



Sound Policy. Quality Care.

September 26, 2011

Glenn M. Hackbarth, J.D.
Chairman
Medicare Payment Advisory Commission
601 New Jersey Avenue, NW
Suite 9000
Washington, D.C. 20001

Dear Chairman Hackbarth:

The Alliance of Specialty Medicine (Alliance) and its member organizations are writing to express our opposition to the Chairman's recommendations on the Sustainable Growth Rate System (SGR) proposed at the MedPAC meeting of September 15, 2011. The Alliance is a coalition of 11 national medical specialty societies representing more than 100,000 physicians and surgeons. We are dedicated to the development of sound federal health care policy that fosters patient access to the highest quality specialty care.

Chair's Recommendations on the SGR

The Alliance recognizes that MedPAC has called for repeal of the SGR repeatedly and we welcome your understanding of the critical need to rationalize physician payment to assure stability of patient access to quality physician care. However, we were dismayed to hear the Chairman's first recommendation to slash the conversion factor for specialist services by 5.9 percent each year for three years to be followed by a freeze for seven years. The cumulative cut to specialty physician payments would be 18 percent over the first three years. The recommendations seek to shield a small percentage of primary care services furnished by primary care specialties by imposing only a 10-year freeze rather than an absolute cut on these services. Despite the effort to shield primary care, which pits specialist physicians against our primary care colleagues, it is clear that this recommendation on updates to physician payment will place a large percentage of the cost-offset burden on the physician community. Limited physician payment increases over the last ten years dictated by hurried Congressional "fixes" to the failed SGR and additional cuts imposed by the Medicare Program have yielded physician payment rates that do not cover the increasing costs of practice and another 18 percent cut and 10 year freeze will only exacerbate this problem.

The Alliance repudiates this effort to compound recent physician underpayment with a new payment cutting proposal to offset the unreasonable SGR policy. Why should doctors and patients who have suffered under this policy for years be required to pay so heavily for its repeal, particularly in light of the fact that physicians did not cause the problems with the flawed SGR formula in the first place? The cost of eliminating the SGR should be viewed as a societal cost and other Medicare providers and/or programs outside of Medicare should share in the cost of the offset.

Furthermore, while the Alliance understands MedPAC's desire to support primary care, we have serious objections to the recommended proposal to essentially hold primary care "harmless" while cutting specialty physicians' reimbursement. It is important to recognize that physician shortages are looming in many specialties. According to the Association of American Medical Colleges (AAMC), by the year 2025, there will be an overall

shortage of 130,600 physicians nationally, equally split between primary care and specialties. The average age of many specialists is over 55. Specialties beyond primary care also require support, higher payments and workforce incentives. Shrinking access is not unique to primary care. Of note, Congress and the AMA/Specialty Society RVS Update Committee (RUC) have instituted policies in statute or practice that increased primary care payment. Payment incentives and other policies that increased reimbursement for primary care include (1) a 10% Medicare bonus payment for primary care established by the Affordable Care Act; (2) raising Medicaid payments to Medicare levels for primary care services; and (3) additional resources directed at preventive medicine and primary care.

The RUC has changed values for physician services that resulted in increased reimbursement for primary care including: (1) between 2006-11, payments to specialty physicians were significantly reduced, while payments to primary care increased by 22.5%, (2) the third five-year review of values resulted in a 37% increase for Medicare's most frequently billed office visit code, 99213, which is also used most often by family physicians and internal medicine physicians; and (3) the third five-year review also shifted more than \$4 billion to evaluation and management (E&M) codes, which are largely provided by primary care specialties. If primary care still requires additional support despite these initiatives, establishing different conversion factors for specialist and primary care services is not the appropriate mechanism to provide that support.

Primary care services should be reimbursed appropriately for the time and intensity of care provided. The RUC and CPT have developed recommendations to support care coordination of patients with chronic diseases for many years. CPT codes and relative values have been developed for telephone calls, team conferences, and case management. The RUC has also explored resource costs for the provision of Medical Home monthly management services. Unfortunately, CMS has not chosen to use any of these options to more appropriately pay for care coordination services central to quality primary care. This policy should be reversed. Paying more for objectively established time and intensity requirements for care coordination is a reasonable approach to increasing access to primary care. The cut in the specialty conversion factor recommended by the Chair arbitrarily devalues specialty care without evidence that the value of these services has fallen and undercuts any claim to methodological rigor.

With respect to overpriced services, the Alliance agrees with MedPAC that some services in the Medicare Physician Fee Schedule may be overpriced, while others may be underpriced. The RUC established a process to objectively identify potentially misvalued services in 2006. The RUC has identified over 1,000 physician services for review and has made recommendations for revaluing approximately 850 services. According to the RUC, much of this analysis led to clarification or bundling of CPT codes resulting in a comprehensive review and involving the work of hundreds of volunteer physicians. More than \$1.5 billion has been redistributed as a result of these efforts. These results demonstrate the commitment of physicians participating in the RUC process to obtaining objective data and the strength and flexibility of the committee's review process that relies on clinical expertise and objective data. MedPAC has concluded that the RUC process is "time-consuming" and has inherent conflicts. Rather than continue to rely on the RUC process for valuing services in the fee schedule, the Chair is recommending that Congress direct the Secretary of Health and Human Services to meet an annual, arbitrary numeric goal for reducing RVUs. This arbitrary goal would be established without analysis of the actual time and intensity invested in the services in question. Such an approach threatens the integrity and relativity of the resource based relative value scale that is the foundation of the Medicare Physician Fee Schedule. The resulting arbitrary annual cuts in RVUs would reduce physician payment beyond the cuts called for in Recommendation #1 discussed above.

We also note that physicians will be subject to further cuts in payment through the e-prescribing penalty beginning in 2013, the PQRS penalty beginning in 2015, and the value-based modifier, whose potential impact is not clearly known at this time. Payment cuts in practice expense RVUs due to adoption of the Physician Practice Information Survey are still transitioning and will not be fully implemented until 2013. All these cuts will come on top of the cuts and freezes recommended by the Chair if adopted by Congress. We fear access to specialty

care for Medicare beneficiaries may be seriously jeopardized by these policies. We urge MedPAC to reconsider these short-sighted recommendations on the SGR.

Private Contracting with Physicians Under Medicare

The Alliance was pleased that you raised the issue of balance billing with the Commission on September 15. The Alliance strongly supports empowering patients with the ability to obtain medical services from the physician of their choice. To that end, we believe that patients and physicians should be allowed to privately contract for Medicare services without penalty. We believe the "Medicare Patient Empowerment Act" (H.R. 1700/S. 1042) strikes the right balance, appropriately protecting vulnerable beneficiaries by ensuring that private contracts may not be entered into when a beneficiary is facing an emergency medical condition or urgent health care situation. Also, the bill does not allow low-income, dual-eligible beneficiaries to privately contract with physicians. Currently, Medicare beneficiaries must pay out-of-pocket the full contracted fee when they seek care from a physician who has opted out of Medicare. As we work toward the long-term stability of the Medicare program, beneficiaries should be allowed to use their Medicare benefit to offset a portion of the contracted fee and we should not require physicians to "opt out" of the Medicare program for two full years. Thank you for your attention to the concerns of specialty medicine.

Sincerely,

American Academy of Facial Plastic and Reconstructive Surgery
American Association of Neurological Surgeons
American Gastroenterological Association
American Society of Cataract & Refractive Surgery
American Society of Plastic Surgeons
American Urological Association
Coalition of State Rheumatology Organizations
Congress of Neurological Surgeons
Heart Rhythm Society
North American Spine Society
Society for Cardiovascular Angiography and Interventions

CC: The White House
Members of the US Congress