



Sound Policy. Quality Care.

December 2, 2009

The Honorable Harry Reid
Majority Leader
United States Senate
S-221 Capitol Building
Washington, DC 20510

Dear Majority Leader Reid:

As the Alliance of Specialty Medicine (Alliance), our mission is to advocate for sound federal health care policy that fosters patient access to the highest quality specialty care and improves timely access to high quality medical care for all Americans. As patient and physician advocates, the Alliance believes that true health reform should be enacted through a responsible and transparent process. Over the past year, the Alliance has provided substantive comments on those health reform provisions that concern specialty physicians and patients in their care. We are extremely concerned that your substitute amendment, the "Patient Protection and Affordable Care Act," to H.R. 3590, fails to address our previously mentioned concerns. Therefore, we oppose the substitute amendment in its current form. We stand ready to work with you to address the issues, outlined below, that continue to concern us.

Physician Payment Update (Section 3101)

Medicare's sustainable growth rate (SGR) formula needs to be replaced with a permanent, stable mechanism for updating Medicare fees to continue to assure Medicare beneficiary access to high quality care. Rather than come back year after year, providing a short-term fix to this large problem, we must stop utilizing band-aid solutions and establish a new baseline for physician reimbursement. President Obama agreed with that proposal when he sent this year's budget to the Congress. The cost of interim updates to the physician fee schedule should not be shifted to out years, making permanent SGR reform even more difficult, and costly, to achieve. Already, as a result of previous interim updates, physicians currently face a 21% fee reduction beginning in January 2010. Medicare physician payment rates already are below market rates. Therefore, any long-term solution should, at the very least, recognize reasonable inflationary cost increases.

Value-Based Physician Payment Modifier (Section 3007)

Rather than create a stable physician payment schedule, Section 3007 would dramatically alter the current payment system by adding a new, untested payment modifier that would redistribute Medicare payments based on quality and geographic cost variation, without a more systematic review of the potential consequences. While the Center for Medicare and Medicaid Services (CMS) has been testing various models in this area, CMS does not have the current capability to implement such a proposal and no valid methodology that incorporates appropriate risk adjustment factors and outcome measures even exists. Furthermore, there are many reasons for geographic cost variation, including differences in population demographics that merit significantly more study before such a measure could be implemented. Therefore, rather than add stability to the physician payment mechanism, the proposal would create yet more instability with an unrealistic and unachievable timeline.

CMS should be allowed to fully test models for value-based payment and determine which system would achieve maximum benefit before further modification of a flawed Medicare physician payment formula. There is widespread agreement that the current SGR process results in arbitrary and damaging cuts to Medicare physician payment. We cannot achieve a reliable or stable incentive for quality care by modifying arbitrarily – and arbitrarily changing – reimbursement rates. And because this new modifier in Section 3007 would be budget neutral, some providers would face the dual blow of arbitrary SGR cuts and neutrality-imposed value-based purchasing cuts.

Payment Cuts for Specialty Care (Section 5101)

While we understand the potential need to increase the payment rates of primary care physicians, many surgical and specialty medicine disciplines have faced significant cuts over the years while primary care fees have increased. As Medicare payments have continued their steady decline over the past few years, reimbursement for primary care services has actually increased. For example, CMS recently approved a more than \$4 billion increase in the fee schedule for primary care services, as well as a 37 percent increase in one key code used by primary care physicians. In its March 2009 report, MedPAC noted that Medicare payments for primary care have increased 10.6 percent between 2006 and 2009. And these changes will continue in the future. Indeed, under the 2010 Medicare Physician Fee Schedule, reimbursement for primary care physicians will increase between 2- 4 percent.

While primary care payments have been increasing, specialty care payments have been decreasing. Since 1992, specialists have seen significant reductions in the fees they receive for procedural services. Although modest increases may have been provided for physician services in recent years, they have not kept up with the rate of inflation nor have all physicians seen increases. In fact, many surgical services were cut again in 2008 and a number of specialties are facing additional cuts in 2010 as a result of changes CMS has made in the fee schedule. Specialists continue to lose more ground in the fees they receive for serving Medicare beneficiaries while their practice costs continue to steadily rise. This is particularly troubling because much of the funding for this health care reform proposal already relies on cuts to Medicare and to the physicians that provide those key services. Additional cuts will likely result in decreased patient access to critical health care services. With a shortfall of 49,000 surgeons and other specialists predicted by the year 2025, we can ill-afford to further exacerbate the access to care problem.

Independent Medicare Advisory Board (Section 3403)

Congress should retain proper oversight of the process that determines how services are provided under Medicare and not relegate it to another entity. If the goal of a new Advisory Board is to find new ways to eliminate spending in the Medicare program, the end result may well be detrimental to patient care for our nation's elderly. Already, Medicare reimbursement rates are well below market rates for similar services. And yet, the solution seems to be to further ratchet down the costs, without oversight, without care to ensure that our seniors receive the care that they deserve. Further, the construct of the Board seems to selectively exempt certain providers from its purview – placing more pressure to cut Medicare in those areas under its jurisdiction. There is no question we need to improve the Medicare program to make it sustainable well into the future. However, Medicare cannot be “fixed” when we do not look at the whole program, but rather, chop it up and force program savings into specific areas, such as provider reimbursement. We certainly understand and appreciate concerns with the rising costs of health care. But this is not the way to approach this problem. Rather than develop a coherent proposal to appropriately address the issue, the proposal contained in the substitute amendment abdicates Congress' fundamental responsibility and instead hopes that others can develop additional solutions and then allows them to be implemented. If we go forward with this process, there will be myriad, unintended consequences, including restricting access to important interventions and services for Medicare patients. You should not allow important health care decisions to be made with little clinical expertise, resources, or oversight required to ensure that seniors are not placed in jeopardy.

Medical Liability Reform (Section 6801)

We remain concerned that the current health care proposal before us does not address our broken medical liability system. Medical liability reform will help achieve health system savings by reducing the incentives for defensive medicine and it will also protect physicians from unaffordable liability premiums. Last fall, President Obama stated in the

New England Journal of Medicine that he would be “open to additional measures to curb malpractice suits and reduce the cost of malpractice insurance.” Earlier this year, at the American Medical Association’s Annual Meeting, the President also noted that we will not be able to implement changes in our health care delivery system that reflect best practices, incentivize excellence and close cost disparities “if doctors feel like they are constantly looking over their shoulder for fear of lawsuits.” With a President that understands the need for medical liability reform, we do not understand why your proposal only includes a Sense of the Senate on the topic.

We would prefer a more comprehensive approach to this dire problem, such as federal medical liability reform based on the California or Texas models, which include, among other things, reasonable limits on non-economic damages. As you are aware the Congressional Budget Office recently scored comprehensive and proven medical liability reforms, similar to those above, as saving the federal government \$54 billion over the next decade. In addition to this savings, these reforms will also improve patient access to specialty care, particularly in rural and underserved areas. However, at the very least, we should do something in this area, and there are several bipartisan proposals which we should debate, consider, and then include within a comprehensive health care reform package.

Excise Tax on Certain Elective Medical Procedures (Section 9017)

Physicians strongly oppose taxes on distinctive physician services to fund health care programs or to pay for health care reform and we therefore are extremely concerned by the last minute addition of the tax on elective cosmetic surgery and medical procedures. This is a dangerous precedent to set as it places physicians in the role of tax collector, compromises patient safety by encouraging individuals to circumvent the tax by seeking procedures from non-medical personnel or providers in other countries, and jeopardizes patient privacy by opening physician practices up to IRS audits. Furthermore, once in place, we fear that this tax could easily be expanded to other health care services. As demonstrated by New Jersey’s experience with a similar tax, the application of such a tax is arbitrary and confusing to administer.

Provisions Important to Maintain in Any Health Care Reform

We applaud many of the provisions in your substitute amendment that improve access to health insurance and believe a number of provisions must be included in any meaningful health reform package to improve access to affordable health insurance and assure access to specialty medicine. Those provisions included in your substitute amendment that we believe should be maintained include eliminating pre-existing condition exclusions, providing adequate access to specialty care through the benefit package, addressing rescission of health coverage, ensuring continuity in Medicaid coverage for children who go in and out of the system, and prohibiting annual and lifetime coverage limits.

In addition, the Alliance is pleased that your legislation includes a provision to expand comparative effectiveness research (CER). Like you, the Alliance believes appropriately designed CER conducted by an independent entity with full participation of all relevant stakeholders should enhance information about treatment options and outcomes for patients and physicians, helping them to choose the care that best meets the individual needs of the patient. CER needs to recognize the diversity, including racial and ethnic diversity, of patient populations and subpopulations and communicate results in ways that reflect the differences in individual patient needs. It should not be a vehicle for making centralized coverage and payment decisions or recommendations.

The Alliance also appreciates the elimination of a provision which would automatically reduce payment rates by 5% for physician services if they are deemed “outliers”, regardless of patient acuity or other key factors.

Finally, we appreciate that you addressed our concerns related to imaging services and clarified that the definition of advanced imaging does not include ultrasound as it relates to the increase in the utilization rate for imaging services.

Thank you for commitment and leadership on this issue. Physicians are an integral part of the health care system and are on the front lines of patient care. The Alliance hopes you will work with us to improve the Senate health reform package.

Sincerely,

American Association of Neurological Surgeons
American Association of Orthopaedic Surgeons
American Society of Cataract and Refractive Surgery
American Urological Association
Coalition of State Rheumatology Organizations
Congress of Neurological Surgeons
Heart Rhythm Society
National Association of Spine Specialists
Society for Cardiovascular Angiography and Interventions