



Sound Policy. Quality Care.

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May 15, 2009

Honorable Max Baucus  
Chairman  
Senate Committee on Finance  
219 Dirksen Senate Office Building  
Washington, DC 20510

Honorable Chuck Grassley  
Ranking Republican  
Senate Committee on Finance  
219 Dirksen Senate Office Building  
Washington, DC 20510

Dear Mr. Chairman and Senator Grassley:

As the Alliance of Specialty Medicine, our mission is to develop 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. We sincerely appreciate your work to provide a series of options for health care reform, and we would like to take this opportunity to provide requested feedback on the April 29, 2009, options paper, *"Transforming the Health Care Delivery System: Proposals to Improve Patient Care and Reduce Health Care Costs."*

**Physician Payment Update.** 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 22% 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 two options proposed for the SGR because neither provides a permanent solution. We would like to work with the Committee as you explore other options and develop additional alternatives to ensure honest budgeting within Medicare and the broader health care reform package. We urge you to encourage the Obama Administration to exclude the costs of prescription drugs administered in the physician's office from the SGR formula calculation **retroactively**. Before you consider building upon the faulty design of the current Medicare payment system with a public health insurance option that follows Medicare payment methodologies, we urge you to first correct the underlying problems with Medicare and not further exacerbate the funding situation.

**Primary Care.** The Alliance recognizes the importance of improving access to primary care for Medicare beneficiaries and strengthening the role of primary care providers. However, efforts should strive to maintain appropriate access to specialty care. Many surgical and specialty medicine disciplines have current or projected workforce shortfalls. In addition, specialty care has faced significant cuts over the years.

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 proposals 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.** We appreciate your mention that the increases could be paid for through other funding sources and would like to work with you to find an alternative mechanism to pay for any primary care and general surgery bonuses.

**Physician Quality Reporting Initiative.** 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. We appreciate your efforts to further improve and refine the Physician Quality Reporting Initiative. In particular, we thank you for recommending changes to PQRI that would allow physicians to access their data in a timely manner and have a reasonable appeals process. However, the Alliance is concerned that the two options for the PQRI are punitive in nature because the incentives are eliminated and replaced with penalties.

The Alliance supports options that would provide alternatives to the traditional method of participating in PQRI. For example, the idea of providing maintenance of certification (MOC) may increase participation in the program. Many specialties must recertify every ten years. Another option to consider is allowing physicians to qualify for the PQRI bonus for those physicians who accumulate a certain amount of continuing medical education (CME) credits every two years, which is another way physicians improve the quality of care they deliver. This should be an acceptable and less cost prohibitive option.

The Alliance fails to see how calculating incentives without regard to the geographic adjustment would improve PQRI as CMS currently recognizes that the cost of providing care can vary significantly by region and therefore the cost of improving the quality of care can as well. There is growing evidence that geographic variation is not solely due to arbitrary practice patterns or measurable differences in quality; therefore, further analysis of geographic variation is needed before payment differentials are eliminated. Therefore, we believe that to maximize participation nationwide, CMS must include the geographic adjustment when calculating bonus payments earned under PQRI.

In addition, the Alliance recommends that the Committee consider additional changes to PQRI, including verifying quality information before making it public and ensuring that the program has adequate funding. The increased systems cost to report quality measures should be recognized and physicians provided with adequate funding to implement reporting requirements.

We encourage the Committee to consider establishing a public private partnership to provide long-term support for clinical data registries and measure development currently undertaken solely through the limited resources of medical specialty societies. Additionally, the PQRI program should reward physicians who report clinical data to such registries.

**Health Information Technology.** With respect to your recommendation regarding the expansion of the eligibility for the electronic health record (EHR) Medicare incentive payments to include nurse practitioners and physicians assistants, the Alliance has no concerns regarding this expansion. However, we would like to take this opportunity to point out some concerns that we do have regarding 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.

**Comparative Effectiveness Research.** The Alliance is pleased with the comprehensive focus on comparative effectiveness research (CER), including the focus on transparency, public input, and patient safeguards. Like the Committee, the Alliance believes CER 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. With the options provided, the Alliance would prefer the public-private funding partnership and independent structure of CER to be similar to S. 3408 (110<sup>th</sup> Congress). The Alliance also urges the Committee to include medical liability protections for health care providers when they follow practice guidelines recommended by the CER entity.

**Physician-Owned Hospitals.** 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 patients 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.

**Physician Sunshine.** The Alliance is pleased that the Committee appears to have adopted a proposal similar if not identical to the "Physicians Payment Sunshine Act of 2009" (S.301) introduced by Senators Grassley and Kohl. The Alliance believes that while relationships between physicians and Industry are an important component of advancing medical technologies and improving patient care, uniform procedures for transparent disclosure must be in place to minimize confusion and misrepresentation. The proposals outlined will strengthen transparency in the medical profession and uphold the professional standards that professional medical societies have in place to govern interaction between physicians and the pharmaceutical and device industry. The Alliance encourages the Committee to adopt language that would provide physicians with the ability to correct inaccuracies in their report and provide background information on their relationships with industry prior to the public release of this information. Addressing the questions asked by the Committee, the Alliance believes that the reporting threshold of \$100 per recipient is appropriate and suggests expanding disclosure beyond individual physicians and include transfers of value from industry to physician group practices, hospitals and research centers. However, we would be very concerned of any restrictions on funding of continuing medical education (CME) courses, which already are managed for conflict of interest through the accreditation process overseen by the American Council for Continuing Medical Education (ACCME). There is a legitimate place for ethical partnerships between industry and medical associations and this support has long helped support the advancement of cutting edge science, clinical innovation and continuing medical education.

**Development of a National Workforce Strategy.** It is important to consider workforce issues as you consider health reform. Specialists are an integral part of American medicine and as you work with the Committee on Health, Education, Labor and Pensions (HELP) to develop workforce policy options, the Alliance urges you not to take access to specialists for granted.

It takes more than 12 years to produce a specialist. 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.”*<sup>1</sup> 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.”*<sup>2</sup>

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.<sup>3</sup>

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

**Accountable Care Organizations.** The Alliance appreciates the Committee’s efforts to allow groups of providers to voluntarily work together to improve quality and save costs. We support exploration of alternative payment systems. However, to succeed, we believe specialty medicine must be an integral part of the planning and execution of these various models. We appreciate that the proposed ACOs are voluntary and inclusive of all providers wishing to participate. As you explore these alternative systems, we urge you to consider the full cost of the treatment of disease and not focus on a single event. Our vision should remain long term and not result in pressure to save money in the short term for a single event/procedure, only to require additional interventions down the road because of choices made in a vacuum. Therefore, it is important to fully test alternative systems to understand their implications on quality of care and determine whether they achieve their stated goals.

**Quality Measurement.** Building on the provision set forth in the Medicare Improvements for Patients and Providers Act (MIPPA), the committee proposes to provide additional resources to the Department of Health and Human Services, working in cooperation with the Agency for Healthcare Research and Quality (AHRQ) and CMS, to further strengthen and improve quality measurement and development processes. The Alliance welcomes this proposal and recommends that these resources be used to fill gaps in clinical research that will allow us to build a better supply of evidence-based clinical practice guidelines; to fund clinical data registries and other innovative quality improvement activities; to develop valid risk adjustment mechanisms that will allow us to take full advantage of clinical outcomes data; and to conduct studies on whether currently used measures have any impact on quality and cost.

We also appreciate that the proposal recognizes the need for measures to focus on a range of important areas, including patient outcomes, functional status, patient experience/satisfaction, and care coordination. However, we urge the committee to carefully consider the implications of measuring efficiency. Cost should not trump quality and information accrued from measures should be presented in a manner that is meaningful and actionable to both physicians and eventually patients.

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

<sup>2</sup> Ibid, page 13

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

We have concerns about the proposal's continued heavy reliance on only NQF-endorsed measures. The National Quality Forum (NQF) is certainly the most balanced, structured, and fluid of all the current multi-stakeholder groups. However, its ever-expanding size and scope often make it difficult for the NQF to focus on unique quality improvement activities that are most relevant to smaller specialties, such as outcomes measures that rely on clinical data sources.

Finally, the proposal calls on the HHS Secretary to "develop a strategy for improving the public reporting of quality and performance information." While we recognize the value of public reporting and the need to improve the manner in which information is distributed to various stakeholders, Congress must very carefully consider the unintended consequences associated with releasing individual physician data to the public prematurely. If measures are not meaningful and data are not adjusted accurately (and few valid risk-adjustment mechanisms currently exist) or presented in an understandable manner, it may create further confusion among patients, limit patient's access to care as physicians avoid high-risk patients or otherwise game the system and/or unfairly harm the reputation of a physician and increase one's exposure to medical liability. Public reporting, if adopted prematurely, creates perverse incentives and discourages the very collaborative spirit and trust that is currently needed among health professionals. Furthermore, the measures on which public reporting would be based have not yet been tested and their true effect on quality/cost is unknown.

**Imaging – Transparency in Self Referrals.** While the Alliance understands that your proposal to amend the in-office ancillary services exception to the physician self-referral prohibitions under Stark may provide an administrative burden on physician practices, we believe it is a fair and reasonable approach to providing ethical referral to physician-owned imaging services. Furthermore, the Alliance believes that specialists that are experienced in diagnostic radiologic methods are fully competent to supervise the performance of and interpret imaging studies in their offices for the evaluation and management of certain conditions. Many specialists perform the immediate and timely interpretation of imaging studies, correlate these studies with clinical findings, and assume the responsibility for determining the treatment of their patients. The quality and accuracy of imaging studies and interpretations performed by these specialists are consistently high.

As the details of the proposal are further developed, the Alliance urges the Committee members to consider, with respect to frequency of disclosure, the utility and burden of providing patients with a list of alternate suppliers "at the time of referral." In particular, we are concerned about multiple referrals to the same patient, the usefulness of subsequent disclosures, and the burden to the patient and physician. Providing the list to the same patient in multiple instances will neither improve quality nor lower costs, and it risks confusing the patient and adding administrative costs. We propose that, after the initial disclosure to a particular patient, physicians would then be required to make a disclosure annually to that patient. With a clarification regarding the frequency of disclosure and provision of alternate providers to a single patient, the physician specialty community agrees that transparency and informed decision-making can increase the integrity of our health care system.

**Imaging – Appropriateness Criteria.** The Alliance recognizes that appropriateness criteria would improve patient care provided they are developed in conjunction with the national specialty societies developing quality guidelines for each specialty. We greatly appreciate your recognition of this in the Options Paper and urge you to maintain the requirement that HHS work with the physician specialty societies to achieve this. We are very concerned that the timelines proposed in the Options Paper are too ambitious.

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. In fact, we have member organizations willing to test options, provided they are not penalized for it. Penalties should not be imposed before there is a full understanding of growth in this area. 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. Also, poor quality of a previous scan may lead to a new scan. It is our hope that the imaging accreditation provisions of MIPPA will improve the quality of imaging equipment and thus reduce the need to order additional scans due to poor quality.

The Alliance opposes the use of radiology benefit managers (RBM) and is concerned that RBMs may prevent patients legitimately requiring imaging to have timely access to these services.

In closing, the Alliance would like to state that the absence of options 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 system 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 any health care reform package that is introduced.

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. For your convenience, we enclose a copy of our recent testimony before the Senate HELP Committee which provides additional comments in a number of areas discussed above.

Thank you for commitment and leadership on this issue. Please contact Vicki Hart if you have any questions or would like additional information. Ms. Hart may be reached at 202-441-3515 or [vhart@hhstrategies.com](mailto:vhart@hhstrategies.com).

Sincerely,

American Association of Neurological Surgeons  
American Association of Orthopaedic Surgeons  
American Gastroenterological Association  
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