision to use 2013 as the basis of the initial 2015 VBM adjustment, but CMS explained it had limited authority to make changes to the timeline. Nonetheless, the Alliance also took the opportunity to share its appreciation for CMS’ decision in the 2013 Medicare Physician Fee Schedule to limit application of the modifier in the first year to group practices with 100 or more eligible professionals rather than 25 or more. In addition, the Alliance thanked the agency for agreeing to recognize and hold unaccountable to the modifier large groups that at least attempt to report Physician Quality Reporting System (PQRS) measures even if they do not fully satisfy PQRS reporting criteria.

The Alliance’s network of “super users” continues to engage with CMS and is preparing its response to CMS’ request.

**MOHS COLLEGE JOINS THE ALLIANCE!**

The Alliance of Specialty Medicine is pleased to welcome its newest member, the American College of Mohs Surgery (ACMS, or “Mohs College”). Through participation in fellowship training, ACMS surgeons become highly skilled in Mohs micrographic surgery, the most effective and advanced treatment for skin cancer today. Members of ACMS promote the highest standards of patient care with respect to Mohs surgery and cutaneous oncology through this fellowship training, research, education and public advocacy.

Learn more about ACMS by visiting their website at [www.mohscollege.org](http://www.mohscollege.org).

Like the Alliance of Specialty Medicine on Facebook!

Our Patients Need Us—We Need to Make Our Voices Heard

by Michael H. Heggeness, MD, PhD
Immediate Past President, North American Spine Society

Doing my best to serve the NASS membership in 2012 involved a lot of travel, lost sleep and some general inconvenience. On several occasions, maintaining the balance between my “day job” of teaching residents and students, pursuing my research, and most importantly, healing the sick, has been difficult. That last mission is the most important and ultimately drives my other work.

Before I joined NASS leadership, I saw the society as primarily a forum for the exchange of ideas concerning the art and science of spine care. Others see NASS primarily as a wide-ranging education provider, from coding to basic science and ethics. NASS also funds research grants.

While these are important parts of NASS, many members do not see the hardworking member volunteers and staff who pursue NASS’ important advocacy mission. This was the NASS mission I knew the least when I entered the NASS leadership. Perhaps ignorance was bliss.

When I began my practice 22 years ago, I enjoyed (but did not properly appreciate) tremendous freedom in the way I evaluated patients and the procedures I performed. I saw my university affiliate hospitals as friendly partners in the noble process of providing patient care. I had no notion that I would ever enjoy anything other than a reasonable level of remuneration. At that time, I was puzzled by colleagues who obsessed over coding issues and who wrote me letters urging contributions or votes for one or another national political candidate. Times have changed.

During my last two decades of blissful ignorance, the world around me has indeed changed. The hospital lobbies, the Trial Lawyers Association and other effective, powerful lobbying groups have left most health care providers with a much smaller share of the revenue. New unfunded mandates for electronic health records (EHR) and the long list of “meaningful use” requirements are also driving up costs and adding administrative burdens. All of this is causing a historic migration of physicians out of independent practice and into either hospital employment or retirement. This cannot be good for our patients.

As if this wasn’t bad enough, the national debate about health care costs has left most of the general public with the impression that physicians’ fees are the principal cause of the Medicare funding gap. Physician’s fees represent only 8% to 10% of the Medicare dollar, so why are physicians such a favorite target?

The government’s obsession with attacking the wrong target has recently escalated with expansion of the Medicare audit program commonly referred to as the “RAC” (Recovery Audit Contractor). This program actually began in the Bush years as a postpayment audit program, but has taken a crazy new turn recently. The initial rollout of a prepayment authorization review demonstration program is underway in 11 states for a limited number of Diagnosis Related Groups (DRGs), but a
massive expansion of the program is planned. Charged with reviewing charts for Medicare patient treatments (as many as three years retroactively under the postpayment program), RACs are paid a commission on any “overpayments” they identify. Thus far in the pilot programs, arbitrary and bizarre criteria have been applied to assess for these “overpayments.” If you have noticed a number of brand new and highly illogical administrative changes to your hospital’s admitting procedures, this magnificent new Medicare audit program may be driving the change.

But wait there’s more...

Now that most of us have been forced to purchase expensive and cumbersome EHR systems, we will soon be experiencing Meaningful Use audits. Quality and Resource Use Reports (QRUR) are coming in 2013. Also, a data collection process is about to start to support the introduction of a Value Based Payment Modifier, the “VBPM!” We may run out of letters soon.

These new requirements all consume time and resources that independent physician practices can ill afford. The result is that the physician in independent practice is very rapidly becoming an endangered species.

To my eyes, both political parties are drinking from the same faucet of lobbying dollars. Our patients need us, but there seems to be no doubt that greed and politics are combining to radically change the way you and I are forced to practice now. The changes are coming at us so quickly that reacting to them has us on the run.

We have to keep fighting. Stay active in our medical societies, like NASS. Stay active in the Alliance of Specialty Medicine. Give to PACs that champion our concerns. Show up to the polls every election day and vote. I also hope that, like me, you will become more directly active in contacting and engaging your own elected representatives. Let us try to make our voices heard.
The supply of urologists per capita in the United States continues to decrease, a trend that started in 1991 and continues to accelerate. In 2009 there were only 3.18 urologists per 100,000 population which is a thirty-year low. This is compounded by the fact that urology has the second oldest surgical subspecialty workforce with an average age of 52.5 years, greater than 18% of whom are age 65 or older. Another concerning trend is the higher density of urologists practicing in urban as compared to rural areas (7:1 ratio) leaving many counties in the United States without the services of a urologist.\(^1\)

Mirroring this nationwide shortage of urologists is a similar decrease in the academic urology workforce as compared to previously reported trends.\(^2\) A recent survey of the academic urologic workforce projected that over 369 faculty positions need to be filled over the next five years suggesting that a shortage of academic urologists, the prime educators of urology graduate medical education (GME), may be more profound than that of independent practice.\(^3\)

Shadowing these workforce trends is the existing cap on GME funding for residency training, and the new Accreditation Council for Graduate Medical Education (ACGME) mandated requirements which include an increased emphasis on didactic teaching along with resident duty hour restrictions. These requirements coupled with the increasing use of organized proficiency training labs and surgical simulators have proven costly to urologic academic training programs, and are not supported by existing GME funds. In essence there is much more to teach and less time to teach it with increasingly expensive resources required.

A recent Society of University Urologists survey addressing these issues was sent to academic urologists in the United States. Over 40% of the survey respondents indicated their program has residency positions not funded by GME or the VA system, and a majority indicated that the lack of GME funding is an obstacle to adding much needed new residency positions. Survey respondents indicated that clinical revenue and hospital funds were the main financial support engines used to subsidize residency positions not funded by GME. However as Medicare and private payers continue to reduce reimbursement for clinical services; these sources of revenue do not appear sustainable.

With 10,000 seniors aging into the Medicare program every day for the next 18 years, along with the impending influx of patients as a result of the Patient Protection and Affordable Health Care Act, urology is facing a severe workforce shortage overall and in the academic setting. These shortages in combination with the 1997 cap on GME funding have led to a very precarious situation regarding the ability to train high quality urologists in the near future. The current system of GME funding for urology residency programs requires fundamental change as its impact has contributed to a significant shortage in the supply of urologists in the United States. An ad hoc Institute of Medicine committee has been assembled to study the governance, finance, and regulation of GME in the United States. A final report is expected from this independent advisory commission in March 2014.

Healthcare is central to our daily lives and policymakers in Washington, DC have an enormous influence and control over this vital aspect of society. Yet despite this, most people cannot see what goes on behind the scenes of health policy circles in our Nation’s capital. There is no shortage of organizations with ideas and opinions, but, what most people don’t realize is that most of those opinions and ideas come from a process in which good policies often fall by the wayside, trumped by politics. It is in this very notion where the idea for Neurosurgery Blog (www.neurosurgeryblog.org) was born. The American Association of Neurological Surgeons (AANS) and the Congress of Neurological Surgeons (CNS) believe it’s imperative to always give an honest take on key health policy discussions — whether it’s good, bad, or just plain ugly — even if, in some cases, it makes us unpopular or ruffles a few political feathers. The mission of Neurosurgery Blog is not only to investigate how healthcare policy affects healthcare practice and to illustrate that the art and science of neurosurgery encompasses much more than brain surgery, but it’s also to get people talking about healthcare in an open and honest way. In our first blog posts, we have blogged on topics such as the sustainable growth rate (SGR), the Independent Payment Advisory Board (IPAB), medical liability reform and health reform in general. We invite you to visit the blog and subscribe to it so that you can keep your pulse on the many health-policy activities happening in the nation’s capital.

Disclaimer: All Specialty Spotlight articles are contributions from Alliance of Specialty Medicine member organizations. All statements and opinions included in the Specialty Spotlight are strictly that of the contributing organization and do not necessarily imply those of the Alliance of Specialty Medicine.
UPCOMING ALLIANCE EVENTS

Physician Advisory Council Conference Call  January 29, 2013

  Topic: Workforce/GME
  Location: HVC 200, Capitol Visitors Center

Physician Advisory Council (In-Person Meeting)  July 8, 2013

Legislative Conference and Fly-in  July 9-10, 2013

NOTE: Participation in Alliance events is by invitation-only, with some exceptions. To learn more about how you or your organization can participate, please contact your organization’s staff liaison to the Alliance or Vicki Hart at vhart@hhs.com.

SPECIALTY DOCS BLAST NYT EDITORIAL ON IPAB

Recently, the House established modified rules related to the IPAB’s “fast-track” provisions for this two-year Congressional session. Specifically, H.Res. 5 alters Sec. 1899(d) making it harder for the IPAB recommendations to “fast track” through the House. However, at the close of this Congress, these special rules for IPAB would no longer apply.

Despite this change, the Independent Payment Advisory Board (IPAB) remains a primary concern for specialty physicians as evidenced by a letter-to-the-editor submitted by Alliance spokesperson, Alex Valadka, MD, in response to a New York Times editorial.

“Your November 18th editorial opposing repeal of the Independent Payment Advisory Board or IPAB ["A Bad Idea Resurfaces"] clearly misleads readers about the dangers of this board. Physicians who participate in Medicare are already reimbursed at below market rates for providing care. They are facing their own “fiscal cliff” due to massive rate cuts over the next decade -- 26.5% this year alone -- unless Congress acts. Such cuts will require physicians to limit the number of Medicare patients they see if they are to keep their offices open, pay their staff, etc. Physicians who cannot afford to maintain their practices cannot treat patients and, like it or not, this is de facto rationing of care.

The IPAB will only add to this. Its cuts will have the force of law and fall squarely on the shoulders of physicians, further limiting their ability to treat Medicare patients.”

Read more about the Alliance’s opposition to the IPAB and the negative impact on Medicare beneficiaries by visiting www.specialtydocs.org.
Join the most powerful group of specialty physicians!

Joining forces with specialty doctors from across the country helps amplify the concerns specialty doctors share. By working together, specialty medical organizations can work more effectively to influence health care policy and ensure our primary goal: to continue to provide our patients the optimal care they need. As a part of the non-partisan umbrella organization representing all of specialty medicine, your organization will:

- Promote specialty specific issues as part of a larger coalition, increasing visibility and understanding of issues.
- Help increase exposure for specialty medical care.
- Gain access to insider information, background materials and research on health policy initiatives and the political landscape.
- Receive expert analysis on proposed legislation
- Caucus with other specialty organizations at the AMA House of Delegates and other forums to promote key issues that are important to specialty physicians.
- Coordinate physician and patient grassroots efforts through a large and robust network.
- Participate in future Alliance Fly-In events in Washington, D.C. Past events have included Capitol Hill visits and presentations by health policy experts.

For information on joining the Alliance of Specialty Medicine, visit our website at www.specialtydocs.org or contact Vicki Hart at vhart@hhs.com.