

Comments

of the

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
The Society of Thoracic Surgeons

on the

Senate Finance Committee Policy Options

Expanding Health Care Coverage: Proposals to Provide Affordable Coverage to All Americans

and

Financing Comprehensive Health Care Reform: Proposed Health System Savings and Revenue Options

Contact: Kristen V. Hedstrom, MPH
Assistant Director, Legislative Affairs
American College of Surgeons
1640 Wisconsin Ave, NW
Washington, DC 20007
202-672-1503
khedstrom@facs.org

May 29, 2009

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

Dear Chairman Baucus:

We, the undersigned surgical organizations, write in response to the Senate Finance Committee's proposals entitled *Expanding Health Care Coverage: Proposals to Provide Affordable Coverage to All Americans* and *Financing Comprehensive Health Care Reform: Proposed Health System Savings and Revenue Options*. We appreciate the leadership that you and your colleagues in Congress have dedicated to enacting comprehensive reform of our nation's health care system, and we look forward to continuing to work collaboratively with you.

As we have previously stressed, expanding coverage to more Americans and improving the quality of care will mean little if Americans are not able to access the care they need. As you contemplate implementation of health care reform, we implore you to consider the systemic needs of health care delivery on the same level with coverage and financing. The surgical community strongly supports ensuring that individuals have consistent access to patient-centered, timely, unencumbered, affordable, and appropriate health care and universal coverage while maintaining that physicians are an integral component to providing the highest quality treatment. At the same time, we must be certain that coverage reforms are accompanied by system reforms that improve the delivery of health care. Without these system reforms, the efforts to increase insurance coverage could result in not increased, but decreased access to care. In particular, we are concerned that we have not yet seen a discussion of some provisions. A comprehensive health care reform proposal must include provisions that:

- properly allocate resources to improve patient access to trauma and emergency services;
- ensure that access to acute and surgical care is included in a basic benefit package for all individuals;
- lower the administrative costs in our health care system and reallocate those resources to patient care;
- address the decreased access to care and the costs associated with the practice of defensive medicine caused by the lack of medical liability reform;
- level the playing field between physicians and insurance companies by enacting antitrust reform; and
- develop a comprehensive workforce and medical education strategy distinct from the current piecemeal financing mechanisms compartmentalized among various payers.

To that end, the surgical community stands united in the effort to bring fundamental and long-term change to the health care system and overall comprehensive reform.

I. Expanding Health Care Coverage: Proposals to Provide Affordable Coverage to All Americans

Public Health Insurance Option (pgs. 13-14)

The surgical community supports the commitment to extending health insurance coverage to more Americans. If done appropriately, extending this coverage would help ensure that every American will be able to access the care they depend on America's physicians to provide in a timely manner without compromising their own financial well-being. Unfortunately, if done incorrectly, extending insurance coverage to more Americans will mean little if they are forced to wait in lines and are not able to access a physician when one is needed. This scenario becomes particularly troubling when considering the life-saving and impairment-preventing acute care that surgeons provide to their patients every day. Whether or not a surgeon is available can be a life or death issue for a patient facing an emergency or trauma care situation.

Given the history of physician reimbursement under government-sponsored health plans where Medicare reimbursement rates have repeatedly failed to keep pace with the rising cost of practicing medicine, the surgical community is concerned whether or not such a plan will appropriately reimburse surgeons and other physicians for the care they provide to patients. Rightly, the Committee's option document recognizes the first issue in a public plan would be determining how providers would be reimbursed.

As described in the options document, the Medicare-like plan would reimburse providers according to Medicare rates plus 0-10 percent, which raises a number of concerns for the surgical community. Most importantly, we believe it is untenable to construct true and meaningful comprehensive health reform that is in large part based on the Medicare program without immediately and permanently addressing the physician reimbursement system. Physicians are widely recognized as the foundation of our health care delivery system. In order for the health reform effort to expand insurance coverage, improve access to care, and improve the quality of care that Americans receive, Congress must once and for all reform the Medicare physician payment system with a more reasonable reimbursement structure that, while promoting better value and better quality of care, also keeps pace with rising practice costs. If Congress does not use this opportunity to address the issue of Medicare reimbursement, the health reform effort will be constructed on a foundation of sand, and one day, the system will inevitably collapse upon itself.

In addition, the Medicare-like public plan option would not have solvency requirements. By not requiring that the plan meet certain solvency requirements that must be met by every private insurer, Congress would be charting a course for the plan that would follow Medicare and Social Security into an uncertain financial future. A failure to include a solvency requirement would lead the program on a path where Congress will seek to rein in costs, inevitably leading to further squeezing of reimbursements.

With respect to proposed Third Party Administrators, the document provides few details, but the requirement that TPAs form networks would be an improvement over the Medicare-like option. In addition, a state-run public option would have the advantage of positioning states to better address the needs of their own citizens, but it would offer its own challenges as well —

particularly as it relates to financing and how such a program might be integrated with state insurance laws.

For the reasons stated above, the surgical community cannot support and will vigorously oppose the use of the current and seriously flawed Medicare payment system as a basis for a public plan option. To this end, the surgical community is committed to working with the Finance Committee and Congress to reform Medicare's payment system.

Medicaid Coverage - Medicaid Program Payments (pg. 15)

One of the Committee's proposed options is to require that Medicaid payments to all providers not fall below a given percent of Medicare reimbursement rates for the same or similar services. The surgical community is extremely appreciative of the Committee's acknowledgement of the variation and insufficiency of reimbursements that providers face when delivering services in the Medicaid program. As the Committee acknowledges in the paper, states have broad authority in setting payment rates under Medicaid – an authority that states often exercise in periods of state budget pressures because it is one of the only tools they can use to address costs given all of the other restrictions in administering the Medicaid program. We believe that the Committee must ensure that States do not treat access to the services and physicians that Medicaid patients need as a discretionary expense.

We do not believe, however, that any percentage below Medicare rates will ensure the access to care that Medicaid patients need and deserve. Medicaid patients are some of the most vulnerable patients in our country. To suggest that Medicaid patients are in need of fewer resources for their care and treatment is problematic. As the surgical community has previously stated, we have serious concerns about the current Medicare reimbursement formula. However, with the Committee's emphasis on coordination of care and ensuring that no one go without the coverage or access that they need, and if the current Medicare payment structure is maintained, a policy of at least Medicare equivalency should be enacted for the Medicaid program.

Finally, a few states, like Arizona, have recognized the inequalities of under-funding Medicaid providers and the opportunities for improving care for patients when dedicating appropriate resources to the Medicaid program by ensuring that Medicaid reimbursements for facilities and providers are at or greater than Medicare. We ask the committee to be aware of the efforts of these states and to consider the incentive to facilities and providers in improving patient access to needed health care services that a policy of setting a reimbursement floor for Medicaid at 100 percent of Medicare would create and how that will negatively impact patients.

Other Improvements to Medicaid - Treatment of Selected Optional Benefits (pg. 24)

The Committee proposes to mandate provider status to podiatrists, optometrists and free-standing birthing centers. The surgical community believes that a federal mandate is unnecessary and complicates scope of practice battles in the states.

If the Committee intends to move forward with mandating these providers, the surgical community urges that it be made clear that this action should not be construed to expand the scope of practice for any provider; and that all providers should identify for patients the type of license under which the provider is practicing. In addition, any freestanding birthing center that would be given provider status must be required to meet the standards of the Accreditation

Association for Ambulatory Health Care or The Joint Commission or the American Association of Birth Centers.

Promotion of Prevention and Wellness in Medicare (pgs. 43-45)

Personalized Prevention Plan and Routine Wellness Visit

The surgical community strongly supports the proposal's recommendation that would help assess health status indicators for chronic diseases, such as obesity, by developing a personalized prevention plan for all enrolled beneficiaries once every five years. Beneficiaries would first receive a comprehensive health risk assessment (HRA) including at least a complete medical and family history, age, gender, and risk appropriate measurements (including height, weight, body mass index, and blood pressure if not already part of the patient's record). The assessment would also identify chronic diseases, modifiable risk factors such as smoking, and emergency or urgent health needs. Identifying and treating chronic disease is critical because, if left untreated, the complications stemming from the disease can often hinder surgical intervention needed for acute conditions, such as stroke.

When developing a personalized prevention plan, we urge the committee to consider how the periodic HRA would apply to the Medicare patient who has a body mass index (BMI) that would classify them as overweight, obese or morbidly obese. As numerous studies show, being overweight or obese increases the risk for several other chronic diseases such as diabetes, heart disease, certain cancers, arthritis, sleep apnea and other health conditions. While Medicare generally provides coverage for a comprehensive treatment approach for many of the above mentioned chronic diseases, the same is not true regarding obesity. Medicare should provide coverage for support services like nutrition and dietary counseling in the context of a comprehensive treatment approach for the overweight or obese patient. Such an approach would include both identification of the chronic disease as well as behavioral, pharmaceutical and surgical treatment so as to be consistent with Medicare's diagnosis and treatment coverage policy for other chronic diseases.

Coverage of Evidence-Based Preventive Services

While the surgical community supports giving the Secretary authority to withdraw Medicare coverage for demonstrably ineffective preventive services, we believe that there should be broad discretion for decision-making. The US Preventive Services Task Force (USPSTF) is well respected and a leading body in translating evidence into policy recommendations. However, the USPSTF was originally chartered by Congress to focus on prevention initiatives in the primary care setting and the USPSTF lacks direct expertise related to some subspecialty care, such as ophthalmology, vascular surgery, and the multi-disciplinary expertise needed for the treatment of osteoporosis. The USPSTF demands randomized prospective trial data as evidence of effectiveness for screening interventions. In some cases, such data cannot be obtained because the preponderance of medical evidence makes it unethical to randomize patients to a control group in such a trial. USPSTF openly recognizes this problem and states that a finding of "Insufficient Evidence" should not be equated with an inference that a particular screening intervention is not effective or should not be covered.

The lack of specialty expertise is evident using the example mentioned in the Committee's proposal where the USPSTF recommends an abdominal aortic aneurysm (AAA) screening by

ultrasound for men who have ever smoked, but recommends against the same screening for women, rating the service “D”. The USPSTF remained silent regarding recommendations for screening men or women with a family history of AAA, despite inclusion of the statement, “A first-degree family history of AAA requiring surgical repair also elevates a man’s risk for AAA; this may also be true for women but the evidence is less certain.”

A review of the scientific literature for AAA’s prevalence in first-degree relatives of those with established AAA is very convincing although the numbers of patients in these articles is naturally less than studies of male smokers. Evidence shows that even though there is a lower prevalence of AAAs in women, the natural history of AAA in women is even more dangerous than in men, with rupture occurring in smaller sized aneurysms and causing an even higher mortality rate. Thus, patient longevity is less for women than men with AAAs and death after rupture is greater in women than in men. In fact, studies performed after the USPSTF decision demonstrate that screening women for AAA is cost-effective.

It may be prudent to provide for the Secretary’s discretionary authority to consult with other respected organizations such as National Committee for Quality Assurance (NCQA), national medical organizations, etc., in both adding new Medicare preventive services or withdrawing.

II. Financing Comprehensive Health Care Reform: Proposed Health System Savings and Revenue Options

Ensuring Appropriate Payment (pgs. 5-13)

Updating Payment Rates for Inpatient Services

The Committee’s options document does not describe specific proposals but rather identifies three broad approaches that the Congress could consider:

- 1) Revise the current medical education and DSH payment adjustments to better reflect hospitals’ actual costs for treating low-income and uninsured patients and for training medical residents;
- 2) Adjust DSH payment levels over time as the need for these resources decrease because more individuals will be insured as a result of health care reform; or
- 3) Consolidate Medicare and Medicaid payments to hospitals to streamline and better account for and coordinate federal funding in the DSH and GME payment areas.

The surgical community urges the Committee to carefully consider the long-term implications that could result in reductions in payments for medical education. If substantial, reductions could put significant pressure on residency programs as hospitals seek changes to recover their unreimbursed costs. With the Bureau of Health Professions projecting declines in specialties such as general surgery, thoracic surgery and urology between 2005 and 2020, we believe that great care must be taken to ensure that the surgical workforce shortage is not further exacerbated.

Adjusting Reimbursement for High-Growth, Over-Values Physician Services

The surgical community believes that the American Medical Association’s Specialty Society Relative Value Update Committee (RUC) is, while not flawless, an appropriate entity that allows

all physicians a seat at the table when valuing physician services and we believe that establishing another panel would be duplicative and would add another bureaucratic layer to an already complicated process. In addition, we urge the Committee to distinguish between irrational growth and growth that is attributable to changing demographics or advancing technology in order to ensure that patients continue to have access to high quality care and that they experience the best possible outcomes.

In addition, the surgical community finds the MedPAC rationale and recommendation to increase the equipment use factor for advanced imaging problematic. MedPAC cited two sources of data: a survey conducted in 2006 by NORC, which looked at only two imaging modalities in 133 physician offices in six urban markets; and a survey by a market research firm (IMV) of 803 CT providers that were mainly freestanding imaging centers. MedPAC acknowledged that the NORC study *was not nationally representative* and professed ignorance of whether or not the IMV survey was representative. CMS declined to accept the MedPAC recommendation previously due to lack of sufficient empirical evidence.

Bluntly, increasing the equipment use rates for advanced imaging will further reduce the adequacy of payment for physicians providing these critical services. Cuts were already implemented by the Deficit Reduction Act (DRA) of 2005 that totaled \$1.64 billion in 2007 alone, according to the General Accounting Office (GAO). Utilization of advanced imaging also declined as a result of the DRA cuts. In addition, CMS made major changes to the method of calculating practice expense relative value units (PE RVUs) in 2007. PE RVUs for imaging will be cut 9 percent by 2010 when these changes are fully implemented.

Existing and scheduled cuts will limit access to imaging for Medicare beneficiaries, particularly in rural areas. It should be noted that MedPAC did not use data reflecting the needs of rural areas. The shortage of specialists and lower population densities in rural areas limits imaging utilization rates. For example, urology practices in Montana report imaging use rates of 25-30 percent. 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. Finally, the surgical community urges the Committee to ensure that any savings generated from a change in imaging rates should remain within the program.

More Appropriate Payment for Durable Medical Equipment

The Committee states that it intends to pursue options that would improve payment accuracy for durable medical equipment, prosthetics, and orthotics (DMEPOS). The surgical community is supportive of this effort and understands that a substantial amount of fraud and abuse occurs in the Medicare program for DMEPOS.

As the Committee explores these options, the surgical community would like to ensure, however, that the Committee distinguishes between commercial DMEPOS suppliers and physicians who provide certain DMEPOS as part of providing high quality care to their patients. As we experienced during the implementation of the DMEPOS Competitive Bidding Program and the attempted application of quality standards intended for commercial DMEPOS suppliers, subjecting physicians to instruments intended for retail outlets leads to access to care issues for patients. Physicians are not similarly situated to commercial DMEPOS suppliers in that

physicians provide DMEPOS in order to address a patient's condition *during* the patient visit. In addition, physicians who supply DMEPOS do so *only for their patients*, not to the general public

We look forward to working with the Committee and the Department of Health and Human Services to ensure that steps to reduce unnecessary DMEPOS costs acknowledge the role of physicians in the program. The ability of a physician to address a patient's condition *during* the physician-patient visit and to ensure that the patient has received the appropriate DMEPOS with proper instruction on its use and application is integral to the quality and efficiency of patient care.

Reducing Geographic Variation in Spending (pgs. 13-14)

Much has been said about the variation of health care spending both regionally and nationally and we appreciate the Committee's recognition that increased spending does not necessarily correlate to improved care or better outcomes for patients. For example, as acknowledged by the 2003 National Institutes of Health (NIH) consensus panel on total knee replacement (TKR), patient acceptance of physician recommendations varies greatly and can thus lead to increased spending.

The surgical community strongly believes that payment alone is an ineffective and inappropriate instrument to reduce or eliminate geographic variation and could have the unintended consequence of restricting access to care. In our experience, physicians will more readily alter their practices based on feedback from clinical data and comparisons to their peers. We believe that so-called inefficient spending could be better addressed by ensuring that limited resources are redirected to those services and treatments with demonstrated value to patients. Among the tools that could be employed to ascertain value of health care services and treatments are clinical data registries, comparative effectiveness research, and evidence-based guidelines. Through the use of these and other tools, while at the same time preserving physicians' rights to use their best judgment in making care decisions, we believe it is possible to not only improve the quality of care, but reduce variation and possibly costs. In fact, several surgical groups are currently utilizing clinical data registries including the Society of Thoracic Surgeons (STS), the NeuroPoint Alliance created by the American Association of Neurological Surgeons and the Congress of Neurological Surgeons, the American Society of Plastic Surgeons, the American College of Surgeons' National Surgical Quality Improvement Program (NSQIP) and American Society of Breast Surgeons' Mastery of Breast Surgery Program.

The treatment of cardiovascular disease presents a good example of how these tools can be used together with the aim of providing high-value care and reducing variation. Last year, the Society of Thoracic Surgeons (STS), the American College of Cardiology (ACC) and other organizations released appropriateness criteria for coronary revascularization. These criteria will help physicians make decisions about whether it is appropriate to treat chest pain by performing revascularization (percutaneous coronary intervention) or bypass surgery. Because both the STS and ACC collect clinical data on these procedures, the goal is to examine whether the use of the evidence-based guidelines are effective at influencing practice patterns and improving outcomes. By linking the STS and ACC data, an effort that is currently underway, comparative effectiveness research will be possible to determine which patient populations may benefit more from one procedure versus the other. With this information, clinical practice guidelines can be continuously updated to reflect the best science and evidence.

We strongly encourage the Committee to take a step-wise and rational approach to reducing inefficient health spending. A good first step is investing in the infrastructure to provide clinical outcomes data that will be necessary to promote the delivery of high-value care. We oppose a punitive approach to reducing variation without giving physicians the tools to understand their practice patterns and outcomes when compared to their peers.

Again, thank you for your leadership and commitment to comprehensive health care reform. The surgical community appreciates the opportunity to provide comments on the policy proposals being considered by the Committee and looks forward to continuing to work with you as the health care reform moves through the legislative process.

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
The Society of Thoracic Surgeons