



Sound Policy. Quality Care.

November 5, 2009

Honorable Nancy Pelosi
Speaker of the House
U.S. House of Representatives
Washington, DC 20515

Honorable Steny Hoyer
Majority Leader
U.S. House of Representatives
Washington, DC 20515

Honorable Charles Rangel
Chair, Committee on Ways and Means
U.S. House of Representatives
Washington, DC 20515

Honorable Henry Waxman
Chair, Committee on Energy and Commerce
U.S. House of Representatives
Washington, DC 20515

Honorable Fortney "Pete" Stark
Chair, Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives
Washington, DC 20515

Honorable Frank Pallone
Chair, Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives
Washington, DC 20515

Dear Madam Speaker, Majority Leader and Chairmen Rangel, Waxman, Stark and Pallone:

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. We sincerely appreciate your work to produce H.R. 3962, the "Affordable Health Care for America Act" and H.R. 3962, the "Medicare Physician Payment Reform Act" and we would like to take this opportunity to provide feedback on issues of importance to specialty physicians.

Physician Payment Update (H.R. 3961). The Alliance appreciates your recognition that an integral part of health reform is a successful change to the underlying physician payment update. In order for the health care system to move forward with important system delivery reform, the physician reimbursement system must be stable to continue to assure Medicare beneficiary access to high quality care. Therefore, we strongly support passage of the "Medicare Physician Payment Reform Act." Like you, we agree that Medicare's sustainable growth rate (SGR) formula needs to be replaced with a stable mechanism for updating Medicare fees and we applaud your continued efforts to address this long-standing problem. Ideally any system that replaces the SGR would update payments based on the Medicare Economic Index, which would allow reimbursements to be based on the cost of providing care to our nation's elderly.

We appreciate your efforts to maintain appropriate access to specialty care while you shift health care towards preventive care. Preventive care is routinely provided by specialists in a number of different venues and should be rewarded in the same way as preventive care provided by any physician. We also support your efforts to ensure these rewards are not distributed in a budget neutral fashion. Budget neutral funding does not take into account significant reductions specialists have seen in their fees over time for the services they provide. Since the introduction of Medicare's Resource-Based Relative Value Scale (RBRVS) in 1992, specialists have seen significant reductions in the fees they received for procedural services. Many specialty medical services were cut in 2008 for a second time during this

review because of an additional reduction in work values. Specialists continue to lose more ground in the fees they receive for serving Medicare beneficiaries while their practice costs steadily rise.

Physician Quality Reporting Initiative (section 1124). All member organizations of the Alliance 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 (PQRI). In particular, we thank you for including changes to PQRI that would allow physicians to access their data in a timely manner, provide physicians with a reasonable appeals process, and ensure that PQRI is not punitive.

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.

Value Based Purchasing (sections 1159 & 1160). As a general concept, value-based purchasing (VBP) has great merit. However, HHS is still working to determine the best way to do so, with the various demonstration projects we have already authorized. We are concerned that the timeline for an Institute of Medicine study, recommendations and implementation plan will short-circuit a process that will completely revamp the Medicare payment system. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) requires the Secretary to submit a report to Congress next year with a VBP program for Medicare payment. We should first allow HHS to further examine how to make this work best and allow the current demonstration projects to finish.

Health Information Technology (section 1124). The Alliance is pleased that the bill ensures clinical reporting on quality measures for PQRI and that the "meaningful use" definition included within the "American Recovery and Reinvestment Act of 2009" (ARRA) (P.L. 111-5) will be more fully integrated. However, we would like to take this opportunity to urge you to consider amending the current HIT timelines. 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. Therefore, we urge you to consider amending the current HIT timelines included in the ARRA.

Comparative Effectiveness Research (sections 1401, 1802 & 2401). The Alliance is pleased that your legislation includes a provision to expand comparative effectiveness research (CER). We believe appropriately designed 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. We appreciate the rules of construction to protect the physician-patient relationship and state that research may not deny or ration care. However, the Alliance is concerned that the proposed CER structure would be placed within the Agency for Healthcare Research and Quality (AHRQ). For a number of reasons, we would prefer that Congress establish an independent CER structure with appropriate input from specialty physicians providing the treatments being evaluated. Finally, the Alliance also strongly urges you to include medical liability protections for health care providers when they follow practice guidelines recommended by the CER entity.

Physician Sunshine (section 1421). 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 in your bill 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, biologics, and device

industry. We appreciate that H.R. 3962 clarifies the physician role regarding the accuracy of information and envisions a system to allow physicians to bring inaccuracies to the attention of those reporting.

We remain extremely concerned with the impact the provision in its current form will have on funding of continuing medical education 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.

Accountable Care Organizations (section 1301). 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, including your proposal for Accountable Care Organizations and appreciate that the legislation retains Rep. Eshoo's amendment to ensure inclusion of all physicians regardless of specialty. 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 or 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.

Public Health Insurance Plan Option (sections 323-325). The Alliance of Specialty Medicine does not have a specific position regarding the establishment of a public plan option; however, we appreciate that H.R. 3962 allows physicians to opt-out of participation, does not penalize physicians who choose not to participate, and does not tie reimbursement directly to Medicare rates.

Health Benefits Advisory Committee (section 123). The Alliance is concerned that the composition of the Health Benefits Advisory Committee does not require greater physician representation. We strongly support explicit language that guarantees that a minimum of three practicing physicians devoting at least one third time to direct patient care and representing different specialties will serve on the Committee.

Adjusting Reimbursement for Over-Valued Physician Services (section 1122). The Alliance is very concerned about the proposal to address suspected over-valued physician services by having the Center for Medicare and Medicaid Services (CMS) directly evaluate and adjust payment for potentially misvalued physician services because this proposal is unnecessary. Already, as part of the Resource-Based Relative Value Scale (RBRVS), AMA has established the AMA/Specialty Society Relative Value Scale Update Committee (RUC). The RUC provides recommendations to CMS for the valuation of new and revised codes as well as codes identified as misvalued under the Five-Year Review of Work. There already is a process in place which assures physician input from a variety of disciplines to examine potentially misvalued physician services. Therefore, we urge you to delete this section.

Physician-Owned Hospitals (section 1156). 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. The requirements laid out in the legislation that are 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 Congress not to discriminate against physician-owned hospitals.

Development of a National Workforce Strategy (sections 1501-1505). 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. 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. Any national workforce strategy must encourage participation by specialty medicine to ensure a stable, balanced workforce to meet future needs.

Improving Accountability for Approved Medical Residency Training (section 1505). Given Medicare’s \$9 billion annual investment in graduate medical education (GME), the Alliance appreciates the need for accountability in this system. However, we are very concerned about the provisions of the draft legislation that would (1) establish in statute the goals of medical education and (2) require a GAO study to evaluate residency training programs. The Accreditation Council for Graduate Medical Education (ACGME) has a very dynamic and robust system for ensuring that our nation’s training programs are meeting the needs of the 21st Century health care delivery system. The six core competencies that must be incorporated into the curriculum of every residency training program – patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice – demonstrate that the profession and medical educators are satisfying the goals of this provision of the draft bill. In addition, the individual specialty societies are also evaluating and reevaluating, on an ongoing basis, GME curricula. Medical education should remain in the purview of the profession and medical educators, and the Alliance firmly believes that the ACGME and specialty societies are doing a superb job in educating and training our Nation’s future physicians. We therefore urge you to delete this entire section of the bill.

Quality Measurement (section 1441). Your proposal provides additional authority to the Secretary of Health and Human Services, working in conjunction with AHRQ, 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 or 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.

We have concerns about the proposal's continued heavy reliance on NQF-endorsed measures, but appreciate the changes. 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.

Geographic Variation (sections 1157-1159). The Alliance is disappointed that the geographic variation provisions in the legislation are focused on costs and cost reduction rather than first examining treatment quality. A better focus should be reducing geographic variation in 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. It is established that there is geographic variation, but much more needs to be understood about the underlying reasons for these differences, including understanding the difference in patient access to care and the difference in physician supply and mix. It is more effective to understand the source of geographic variation and educate physicians about such differences and the resulting patient outcomes with the purpose of improving overall quality of care.

Medical Liability Reform (section 2531). While the Alliance firmly believes that federal medical liability reform based on the California or Texas models, which include, among other things, reasonable limits on non-economic damages, is the gold standard, we appreciate and support the inclusion of Rep. Bart Gordon’s amendment which seeks to encourage states to adopt liability reforms. However, we urge you to strengthen this provision as H.R. 3962 moves through the legislative process because we believe these modest medical liability reforms will not fully alleviate the crisis faced in many states and specialties. One of the key goals in health care reform is to bend the curve in federal spending. As you

are aware the Congressional Budget Office recently scored comprehensive and proven medical liability reforms, as outlined 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.

National Medical Device Registry (section 2571). The Alliance is strongly opposed to the inclusion of this section due to concerns that the National Medical Device Registry (NMDR) could be subject to subpoena or FOIA requests by personal injury attorneys and then used to exacerbate the medical liability crisis. There are no protections for any physician level data in this language which is ill-advised at a time when the public overwhelmingly supports comprehensive tort reform. Additionally, the NMDR would duplicate several post-market programs including those authorized but not yet implemented in the Food and Drug Amendments Act of 2007. We urge you to delete this section from HR 3962.

Thank you for your 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.

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