



Sound Policy. Quality Care.

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May 29, 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 your May 14, 2009 options paper entitled "Expanding Health Care Coverage: Proposals to Provide Affordable Coverage to All Americans" and your May 20, 2009 options paper entitled "Financing Comprehensive Health Care Reform: Proposed Health System Savings and Revenue Options."

**Public Health Insurance Plan Option (Section III, Coverage Options Paper).** The Alliance of Specialty Medicine does not have a specific position regarding the establishment of a public plan option; however, we oppose requiring Medicare providers to also participate in the public health insurance plan (*Proposed Option A, Approach 1*). Such a mandate unnecessarily ties the public health insurance plan option to other, current government health care programs. We are further concerned that directly linking the payment mechanisms between Medicare and the public health insurance plan is under consideration, even if the rates are slightly increased above Medicare rates. As we expressed to you in our May 14<sup>th</sup> letter, 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. 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 the Medicare payment schedule (i.e., the "sustainable growth rate" formula) and not further exacerbate the problem.

**Adjusting Reimbursement for High-Growth, Over-Valued Physician Services (Section I, Financing Options Paper).** The Alliance is very concerned about the two proposed options the committee mentions to address suspected over-valued physician services; specifically, increasing the utilization rate for calculating the payment for advanced diagnostic imaging services and establishing an expert panel to assist CMS in evaluating and adjusting payment for potentially misvalued physician services.

**Imaging Services.** As mentioned in our previous comments related to the delivery system reform options paper, 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. 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. However, any such decisions must be based on solid evidence and data collection which currently are lacking.

The committee mentions that it will explore MedPAC's recommendation to increase the equipment use standard for expensive imaging machines from 25 hours to 45 hours per week. Although MedPAC cites evidence that providers achieve these higher utilization rates, we believe you should be aware that the evidence cited is faulty. Even MedPAC acknowledged that the two small studies were not nationally representative, and the studies did not take into account rural facilities. More timely and nationally representative data collected by US Oncology demonstrated that 94% of CT scanners and 95% of PET equipment operated at less than 50% of open-hours and 56% operated at 25% of open hours. For rural areas, it would be virtually impossible to meet the 45 per week threshold. Urology practices in Montana report imaging use rates of 25-30%. Despite lower use in rural and underserved areas, reimbursement must be adequate to support access of rural Medicare beneficiaries to imaging services. It would be unreasonable to require rural elderly patients to increase their already long travel times to receive services essential for diagnosis and treatment planning.

Also, the Alliance would be concerned if policies are implemented to decrease practice expense RVUs for imaging services that does not result in an increase in RVUs for other physician services.

**Expert Panel.** The Alliance opposes establishing another expert panel to assist the Center for Medicare and Medicaid Services (CMS) in evaluating and adjusting payment for potentially misvalued physician services because this proposal is duplicative of current efforts and unnecessarily politicizes the payment review process. 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. In fiscal year 2009, CMS issued a proposed rule to accelerate the review of the fastest growing higher cost procedures, including services with potentially unexplained high RVUs and procedures that have not been reviewed by the RUC since the fee schedule was created. CMS has requested that the RUC begin reviewing the identified codes immediately, but anticipates that this process may take a number of years due to the large number of services involved. Therefore, there is already a process in place, that assures physician input from a variety of disciplines, to examine potentially misvalued physician services, and any additional process would simply politicize the payment review.

**Geographic Variation (Section I, Financing Options Paper).** The Alliance would like to further explore with the committee the issue of geographic variation in spending and quality. We are disappointed that the initial proposed options seem more 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.

**Modifying Beneficiary Contributions (Section I, Financing Options Paper).** While we do not have a position on proposed options to modify beneficiary contributions, we agree with the stated goal of protecting patients by exploring maximum out-of-pocket protection, while restructuring cost-sharing in a way that does not allow individuals to totally be insulated from the cost of health care. Physicians and their patients will benefit from a more cooperative relationship and more information on the cost of various services, while protecting access to necessary care.

**Medical Malpractice Reform.** We are discouraged that the Financing Options Paper does not touch on the need to address our broken medical liability system as a strategy to achieve health system savings. We had been encouraged by the exploration of various medical liability reform provisions in your earlier **“Call To Action: Health Reform 2009,”** as well as President Obama’s comments last fall in the *New England Journal of Medicine* saying he would be “open to additional measures to curb malpractice suits and reduce the cost of malpractice insurance”. We strongly urge you to again consider that a serious effort at comprehensive health care reform must address medical malpractice. Patient access to care and quality of care will continue to be threatened without such reform.

Again, thank you for the opportunity to provide comments on the Options Papers being considered by the committee. 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. 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](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