



Sound Policy. Quality Care.

September 21, 2009

Honorable Max Baucus
Chairman
Senate Committee on Finance
511 Hart Senate Office Building
Washington, DC 20510

Honorable Chuck Grassley
Ranking Republican
Senate Committee on Finance
135 Hart Senate Office Building
Washington, DC 20510

Dear Mr. Chairman and Senator Grassley:

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 welcomes the opportunity to participate in the debate on Medicare and health care reform during the 111th Congress.

Unfortunately, at this time, we cannot support the Chairman's mark released on September 16, 2009 for the following reasons:

Physician Payment Update (p. 110). Medicare's sustainable growth rate (SGR) formula needs to be replaced with a stable mechanism for updating Medicare fees to continue to assure Medicare beneficiary access to high quality care and also to allow Medicare and the health care system to move forward with important system delivery reform. Congress must avoid band-aid solutions and establish a new baseline for physician reimbursement. 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. As a result of previous interim updates, physicians currently face a 21% fee reduction beginning in January 2010. While acknowledging the central importance of ensuring the financial integrity of Medicare into the future, the Alliance of Specialty Medicine at the same time believes that physician payment reform should recognize reasonable inflationary cost increases that lead to fair reimbursement for the services provided to beneficiaries. *Therefore, the Alliance is discouraged with the manager's amendment because it does not provide a permanent solution.* We would like to work with the Committee as you explore other options and develop additional alternatives to ensure accurate budgeting within Medicare and the broader health care reform package. We urge you to exclude the costs of prescription drugs administered in the physician's office from the SGR formula calculation **retroactively**.

In addition, we are strongly discouraged by your proposal to further modify physician payments based solely on physician resource use (pp. 80-81), not taking into account particular patient characteristics and needs. By basing your payment methodology simply on the "average" physician, your proposal needlessly upsets the doctor-patient relationship. We are further disappointed that your proposal focuses on costs and cost reduction rather than first examining treatment quality. A better focus should be improving health care quality. Volume and spending have not proven to be accurate surrogate end points for quality. We agree that it is a challenge to identify inappropriate spending and many demonstration projects are underway to examine different ideas. Congress has struggled for decades with the challenge of defining inappropriate volume only to result in policies that treat all volume the same and fail to recognize when increased volume may result in quality improvement.

Primary Care (p. 101). The Alliance recognizes the importance of improving preventive care for Medicare beneficiaries. However, it should be noted that specialists routinely provide preventive and maintenance care in a cost effective manner, and equal efforts should be made to maintain appropriate payment rates for specialty care. Many surgical and specialty medicine disciplines have faced significant cuts over the years while primary care fees have increased. If the goal is to increase access for primary care services, then the payment policy should be narrowly tailored to primary care services, not primary care providers.

As Medicare payments have continued their steady decline over the past few years, significant steps have been taken to improve reimbursement for primary care. In fact, the most recent five-year review by the AMA/Specialty Society Relative Value Update Committee (RUC), approved by the Centers for Medicare & Medicaid Services (CMS), resulted in more than \$4 billion in the fee schedule being shifted to evaluation and management (E/M) codes from other services, including specialty care, in 2007. In addition, the most recent review resulted in a 37 percent increase in the work values associated with an intermediate office visit (CPT 99213), the most frequently billed physician service in Medicare. In its March 2009 report, MedPAC noted that Medicare payments for primary care have increased 10.6 percent between 2006 and 2009, which can be attributed largely to the work of the physician community through its work on the RUC.

Budget neutral funding does not take into account significant reductions specialists have seen in their fees over time for the services they provide. With the introduction of Medicare's Resource-Based Relative Value Scale (RBRVS) beginning in 1992, specialists saw significant reductions in the fees they received 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 in 2008 for a second time during this review because of an additional reduction in work values. Specialists are continuing to lose more ground in the fees they receive for serving Medicare beneficiaries while their practice costs steadily rise.

The Alliance cannot support your manager's amendment that would provide additional payments to primary care physicians at the expense of specialists, e.g., through budget neutral adjustments in payments made to specialists.

Medicare Commission Proposal (pp. 156-158). *The Alliance is strongly opposed to altering the current process by which services provided under Medicare are valued and opposes any legislation that removes the oversight of this process from those who have been elected to do so.* Like Robert D. Reischauer, former Congressional Budget Office (CBO) Director and MedPAC Vice Chairman, we find it extremely troubling that this proposal would require a new Commission's reimbursement and cost reduction recommendations to be implemented without full Congressional oversight and review. Given the critical impact that these decisions have on beneficiary access to quality care, the Alliance strongly believes that Congress should continue to exert strong oversight over these critical programs and not inappropriately relegate these critical duties to a new Commission or any other governmental entity.

Some have suggested that the modified MedPAC proposals are similar to the Base Realignment Advisory Commission (BRAC). The Alliance finds this statement to be misleading. Given the scope and breadth of the authorities provided, your proposal for a new Commission is far more expansive than any BRAC process. The BRAC had defined constraints and had looked at which bases should remain open – a narrowly defined topic. The proposals mentioned have the potential to completely restructure payment policies for all Medicare services, which could have dramatic effects on patient care, quality, and access. If the goal of a new Commission is to find new ways to eliminate spending in the Medicare program, the Alliance believes the end result will be detrimental to patient care for our nation's elderly.

The Alliance certainly understands and appreciates concerns with the rising costs of health care. The process and structure proposed however, is fraught with potential unintended consequences – including restricting access to important specialty care interventions and services for Medicare patients. *We therefore strongly urge you to eliminate your proposal to create a new Commission which would make important health care decisions without the clinical expertise, resources or oversight required to ensure that patient care is not placed in jeopardy.*

CMS Innovation Center (pp. 90 - 93). While the Alliance appreciates the need for stronger innovation in developing new payment methodologies, we are concerned with your proposal to establish the new Innovation Center at CMS without additional oversight. Any new payment methodology should be thoroughly evaluated by Congress before being fully implemented, given the potential negative impacts on patient care. Therefore, we strongly urge you not to relegate your oversight activities to a federal bureaucracy.

Physician Quality Reporting Initiative (pp. 79-81). All of the Alliance’s specialty association members are actively engaged in the process of developing evidence-based and clinically relevant quality measures and establishing data registries through initiatives within their own specialty and/or through the AMA’s Physician Consortium for Performance Improvement. The commitment is to provide the highest quality specialty care to Medicare beneficiaries in a transparent health care system so as to improve patient outcomes. *However, the Alliance is concerned that the manager’s mark would make PQRI punitive by eliminating the incentives and replacing them with penalties.*

Health Information Technology. *We remain concerned with the current health information technology (HIT) timelines included in the recently enacted “American Recovery and Reinvestment Act of 2009” (ARRA) (P.L. 111-5) and urge you to consider amending the current HIT timelines.*

HIT has the potential to increase efficiency, improve patient safety, increase the quality of care, and lower health care costs significantly. We strongly support the development of an electronic health information network that is reliable, interoperable, secure, and protects patient privacy. Congress made significant strides towards the implementation of HIT with the passage of the ARRA, and the specialty community is appreciative for the opportunities available for physicians to receive enhanced Medicare payments to support the adoption and effective utilization of HIT. Smaller physician practices, which include the majority of the physicians practicing medicine in this country, continue to face barriers to purchasing HIT systems. In addition, for those practices that manage to adopt HIT, it takes a further investment of significant time and resources to use their systems to the fullest capacity. Funding the operation and improvement of these systems will be difficult without reasonable physician fee updates. Like you, we are closely following the implementation of the ARRA. In particular, we still are waiting to hear back from the Secretary of Health and Human Services about the definition of “meaningful user.”

We also are concerned that many specialty physicians will not be able to take advantage of the enhanced payments to purchase HIT because of the ambitious timelines and the fact that current specialty systems lack certification and interoperability standards. Further, the current **certified** HIT systems have been developed for primary care settings and have not yet been fully adapted for specialty care. The financial incentives and penalties are based on the adoption and “meaningful use” of certified HIT systems and will have a profound impact on our members and their ability to adopt and become meaningful users. Physicians are hesitant to make the considerable investment until certified systems that meet their unique needs are available.

There are specialties that have made significant accomplishments toward achieving interoperable HIT solutions for their members and have been placed on the Certification Commission for Health Information Technology (CCHIT) -- the only recognized certification body that provides a roadmap for HIT Certification. However, due to the obstacles that must be overcome to be identified by CCHIT as one of the planned expansion areas, and the

lack of CCHIT financing and staff, most specialties are not even in the pipeline. In addition, even those who are on the roadmap are facing challenges in the timelines that have been outlined by the Commission.

As a result and under the current timelines, it will be virtually impossible for the majority of specialty physicians to purchase certified systems that are designed for their specialty, become meaningful users, and qualify for the majority of the vitally necessary financial incentives. We continually strive to provide quality care, and we recognize that HIT can play an important role in achieving and maintaining high performance. Therefore, we urge you to consider amending the current HIT timelines included in the ARRA.

Physician-Owned Hospitals (pp. 174-176). The Alliance believes that specialty hospitals are an important component of our health care delivery system. Physician owners in specialty hospitals have greater control over the facility and the quality and efficiency of care (e.g., scheduling of procedures, equipment, staffing etc.) which can lead to higher quality patient care. Furthermore, these facilities tend to have greater patient satisfaction, reduced costs, and lower infection rates. *Therefore, we are concerned with your proposal to alter the current physician-owned hospital requirements.*

The Alliance believes that physicians should have the ability to treat patients in whichever setting they feel offers patients the highest quality of care available. Ethical referral under the current “Stark laws” provides physicians and their patient with the opportunity to determine together, which setting is most appropriate for the treatment they require. Further, those requirements laid out in the committee proposal not related to patient referral or disclosure of ownership interest are overly prescriptive and not currently required of other non-physician owned health care entities. We urge the committee not to discriminate against physician-owned hospitals.

Imaging values (pp. 151-152). The Alliance understands that imaging services represent one of the fastest growing categories of services in the Medicare physician fee system and that this growth is unsustainable. Therefore, we are committed to working with Congress to identify and reduce unnecessary diagnostic imaging services. However, we must better understand how much of the increase is due to legitimate need to achieve high quality care. To date, there has been a presumption that increased imaging services are due to physicians making up revenue lost elsewhere in the system. However, a considerable amount of imaging is utilized because of defensive medicine practices and risk avoidance due to medical liability concerns.

Medical liability reform (p. 174). The Alliance would like to state that the absence of real options (beyond a Sense of the Senate resolution) to address the medical liability climate that negatively impacts patient access to care and adds billions of dollars in additional spending to the health care through defensive medicine practices is disappointing. The current medical liability climate affects primary and specialty care physicians, especially in rural areas, and we urge the Committee to consider incorporating medical liability provisions (including alternatives to traditional approaches) in your health care reform package. In addition, the Alliance also strongly urges you to include medical liability protections for health care providers when they follow practice guidelines.

Development of a National Workforce Strategy (pp. 102-110). The Alliance appreciates your consideration of workforce issues within the context of health reform. In particular, the Alliance supports redirection of unused graduate medical education slots. *However, the Alliance is concerned that this provision does not take into account particular specialist shortages.* The services specialists provide are an integral part of American medicine, and it takes more than 12 years to produce some specialists. If we do not proceed with caution and federal policy discourages young physicians from entering specialty medicine, we will be unable to quickly correct the problem once it becomes visible. Already, there are shortages in many specialty areas which are projected to get worse.

The Council on Graduate Medical Education (COGME), reported that *“In rural areas, there is a clear need for specialty care.”*¹ The report goes on to say that *“Though primary care would be an essential area of medical service and training, subspecialty and surgical disciplines are also sorely needed in underserved areas.”*²

The Bureau of Health Professions (BHP) has cited significant workforce challenges across the surgical specialties. Between 2005 and 2020, BHP projects an increase of only 3 percent among practicing surgeons – with projected significant declines in a number of surgical specialties. Over the same time period, BHP projects that the number of practicing primary care physicians will increase by 19 percent.

The Association of American Medical Colleges (AAMC) published an updated physician workforce study demonstrating essentially equivalent shortages between primary care and surgery. Specifically, the study projects physician supply and demand through 2025 and finds that *“in terms of the general projected shortage of 124,000 FTE physicians, while 37% of the shortage will be in primary care [46,000], 33% will be in surgery [41,000]...”* In addition, the study projects a shortage of 8,000 medical specialty physicians.³

Any national workforce strategy must encourage participation by specialty medicine to ensure a stable, balanced workforce to meet future needs.

Expert panel (p. 112). *The Alliance opposes establishing yet another expert panel to assist the Center for Medicare and Medicaid Services (CMS) in evaluating and adjusting payment for potentially misvalued physician services because this proposal is duplicative of current efforts and unnecessarily politicizes the payment review process.*

As you consider the next steps for health care reform, we hope that you will take into account our comments and suggestions, as well as the unique role of specialty medicine.

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

¹ COGME 18th Report: “New Paradigms for Physician Training for Improving Access to Health Care,” Sept 2007, page 5

² Ibid, page 13

³ The Complexities of Physician Supply and Demand: Projections through 2025, Michael J. Dill and Edward S. Salsberg, Center for Workforce Studies, Nov 2008