

December 10, 2013

The Honorable Max Baucus
Chairman
Senate Committee on Finance
219 Dirksen Senate Building
Washington, DC 20510

The Honorable Orrin Hatch
Ranking Member
Senate Committee on Finance
219 Dirksen Senate Building
Washington, DC 20510

Dear Chairman Baucus and Ranking Member Hatch:

The undersigned organizations appreciate and commend the yearlong collaborative effort and commitment to permanently repeal the sustainable growth rate (SGR) formula and reform the Medicare physician payment system. We are supportive of the overarching goals of repealing the SGR, streamlining existing quality programs, encouraging alternative payment models and generally moving to a system that rewards the provision of high quality, efficient health care. In order to achieve our common goal, we must get the policy right in order to build a more sustainable, fair and efficient Medicare physician payment system.

While we appreciate the changes made to the draft proposal, particularly in regards to the improvements in the sections on the valuation of services and alternative payment models, we must oppose the SGR Repeal and Medicare Beneficiary Access Improvement Act of 2013 in its current form. We understand there are certain political pressures regarding the overall cost of SGR reform legislation, but we must not allow those to undermine the policy. We are concerned about the negative long-term, combined impact of the budget neutral Value-Based Purchasing (VBP) program and the 10 year physician payment freeze (*see also* attached for examples of concerns). We believe the combined impact will hinder our members' ability to keep their practices open, disincentivize the sharing of best practices and place patients' access to surgical services at risk.

We urge the committees to postpone the markup of the current proposal and continue to work with us to revise the proposal and ensure the policy is correct. We believe there are strong policy components in H.R. 2810, the Energy & Commerce Committee's SGR reform legislation, which could be combined with the current proposal. We remain committed to reforming the Medicare physician payment system with sound health care policy and look forward to working, as partners, in forging a new, patient-centric, quality-based health care system.

Sincerely,

American Academy of Facial Plastic and Reconstructive Surgery
American Academy of Ophthalmology
American Association of Neurological Surgeons
American College of Osteopathic Surgeons

American College of Surgeons
American Osteopathic Academy of Orthopedics
American Society of Cataract & Refractive Surgery
American Society of Anesthesiologists
American Society of Metabolic and Bariatric Surgeons
American Society of Plastic Surgeons
American Urological Association
Society of American Gastrointestinal and Endoscopic Surgeons (SAGES)
Congress of Neurological Surgeons
Society for Vascular Surgery
The American Society of Breast Surgeons
The Society of Thoracic Surgeons

Senate Finance Committee Discussion Draft Physician Payment Reform Policy Changes

Provide Regular Updates – Physician payments have been frozen for a decade, another 10 years of frozen payments is unsustainable.

Solution: There should be some mechanism for inflationary adjustments to the conversion factor. We welcome the opportunity to study how shared savings generated within the overall health care system could be used.

Reject Tiered Incentive Payments – The VBP incentive program should not be a tiered or tournament model of redistributing payments where the only way for a provider to get a bonus is for another provider to take a cut. In addition, the tournament model disincentivizes the sharing of best practices, which is contrary to the goal of physician payment reform.

Solution: We feel strongly that incentives in the VBP should be based on achieving a threshold/benchmark. Updates and incentives should be attainable by all providers based upon performance on well defined, appropriately designed, quality measures.

Development of Clinical Registry Infrastructure – We are supportive of the Committee's efforts to promote the role of quality measurement in physician reimbursement. We have long advocated for a system that rewards providers for the quality of care they provide. Unfortunately, PQRS is inherently flawed in as much as it fails to keep pace with specialty-specific quality initiatives.

Solution: We feel that the quality assessment provisions in H.R. 2810 provide a better pathway to meaningful quality assessment for medical specialties. By leveraging the unique power of clinical registries, combined with administrative claims and patient outcomes data, this approach is a more effective way to improve quality and efficiency in the healthcare system. Without a national infrastructure for collecting, aggregating, and evaluating clinical information against valid, risk-adjusted quality measures, any effort towards true payment reform will be extremely difficult.

Targets for misvalued services – The Discussion Draft set a target for identifying and revaluing codes. In 2015, 2016, 2017, and 2018 the target for identifying misvalued services is .5% of estimated expenditures. If the target is met, the full amount would be redistributed in a budget-neutral manner within the physician fee schedule. If the target is not met, all fee schedule payments would be reduced by the difference of the target and the amount of misvalued services identified for that year. This amounts to an across the board cut and is problematic given that the RUC, CMS, and the participating specialty societies have spent a tremendous amount of time and resources to ensure

the accuracy of the current fee schedule. Given the work that has already resulted in decreased RVUs for many high volume codes, it may be difficult to hit the target each year.

Solution: This work is already being done. CMS, the AMA Relative Value Update Committee (RUC) and participating specialty societies engaged in a years-long program, expected to be completed in 2016, to ensure the accuracy of the current fee schedule. Our concerns with this provision are exacerbated by the Discussion Draft's indication that certain code reductions could be greater than or equal to 20%, though the impact of any reduction would be phased in over a two-year period. We have tremendous concerns such cuts would severely impact patient access to surgical care.