Alliance of Specialty Medicine

Sound Policy. Quality Care.

February 19, 2010

President Barack Obama
The White House
1600 Pennsylvania Avenue, N.W.
Washington, DC 20500

Dear Mr. President:

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 this historic opportunity to improve access to quality health care through broader health care reform. As you work to develop your own framework for health care reform, we would like to take this opportunity to provide feedback on issues of importance to specialty physicians.

INDEPENDENT PAYMENT ADVISORY BOARD

Our primary request is that you **not include an Independent Payment Advisory Board (IPAB)** or any other board resulting in an inappropriate delegation of Congress's oversight responsibilities. Already, Medicare reimbursement rates are well below market rates, and it will likely only get worse. The IPAB solution will further ratchet down the costs, without oversight, without care taken to ensure that our seniors receive the quality health care that they need and deserve. Further, at least as currently constructed by Congress, the Board does not have full authority over the health care system but rather is required to selectively exempt certain providers from its purview – placing more pressure to cut Medicare in those areas under its jurisdiction. We do not support allowing important health care decisions to be made with little clinical expertise, resources, or the oversight required to ensure that seniors are not placed in jeopardy.

MEDICARE PAYMENT POLICY PROVISIONS

Sustainable Growth Rate (SGR)– As stated in your last two budget requests, you have made it clear that "honest budgeting" must account for a permanent fix to the Sustainable Growth Rate (SGR) formula, and **we urge you to provide a permanent SGR fix as part of your health care reform proposal**. 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 actual cost of providing care to our nation's elderly. While individuals continue to work toward a permanent solution to the SGR, this critical policy issue must be addressed by February 28 to prevent drastic physician reimbursement cuts. **We urge you to place a high priority on meeting the deadline to avoid Medicare cuts and provide a permanent fix for the Medicare physician payment formula.**

Protecting Access to Specialty Care -- We appreciate efforts to maintain appropriate access to specialty care while shifting health care delivery toward greater preventive care. **We also believe these efforts should NOT be distributed in a budget neutral fashion, which is why we are appreciative of the congressional proposals that allow for additional Medicare primary care payments but not at the expense of specialty care.** In addition, we support proposals which allow **specialists to participate in the accountable care organization demonstration programs**.

However, Congress has proposed a variety of Medicare payment provisions which, if enacted, will be detrimental to patient care. As you consider your own health care proposal, **we strongly urge you to EXCLUDE the following congressional provisions from your proposal**:

- ***Center for Medicare and Medicaid Innovation*** (sections 3021 and 10306 of HR 3590) which inappropriately delegates Congress's oversight responsibilities.
- ***Value-Based Purchasing*** (sections 1159 & 1160 of HR 3962 and section 3007 and 10301 of HR 3590) which arbitrarily accelerates the current value-based purchasing program before the demonstrations are completed and previously mandated reports are completed. Also, we do not support the new budget neutral modifier in Section 3007 of HR 3590.
- ***Mis-Valued Physician Payment Services*** (section 1122 of HR 3962 and section 3134 of HR 3590) which create additional layers of bureaucracy to review payment codes and fail to provide adequate physician input.
- ***Geographic Variation*** (sections 1157-1159 of HR 3962 and section 3102 of HR 3590) which is used as a marker for quality of care, but focused on costs and cost reduction rather than treatment quality.

QUALITY PROVISIONS

Comparative Effectiveness Research (CER) -- We strongly **support appropriately structured comparative effectiveness research as outlined in sections 6301 and 6302 of HR 3590 and urge you to include those provisions in your health care reform proposal.** 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.

Physician Quality Reporting Initiative (PQRI) -- We appreciate efforts to further improve and refine the Physician Quality Reporting Initiative (PQRI) (as outlined in section 1124 of HR 3962 and section 3002 of HR 3590). In particular, **we urge you to include in your health care reform proposal changes that were included in section 1124 of HR 3962 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.**

***Health Information Technology (HIT)* --** The Alliance is pleased that Congress understands the need to ensure 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, and urge you to include those changes in your health care reform proposal. In addition, **we urge you to amend 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.

In addition, there are a variety of quality provisions which, if enacted, would have detrimental effects on patient care. As you outline your own health care reform proposal, **we strongly urge you to EXCLUDE the following provisions**:

- ***Physician Compare Website*** (section 10331 of HR 3590) which will provide patients with confusing and conflicting information.
- ***Hospital Readmissions*** (section 1151 of HR 3962 and section 3025 of HR 3590) which fails to ensure that measures used to report readmission data are evidence based. At this juncture, the measures are not fully developed, approved or validated. The measures could penalize the specialties that have been at the forefront of measurement development and discourage the future development of similar measures. Additionally, the legislation requires payment reductions even if all unnecessary admissions are eliminated. There needs to be an agreed upon acceptable rate of readmissions. As you acknowledged in your letter to Sen. Kennedy and Sen. Baucus on June 2, 2009, the focus should be on "unnecessary hospital readmissions," not on all readmissions.

MEDICAL LIABILITY REFORM

Mr. President, as outlined by the Congressional Budget Office, 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. For those reasons, we were heartened when you stated in last fall's New England Journal of Medicine that you would be "open to additional measures to curb malpractice suits and reduce the cost of malpractice insurance." More recently, at the American Medical Association's Annual Meeting, you 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." We therefore appreciate your recognition that comprehensive health care reform must include medical liability reform. 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 additional efforts to address this issue. Therefore, we strongly support more comprehensive proposals for medical liability reform as outlined in various Senate amendments, including Hatch D8-D10 (non-economic caps), Kyl C25 (caps, expert witness, and other changes), as well as a variety of proposals which provide state incentives for caps on non-economic damages (e.g., Ensign D3-D4, Enzi D2, Cornyn D13, and Cornyn D18). We also support additional reforms for medical liability as outlined in Carper D4 (Sense of Senate), Carper D5 (safe harbor), Ensign D1 (liability protections for pro bono work), Ensign D2 (liability protections for assisting with disaster relief), Enzi D1 (state incentives for medical liability reform), Cornyn D 16 (settlement offers), Cornyn D 17 (safe harbor), Cornyn D19 (certificate of merit), Cornyn D20 (periodic payments), Kyl C24 (emergency room services), and Hatch F22 (charges for attorney's fees). If, however, your medical liability proposal focuses on the current Congressional legislation, we urge you to include **section 2531 of HR 3962 (and NOT section 10607 of HR 3590) because section 2531 of HR 3962 provides stronger incentives for appropriately designed State medical liability demonstration projects with measureable results**. As you further refine the proposal, we strongly encourage you to **expand the State options as originally proposed in the House Committee on Energy and Commerce** to provide a full range of solutions to this drastic problem.

OTHER KEY ITEMS

Physician Sunshine Act – If, Mr. President, you decide to include provisions related to Physician Sunshine, we urge you to include **section 6002 of HR 3590 (and NOT section 1421 of HR 3962)**. 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. Due to key differences within the proposals, the Alliance supports section 6002 of HR 3590, given that section 1421 of HR 3962 will have a detrimental impact on funding of continuing medical education (CME) courses.

Health Benefits Advisory Committee – If you opt to include a provision related to a Health Benefits Advisory Committee (as outlined in section 123 of HR 3962), **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.

Imaging provisions – If you consider provisions related to utilization rates for imaging services, we urge you to include specific changes included within the Congressional proposals to ensure that ultrasound and X-ray are not included but rather focus on more advanced, expensive imaging services and not catalog all imaging services into one category. As you know, the MedPAC recommendation upon which this policy proposal is based only applied to advanced imaging equipment, with a cost of one million dollars or more. Ultrasound equipment cost on average $40,000 -- far less than MedPAC's recommendation.

We urge you NOT TO INCLUDE the following provisions in your health care reform proposal:

- ***National Medical Device Registry*** (section 2571 of HR 3962) which could be subject to subpoena or FOIA requests and exacerbate the medical liability crisis. We are concerned that there are no protections for any physician level data and it would duplicate current post-market programs including those authorized, but not yet implemented, by the Food and Drug Amendments Act of 2007.
- ***Physician-Owned Hospitals*** (section 1156 of HR 3962 and section 6001 of HR 3590) which focus referrals on ownership and not overall quality of care.

- ***Medical Residency Training*** (section 1505 of HR 3962)**.** 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 HR 3962 that would (1) establish in statute the goals of medical education and (2) require a GAO study to evaluate residency training programs.
- ***Excise tax on certain elective medical procedures*** (previously section 9017 of HR 3590) 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 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.

We applaud many of the health care reform provisions 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 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.

Thank you for your commitment and leadership on this issue. If you have any questions or would like additional information, please e-mail us at info@specialtydocs.org.

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