



Sound Policy. Quality Care.

---

August 5, 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 (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 ongoing work to craft a health care reform proposal that will benefit all Americans.

As you work to craft your legislation, the Alliance wishes to re-iterate the following concerns: (1) President Obama's proposal to create an independent agency within the Executive Branch that would be charged with determining Medicare payment rates and any similar proposal that would remove critical reimbursement rules and decisions from the purview of Congress (including S. 1110 and S. 1380); (2) the lack of a stable mechanism to replace Medicare's SGR formula for updating Medicare fees; and (3) using budget neutrality to offset the costs associated with increasing reimbursements for primary care and general surgery.

**MedPAC/IMAC Proposals.** *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 MedPAC's reimbursement and cost reduction recommendations to be implemented unless opposed by a joint resolution of the Congress. We believe that such a change would place many important reimbursement and patient care decisions into the hands of a body that is unelected and largely unaccountable. 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 MedPAC 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, the MedPAC and Independent Medicare Advisory Council (IMAC) proposals are 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. It is particularly troubling that all of this could be done with little or no government oversight.

Such drastic measures are highly likely, given that this newly organized body must recommend and implement payment policies that are “financially sustainable.” While we agree that a financially sustainable Medicare program is beneficial for all Americans, recent scoring from the CBO on these proposals show that they would have little impact on overall Medicare spending while putting at risk patient access to high quality care. If the goal of a revised MedPAC or the creation of IMAC is to find new ways to eliminate spending in the Medicare program, the Alliance believes that these proposals will not be able to achieve this goal given the most recent review by the CBO, and 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. The Alliance believes that MedPAC or the proposed IMAC have neither the clinical expertise nor the research capacity to examine the national and regional effects of proposed recommendations to ensure patients are not unduly impacted. We therefore strongly urge you to reject any proposal to alter MedPAC’s current advisory status or establish a new entity that would make important health care decisions without the clinical expertise, resources or oversight required to ensure that patient care is not placed in jeopardy.

**Sustainable Growth Rate (SGR).** The Alliance is discouraged by reports that the proposal under discussion does not provide a permanent solution for the sustainable growth rate (SGR). ***Medicare’s 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. While acknowledging the central importance of ensuring the financial integrity of Medicare into the future, the Alliance 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 options being discussed for even short-term solutions to the SGR and wants to work with the Committee to develop additional alternatives.

The current SGR predicament allows us to consider how the proposed MedPAC or IMAC proposals would have addressed the situation. The SGR was recommended by the Physician Payment Review Commission (PPRC) and broadly supported by Congress, the Administration and the medical community. However, within the first few years of enactment, it became apparent that the formula was fatally flawed. As MedPAC reviewed the SGR, they proposed two different solutions to Congress. In addition, the Government Accountability Office (GAO) and CBO made recommendations. To ensure Medicare's solvency, Congress must provide a long-term solution to the failed Medicare SGR funding formula. Tackling the SGR issue is difficult because of the significant costs associated with each of the various recommendations that have been proposed. Although an independent MedPAC/IMAC may have implemented the initial SGR proposal faster, we doubt it would have been vetted through Congress, the Administration and the medical community at the same level. After implementation, when the problems with the SGR formula became known, we question whether an independent body would have fixed it. The proposed MedPAC/IMAC language does not focus the entity on policy, but instead on cost savings. As physicians, we have to question if an independent body would seek to fix the SGR problem on its own or arbitrarily opt for drastic physician cuts to meet an annual savings quota, a policy that would certainly impact patient access and quality. The construct of the language focuses MedPAC/IMAC on cutting provider payments, which is in opposition of the true purpose of comprehensive health care reform, and carves out many areas of Medicare for which recommendations would not be allowed. We understand that some in Congress feel that it will be easier to cut Medicare if left to an independent body, but we strongly caution you that such deferrals only result in bigger problems that will be left to Congress to eventually solve. Given the experience of the SGR implementation and the need to replace it, as well as the critical nature by which Congress needs to ensure access for Medicare beneficiaries, the Alliance strongly believes that the appropriate oversight and reform must stay within the hands of those elected to oversee government spending and public interests and not inappropriately delegated to closed door negotiations

**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 part of the American Medical Association's (AMA) Specialty Society Relative Value Update Committee (RUC) process.

As Medicare payments have continued to decline steadily over the past few years, significant steps have been taken to improve reimbursement for primary care. In fact, the most recent Five-Year Review completed in 2007 by the RUC and approved by the Centers for Medicare & Medicaid Services (CMS), resulted in the shifting of more than \$4 billion from services provided mainly by specialists to evaluation and management (E/M) codes. 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

Chairman Baucus and Senator Grassley  
August 5, 2009  
Page 4

be attributed largely to the work of the physician community through the RUC. Most recently, CMS has proposed several changes in the 2010 Medicare Physician Fee Schedule that will significantly increase reimbursement for primary care physicians – 8 percent for family physicians and 6 percent for general internal medicine.

Budget neutral funding does not take into account significant fee reductions specialists have experienced over time for the services they provide. With the introduction of Medicare’s Resource-Based Relative Value Scale (RBRVS) in 1992, specialists have seen significant fee reductions for procedural services. Although modest increases have been provided for some physician services in recent years, they have not kept pace with the rate of inflation nor have all physicians seen increases. In fact, many surgical services in 2008 were cut for a second time during this review because of an additional reduction in work values. Specialists are continuing to lose more ground in reimbursement 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 suggestions that increases could be paid for through other funding sources and are interested in working with you to find an alternative mechanism to compensate for any bonus payments for primary care or general surgery.

As you continue to draft a proposal to be considered by the Committee, we hope that you will take our comments and suggestions into account, as well as the unique role of specialty medicine.

Thank you for commitment and leadership on this issue.

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

Cc: Members of the Finance Committee, Senate leadership