

September 22, 2009

The Honorable Max Baucus
Chairman, Senate Finance Committee
215 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Baucus:

The undersigned organizations, representing an important coalition of 20 surgical organizations, are united in our goal of bringing into focus the urgent issues facing access to quality surgical care for our patients. Our members are committed to helping policymakers craft workable solutions that address access problems while preserving and improving high-quality surgical care for all. We appreciate the efforts of you and your colleagues to craft comprehensive health care reform legislation.

Since late last year, the surgical community has taken several opportunities to comment on the Committee's policy options and proposals. Throughout this process, we have stressed that coverage reforms must be accompanied by systems reforms that provide stability for a currently crumbling system and improve the delivery of care. The undersigned organizations do not feel that the "America's Healthy Future Act of 2009" provides the necessary provisions to secure a solid foundation on which to build comprehensive health reform and cannot support the legislation as it is currently written.

We offer the following comments with the hope that they will play a constructive role in crafting a final health reform package. Specifically, we urge you and the Committee to address:

Medicare Physician Payments: While the bill replaces a scheduled 22 percent Medicare payment cut with a 0.5 percent increase in 2010, the bill does not reset the sustainable growth rate (SGR) baseline – a critical step and necessary step to providing long-term reform of the physician payment system. The surgical community has held that in order for health reform to be successful that the Medicare payment system must be permanently reformed.

Budget Neutral Payment Bonuses for Primary Care & General Surgery: The surgical community has consistently opposed cutting surgical reimbursement to finance increased payments for other physicians. In 2011, the bill would provide 10 percent bonus payments for primary care physicians and for general surgeons in health professional shortage areas. Half of these bonus payments would be offset through payment reductions to other physicians, including surgeons. As a result,

most surgeons would be facing an additional cut on top of the 25-plus Medicare payment cut in 2011.

Medical Liability Reforms: The current climate in this country is one in which surgeons and other physicians are forced to practice in an environment of defensive medicine, sometimes ordering additional and possibly unnecessary tests in order to avoid lawsuits. In addition, medical liability insurance premiums have risen steadily over recent decades, at times increasing an average of 15 percent a year. Some states and specialties have seen even more dramatic increases making premiums prohibitively expensive for many physicians. We urge the committee to address this critical issue as an important tool for helping to stem the tide of rising health care costs by including common sense, proven, comprehensive medical liability reform provisions such as: (1) provisions modeled after the laws in California or Texas, which include reasonable limits on non-economic damages; (2) alternatives to civil litigation, such as health courts and early disclosure and compensation offers; (3) protections for physicians who follow established evidence-based practice guidelines; and (4) protections for physicians volunteering services in a disaster or local or national emergency situation.

Medicare Commission: The bill establishes a 15-member commission appointed by the President that would be tasked with making proposals to Congress aimed at extending the solvency of Medicare, slowing Medicare cost-growth, and improving the quality of care to beneficiaries. The surgical community remains opposed to taking Medicare payment policy decisions out of Congress and replacing the transparency of Congressional hearings and debates with a minimally open process overseen by unelected officials with little accountability for the health care decisions it makes – except reducing costs.

Physician Quality Reporting Initiative: While the surgical community appreciates that the bill requires timely feedback to PQRI participants and establishes an appeals process, we strongly oppose making participation in the PQRI mandatory in 2011. We also oppose making the program punitive at such an early date for those physicians who do not successfully participate. The program continues to experience considerable problems, and we have serious concerns about making the program mandatory and punitive in a little more than a year from now.

Misvalued Codes under the Physician Fee Schedule: The surgical community opposes the creation of a duplicative process for determining code values as included in the bill. Surgery supports maintaining the role of the AMA/Specialty Society Relative Value Update Committee (RUC) as the entity through which medical services are valued. The RUC continues to be a dynamic process, which makes

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recommended increases *and* decreases in the value of codes reimbursed under the Medicare Physician Fee Schedule.

Our organizations share your goals of expanding coverage and promoting better access to high quality care and we are committed to working constructively with you and your Senate colleagues to achieve true health care reform. The comprehensive list of surgical health care reform priorities are attached to this letter. It is our hope that as reform legislation is considered by the Finance Committee and ultimately by the full Senate, that measures are approved, which address these critical issues.

Sincerely,

American Academy of Facial Plastic and Reconstructive Surgery
American Academy of Ophthalmology
American Academy of Otolaryngology-Head and Neck Surgery
American Association of Neurological Surgeons
American Association of Orthopaedic Surgeons
American College of Obstetricians and Gynecologists
American College of Osteopathic Surgeons
American College of Surgeons
American Osteopathic Academy of Orthopedics
American Society of Breast Surgeons
American Society of Cataract and Refractive Surgery
American Society of Colon and Rectal Surgeons
American Society for Metabolic & Bariatric Surgery
American Society of Plastic Surgeons
American Urological Association
Congress of Neurological Surgeons
Society for Vascular Surgery
Society of American Gastrointestinal and Endoscopic Surgeons
Society of Gynecologic Oncologists
Society of Surgical Oncology

CC: Members of the Senate Finance Committee

Surgeons and Health Care Reform

The surgical community strongly supports efforts that ensure that individuals have consistent access to patient-centered, timely, unencumbered, affordable, and appropriate health care and universal coverage while maintaining that surgeons are an integral and irreplaceable component of providing the highest quality treatment. To this end, in any health care reform bill, the surgical community strongly **supports**:

Repealing the current sustainable growth rate (SGR) immediately and establishing a new baseline for the physician payment system

- For full-scale health care reform to be successful, Medicare's physician reimbursement system must be set on a path toward full-scale and permanent reform.
- Congress must incorporate a realistic budget baseline that provides physicians with positive updates.
- During the transition period to a new payment system, Congress should replace the SGR with a system of separate service category growth rates (SCGR). The four SCGR categories (primary care; other evaluation and management services; major surgery; and all other physician services) would recognize the differences among the various types of services and account for their varied rates of growth, while providing additional dollars for primary care.

Addressing surgical workforce problems through improvements to the graduate medical education system

- A redistribution of unused residency training positions may begin to address the workforce shortages in primary care and general surgery, but consideration should also be given to lifting residency caps as an option for addressing the emerging workforce shortages in other medical specialties.
- Simply reallocating unused residency training slots has the potential to exacerbate already apparent and emerging workforce shortages in some surgical specialties unless an option to lift residency caps is included.
- Surgery also recommends that the Congress make loan forgiveness programs available to surgical specialties with documented current or potential workforce shortages, especially those specialties with longer training programs.

Incorporating certain medical liability reforms in comprehensive health care reform, including:

- Provisions modeled after the laws in California or Texas, which include reasonable limits on non-economic damages.
- Alternatives to civil litigation, such as health courts and early disclosure and compensation offers;
- Protections for physicians who follow established evidence-based practice guidelines;
- Protections for physicians volunteering services in a disaster or local or national emergency situation

Promoting tested quality improvement initiatives

Surgery understands that all segments of the health care population find a great deal of value in the collection and analysis of physician quality data and that it is important to provide patients, the public and physicians with accurate information on physician quality. However, improvements to the current Physician Quality Reporting Initiative (PQRI) should:

- Ensure the program remains voluntary and provides positive incentives for participation;
- Provide access to data in a timely manner and it must have a reasonable appeals process;

- Delay the release of public reports using data until further evaluation and improvements including risk adjustment occur;
- Provide additional federal funding to develop clinical data registries and other quality improvement tools

Embracing the need for well-designed clinical comparative effective research

- Surgery urges Congress to build off the framework of the *Comparative Effectiveness Research Act of 2009* (H.R. 2502), sponsored by Rep. Kurt Schrader, and the *Patient-Centered Outcomes Research Act of 2009* (S. 1213), sponsored by Senators Max Baucus and Kent Conrad.
- Any comparative effectiveness research should be a tool to improve care on a per-patient basis by providing information on clinical value of varying treatments and interventions and should not be used for determining medical necessity or making coverage and payment decisions or recommendations.

Ensuring responsible physician ownership

- Physicians should have the ability to responsibly and professionally own, either individually or through a joint venture (with hospitals and/or other physicians), facilities (including hospitals), equipment, and services that appropriately provide high quality care for patients. Congress should not prohibit their development and further expansion. Physicians should be obligated, however, to disclose this ownership information to the public.

Encouraging realistic Health Information Technology (HIT) Use and Adoption

- Surgery is concerned about the current HIT timelines for bonuses and penalties established in the *American Recovery and Reinvestment Act (ARRA)* with the continued lack of interoperability and certified HIT systems. We urge Congress to amend the current bonus and penalty timelines so the entire surgical community can participate fully.

Transparency and Evidence-Based Decision-Making for Imaging Services

- Surgery supports the continued ability of physicians to own, operate and refer patients to in-office imaging services and agree that the Stark in-office ancillary exception should be amended to require the referring physician to provide patients with a written disclosure of financial interests and a list of alternate suppliers.
- In those circumstances involving multiple referrals, after the initial disclosure to a particular patient, physicians should only be required to make a disclosure annually to that patient.
- Any appropriateness criteria system must also apply to radiologists when they make recommendations for additional imaging tests.
- Surgery supports a non-punitive approach to eliminate unnecessary imaging based on education and confidential feedback programs; however we are opposed to the penalty system outlined in the proposal.
- Surgery opposes subjecting ultrasound and less expensive imaging modalities to the 75 percent equipment use rate. We therefore urge Congress to specifically exclude ultrasound from the definition of imaging services to which the equipment use rate formula is applied or any other reimbursement reductions directed at imaging services.

Physician Payment Sunshine

- Surgery strongly supports disclosure and transparency of physician and industry relationships through a single, federal reporting system that preempts state law.
- Physicians should have the opportunity to review and correct information about their financial relationships before those disclosures are made publically available.

- Congress should not include reporting of industry funding for continuing medical education (CME) and professional organizations.

Certain Hospital and Readmission Bundling

- Surgery is concerned with the unintended consequences that a hospital readmission and post-acute bundling policy may carry, particularly the potential avoidance of patients with complex medical conditions. The surgical community therefore urges Congress to recognize the need for risk adjustment when calculating readmission benchmarks.
- When the readmission policy is phased out and the bundled payment policy is implemented, a workable and reasonable readmission policy must remain an essential piece of the initiative.
- Congress must also develop a coherent risk adjustment policy as the primary method for preventing the practice of deselecting patients, addressing the readmission issue, and ultimately providing the highest quality and most appropriate level of patient care with these methods of payment.
- Congress should exclude readmissions for a different diagnosis than the original admission in either the hospital readmission or post-acute bundling policy.

Innovative Payment Options

- Surgery supports the development and testing of shared savings payment models for physician, hospital and other provider services. The Secretary or GAO should fully evaluate any shared savings program and report back to Congress within five years of enactment before a more expanded, permanent share savings program is implemented.
- If implemented, participation in shared savings programs should be voluntary, non-punitive and not restrict patient choice.
- Congress should amend the Stark physician self-referral and antitrust laws and/or regulations to allow provider collaboration and flexibility in the development of shared savings programs.

The surgical community **opposes** the following proposals and believes they must not be included in any final comprehensive health care reform package:

Short-term solution to SGR

- Surgery does not support another short-term “patch” that only temporarily prevents Medicare payment cuts and does not directly address the long-term problems with the SGR.

Budget neutrality

- Surgery opposes any measure that would finance increased payments for primary care and general surgery by an across-the-board reduction in payments for all other physician services.

Independent Medicare Advisory Commission

- Surgery opposes the inclusion of the *Independent Medicare Advisory Council (IMAC) Act of 2009* and the *Medicare Payment Advisory Commission (MedPAC) Reform Act of 2009* (H.R. 2718, S. 1110, S. 1380) or other similar construct.
- Medicare payment policy require a broad and thorough analysis of providers and beneficiaries and leaving those payment policy decisions in the hands of unelected, unaccountable governmental body with minimal Congressional input will negatively impact the availability of quality, efficient health care.

Public Health Care Option Tied to Medicare

- Surgery does not support tying the public plan option to Medicare rates. Health reform legislation that includes a public plan option must expressly state that physicians are not mandated to participate in such a plan.

Misvalued Codes under the Physician Fee Schedule

- Surgery opposes the creation of a duplicative process for determining code values. Surgery supports maintaining the role of the AMA/Specialty Society Relative Value Update Committee (RUC) as the entity through which medical services are valued. The RUC continues to be a dynamic process, which makes recommended increases *and decreases* in the value of codes reimbursed under the Medicare Physician Fee Schedule.

Payment for Efficient Areas

- Surgery is concerned about arbitrary adjustments of payments based on geographic differences in utilization of medical services, particularly since such adjustments are not appropriately risk-adjusted. We support addressing any geographic disparities by extending the geographic floor for work.

Improving Accountability for Approved Medical Residency Training

- Surgery opposes any proposals that would (1) set forth in law the goals of medical education and (2) require a GAO study to evaluate training programs.
- Surgery believes very strongly that medical education should remain in the purview of medical educators, including the Accreditation Council for Graduate Medical Education (ACGME). The ACGME and surgical specialties are constantly evaluating and reevaluating graduate medical education curricula to ensure that it is appropriately achieving the goals of medical residency training and education.

Radiology Benefit Managers (RBM)

- Surgery is fundamentally opposed to the use of radiology benefit managers or other draconian pre-certification requirements for imaging services in Medicare.

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