SCOTUS Decision on Health Reform Law Prompts Reaction from Specialty Physicians

In a press release following the Supreme Court’s historic decision addressing the constitutionality of the Patient Protections and Affordable Care Act (PPACA) of 2010, the Alliance of Specialty Medicine called for repeal of problematic provisions in the health reform law, including the Independent Payment Advisory Board and the Value-Based Payment Modifier.

“While we certainly respect the Supreme Court’s decision, we will not be deterred from working to reform or repeal certain aspects of the Affordable Care Act that are onerous to the practice of medicine and are detrimental to patients’ access to quality care,” the Alliance states.

The specialty physician coalition has been working very hard with the Congress and the regulatory agencies to make certain doctors’ voices are heard loud and clear on how this law would affect patient care.

In addition, the Alliance will continue efforts to repeal the flawed sustainable growth rate (SGR) formula used to update Medicare payments to physicians and to pass medical liability reform – two critical aspects of health reform that were not included in the law.

Alliance in the News

The Alliance of Specialty Medicine was recently quoted in the following publications:

♦ *Inside Health Policy*: “Physician Specialists Ask CMS To Delay Duals Demonstration” – May 29, 2012
♦ *Modern Healthcare*: “Specialists push for more time on dual-eligibles demo” – May 27, 2012
♦ *CQ Healthbeat News*: “Specialists Urge One Year Delay in Demo Moving Duals into Managed Care” – May 25, 2012
♦ *The Hill’s Healthwatch Blog*: “Medical specialists push back on initiative from healthcare law” – May 25, 2012
Specialty Physicians Head to Capitol Hill

Maintaining access to specialty medicine, ensuring quality reporting mandates are meaningful and relevant, and securing Medicare physician payment reform are among the primary messages specialty physicians will bring to Capitol Hill during the Alliance of Specialty Medicine’s Advocacy Conference on July 10-11.

The Alliance has long worried about deteriorating access to specialty care as a result of failed policies, the largest of which is the broken Medicare physician payment system that bases updates on the flawed sustainable growth rate (SGR) formula. The Alliance will call on Congress to pass a permanent SGR fix prior to the end of the year and support legislation that would empower Medicare beneficiaries to see the physician of their choice by permitting private contracting.

In addition, the Alliance continues to oppose the Independent Payment Advisory Board (IPAB). Since the health reform law was enacted, the Alliance has urged its repeal, supporting legislation that would eliminate the board. While the Alliance recognizes the need for more sustainable healthcare costs, Medicare payment policy requires a broad and thorough analysis of providers and beneficiaries. Leaving these decisions in the hands of 15 unelected, unaccountable governmental bureaucrats with little or no clinical expertise and minimal Congressional input will most certainly have a negative impact on the availability of quality, efficient health care to Americans. To that end, the Alliance will call on Congress to support IPAB repeal efforts.

Finally, while the Alliance wholly supports efforts to improve the quality and efficiency of health care, it remains concerned that federal quality initiatives—such as the Physician Quality Reporting System (PQRS), the Electronic Health Record (EHR) Incentive Program, and the e-Prescribing Incentive Programs—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. To that end, the Alliance will urge Congress to ensure that physician quality reporting mandates are meaningful and relevant to specialty physicians and their patients and request a delay in the implementation of the Physician Value-Based Payment Modifier (VBPM).

SEE Joins the Alliance!

The Alliance of Specialty Medicine welcomes its newest member, the Society for Excellence in Eyecare (“SEE”). Members of SEE are leaders and innovators in their profession who are committed to the belief that they can best promote the interest of their patients through a cooperative effort, and by providing support for each other through the development and exchange of best practices, both clinical and administrative, and through peer review advocacy.

Learn more about SEE by visiting www.excellenteyesurgery.com.
Alliance Comments on the Medicare Overpayments Rule

In a letter to CMS, the Alliance of Specialty Medicine shared concerns with the agency’s recent proposal on returning and reporting Medicare overpayments. The rule, stemming from a provision in the Affordable Care Act, would require providers receiving funds under the Medicare program to report and return overpayments 60 days after the date on which the overpayment was identified. Failure to comply could prompt action by the agency under the federal False Claims Act and Civil Monetary Penalties Law.

Alliance member organizations raised concerns with the “onerous and burdensome” provisions in the regulation, including the 10-year look back period and the definition of “identified overpayment.”

“This time-frame is pushing the outer limit of the False Claims Act, which is designed to identify intentional fraud not routine errors,” explains the Alliance. “We recommend the look-back period be limited to three years, to be consistent with other CMS audit programs.”

The Alliance also urges CMS to adopt a policy allowing the 60-day period to begin at the completion of the review confirming the overpayment.

“Chasing down the detail of such a situation could take considerable effort and conceivably more than 60 days.”

In addition, the Alliance raised concerns about the lack of coordination with other CMS audit programs, such as the Recovery Audit Contractors (RACs) and the Comprehensive Error Rate Testing (CERT) program, and the harsh penalties associated with the rule.

“Meaningful Use” Remains Challenging for Most Specialty Physicians

In comments on a proposal outlining stage 2 “meaningful use” requirements as part of the Electronic Health Record Incentive Program, the Alliance raised a number of concerns and made several recommendations to improve the program for specialty providers. In general, the Alliance remains concerned that the program continues to be geared toward primary care, putting specialists at a disadvantage.

A chief concern of specialists is measures that hinge performance on patient action. Specifically, the Alliance objects to core measures that propose to measure a physician’s performance based on a patient’s willingness and motivation to engage in specific activities, such as secure messaging or downloading online data. According to the Alliance, it is unreasonable to propose a percentage of patients that must meet these criteria since the behavior falls outside the physician’s control.

In addition, specialty providers are concerned with a number of other measures, most of which are geared toward primary care providers. For example, a measure that would require ongoing submission of electronic immunization data does not universally apply to many specialists. As a result, the Alliance called on CMS to maintain this measure in its “menu” set, rather than moving the measure into the core requirements for all providers.

The letter in its entirety may be read at: www.specialtydocs.org.
Alliance member organizations recently expressed concern over the direction and speed of implementation of the CMS dual integration demonstration and the potential adverse effects it could have on access to specialty care for the dual-beneficiary population.

In a letter to CMS, the specialty coalition notes that patients could be at risk without appropriate safeguards to ensure continuity of care, particularly in light of states’ proposals to implement passive enrollment processes.

“Passive enrollment happens regardless of a choice and often without either clear knowledge or desire,” explains the coalition.

To that end, the Alliance calls on CMS to reject proposals which call for statewide implementation or use passive enrollment to make coverage changes for hundreds of thousands of patients at a time.

In addition, the Alliance calls for strong federal oversight, given most Medicaid managed care plans have historically been focused on the care of children and families, and have little or no experience with the more complex needs of the frail elderly or patients who are mentally ill, developmentally disabled, or institutionalized.

“CMS should carefully ensure it has the necessary infrastructure and processes in place before accelerating large scale implementation of the duals demonstration.”

The specialists also express concern over the potential for inadequate provider reimbursement that could restrict access to needed care.

“We have significant concern that while demonstrations aspire to reduce fragmentation of care, they will in practice lead to unsustainable cuts in provider payment rates, which will consequently reduce access to care”

As a result of their concerns, the Alliance asks that implementation of the duals demonstration be delayed by at least one year so patients, providers and other stakeholders have adequate time to better understand, evaluate and comment on the demonstration program.

Read the full comment letter at: www.specialtydocs.org.

Dual-Eligible Demos May Disrupt Care, Restrict Access to Specialists
Specialty Spotlight: AGA Unveils List of Treatments Doctors, Patients Should Question

AGA, in coordination with the American Board of Internal Medicine Foundation, Consumer Reports and eight leading medical societies, participated in the launch of Choosing Wisely®, a campaign to identify the overuse or misuse of tests or medical procedures.

Lawrence R. Kosinski, MD, MBA, AGAF, chair, AGA Institute Practice Management and Economics Committee (pictured above), represented AGA at a press conference in Washington, DC, announcing the campaign to patients, consumer advocacy groups and government organizations. Media coverage from the campaign includes articles in The New York Times, USA Today and The Washington Post.

“The AGA feels this list focuses on issues of importance to disease prevention,” stated Dr. Kosinski during the press conference. “We feel our patients will benefit from the fact that we are using accepted guidelines to tell them when to have procedures done, by whom to have the procedures done, and when they should come back, even to the point to tell them ‘no, it’s not time for you to come back yet.”

AGA's participation in the campaign is a natural extension of our years of work defining quality GI care and giving gastroenterologists tools for working with patients. In developing the list, AGA targeted the most common issues and most commonly performed tests that GIs want patients to have done, but which have the potential to be the most frequently abused in the process. AGA's list of Five Things Physicians and Patients Should Question is:

1. 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.

2. Do not repeat colorectal cancer screening (by any method) for 10 years after a high-quality colonoscopy is negative in average-risk individuals.

3. 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.

4. 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.

5. 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.

Learn more about Choosing Wisely and read all nine lists at: www.ChoosingWisely.org.

Disclaimer: 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.

The following is an Op-Ed written by Chiledum A. Abaghotu, M.D., F.A.C.S., Chief of Urology at Howard University Hospital rebutting the recent USPSTF recommendation on PSA Testing and discussing the issue and its implications as a healthcare disparity question.

Prostate cancer remains the leading cause of cancer in men in the United States. Over 28 thousand men are estimated to die from prostate cancer this year alone. Also, for reasons that are not completely understood, African-American men are 60% more likely to be diagnosed with prostate cancer and 2.5 times likely to die of the disease. The PSA test is a blood test that measures prostate-specific antigen (PSA), a protein produced by the prostate gland. An increase in the PSA level is often the only sign of early prostate cancer. The PSA test is also valuable in following patients after treatment.

In November 2011, a US Preventative Services Task Force (USPSTF) Committee announced a preliminary recommended that PSA testing should no longer be performed routinely on men in the United States. The task force came to this decision based on studies performed in the United States and Europe suggesting that prostate cancer screening does not appear to improve survival in patients with this disease. The two principal studies quoted in the report are the prostate, lung, colon, and ovarian screening study (PLCO) and the European randomized prostate cancer screening study. Both studies followed men who were screened, comparing them to those who were not screen over a 7-10 year period. The European study actually revealed an improvement in survival whereas the American study did not, thus reporting conflicting results. The committee provided a 6-month response period for public feedback. Despite tremendous opposition from prostate cancer experts, legislators, healthcare advocates and cancer survivors across the country, the task force upheld its preliminary recommendations as reported last month.

One of the major concerns raised by opponents of the report is the fact that the studies that were sited lack representation by African-American participants. Thus, their results may not be applicable to that group of men. Another serious criticism of the report is the committee’s lack of concern for the impact of their recommendation on the promotion of debilitating stages of prostate cancer. In the pre-PSA era, most men who presented with prostate cancer had evidence of metastatic disease. In other words the cancer had already spread throughout the body, causing a host of disabling symptoms. The USPSTF committee also failed to acknowledge the impact of screening on declining cancer death rates. Despite these recent trends, African-American men continue to carry a disproportionately higher death rate and, among men under the age of 60, are 4 times more likely to have metastatic disease at diagnosis.

It is also striking that none of the task force committee members have specific clinical expertise in treating prostate cancer. This attempt to apply a broad-sweeping policy to a very complex disease affecting populations disproportionately is very short sighted. The bottom line is that fewer men are dying of prostate cancer and it is very likely that early detection has played a role in this outcome. Although the PSA test cannot take all the credit, it has been the cornerstone for early detection over the last 2 decades. There is ongoing research to find better screening strategies. However, until these tests have been confirmed, PSA is an important part of early detection and should not be blatantly discarded, especially as it applies to high-risk populations such as African-American men. It is comparable to “throwing the baby out with the

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bathwater,” and in this case, African American men are being thrown out with the bathwater.

Any man interested in having a PSA test should have meaningful dialogue with his healthcare provider to understand the details of the test, its value, and possible shortcomings. That should have been the message from the report. I strongly encourage stakeholders in the fight against prostate cancer to continue to challenge the rationale and method of decision-making by the USPSTF committee on the use of PSA testing in early detection of prostate cancer involved in prostate cancer care will continue strongly to these recent recommendations.

Learn more about the USPSTF’s recommendation on PSA testing and recently introduced legislation aimed at addressing concerns with the USPSTF by contacting the American Urological Association (AUA) at www.auanet.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, visit our website at www.specialtydocs.org or contact Vicki Hart at vhart@hhstrategies.com