



Sound Policy. Quality Care.

January 8, 2010

Honorable Harry Reid
Majority Leader
United States Senate
Washington, DC 20510

Honorable Mitch McConnell
Republican Leader
United States Senate
Washington, DC 20510

Honorable Nancy Pelosi
Speaker of the House
U.S. House of Representatives
Washington, DC 20515

Honorable John Boehner
Republican Leader
U.S. House of Representatives
Washington, DC 20515

Dear Madam Speaker, Majority Leader, and Republican Leaders:

As the Alliance of Specialty Medicine (Alliance), our mission is to advocate for 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 this historic opportunity to improve access to quality health care and your work to produce HR 3962, the "Affordable Health Care for America Act" and HR 3590, the "Patient Protection and Affordable Care Act." We would like to take this opportunity to provide feedback on issues of importance to specialty physicians as you work to remedy the differences between the House and Senate passed bills.

INDEPENDENT PAYMENT ADVISORY BOARD

Our primary request is that you **strike sections 3403 and 10320 of HR 3590 which establishes the Independent Payment Advisory Board (IPAB)**. This provision is an inappropriate delegation of Congress's oversight responsibilities to an arbitrary board. Already, Medicare reimbursement rates are well below market rates, and it will likely only get worse. The IPAB solution will further ratchet down the costs, without oversight, without care taken to ensure that our seniors receive the quality health care that they need and deserve. Further, the construct of the Board seems to selectively exempt certain providers from its purview – placing more pressure to cut Medicare in those areas under its jurisdiction. We do not support allowing important health care decisions to be made with little clinical expertise, resources, or the oversight required to ensure that seniors are not placed in jeopardy.

MEDICARE PAYMENT POLICY PROVISIONS

Sustainable Growth Rate (SGR) -- Sustainable Growth Rate (SGR) -- While there are a host of Medicare payment provisions within HR 3962 and HR 3590, we are discouraged that neither bill includes a permanent fix to the Sustainable Growth Rate (SGR) formula, *and we urge you to provide a permanent fix as part of any health reform bill*. This critical policy issue must be addressed by February 28 to prevent drastic physician reimbursement cuts. **We stand ready to work with you to meet that deadline and urge you to place a high priority on meeting the deadline to avoid Medicare cuts and provide a permanent fix for the Medicare physician payment formula.**

Protecting Access to Specialty Care -- We appreciate your efforts to maintain appropriate access to specialty care while you shift health care delivery toward greater preventive care. **We also believe these efforts should NOT be distributed in a budget neutral fashion, which is why we are appreciative of the changes outlined by section 5101 of HR 3590 and section 1303 of HR 3962.** In addition, we want to **thank you for revisions to both of your bills which would allow specialists to participate in the accountable care organization demonstration programs** (section 1301 of HR 3962 and section 3002 of HR 3590).

However, there are a variety of Medicare payment provisions which, if enacted, will be detrimental to patient care. As you move the bill forward in the legislative process and examine the differences between the House and Senate bills **we strongly urge you to STRIKE the following provisions from any final bill:**

- **Center for Medicare and Medicaid Innovation** (sections 3021 and 10306 of HR 3590) which inappropriately delegates Congress's oversight responsibilities.
- **Value-Based Purchasing** (sections 1159 & 1160 of HR 3962 and section 3007 and 10301 of HR 3590) which arbitrarily accelerates the current VBP program before the demonstrations are completed and previously mandated reports are completed. Also, we do not support the new budget neutral modifier in Section 3007 of HR 3590.
- **Mis-Valued Physician Payment Services** (section 1122 of HR 3962 and section 3134 of HR 3590) which create additional layers of bureaucracy to review payment codes and fail to provide adequate physician input.
- **Geographic Variation** (sections 1157-1159 of HR 3962 and section 3102 of HR 3590) which is used as a marker for quality of care, but focused on costs and cost reduction rather than treatment quality.

QUALITY PROVISIONS

Comparative Effectiveness Research (CER) -- We strongly **support appropriately structured comparative effectiveness research as outlined in sections 6301 and 6302 of HR 3590 and urge you to retain those provisions as you reach final agreement.** All member organizations of the Alliance are actively engaged in the process of developing evidence-based and clinically relevant quality measures and establishing data registries through initiatives within their own specialty and/or through the AMA's Physician Consortium for Performance Improvement. The commitment is to provide the highest quality specialty care to Medicare beneficiaries in a transparent health care system so as to improve patient outcomes.

Physician Quality Reporting Initiative (PQRI) -- We appreciate your efforts to further improve and refine the Physician Quality Reporting Initiative (PQRI) (section 1124 of HR 3962 and section 3002 of HR 3590). In particular, **we urge you to maintain the changes in section 1124 of HR 3962 that would physicians to access their data in a timely manner, provide physicians with a reasonable appeals process, and ensure that PQRI is not punitive.**

Health Information Technology (HIT) -- The Alliance is pleased that the bill ensures clinical reporting on quality measures for PQRI and that the "meaningful use" definition included within the "American Recovery and Reinvestment Act of 2009" (ARRA) (P.L. 111-5) will be more fully integrated. However, **we urge you to amend the current HIT timelines.** Many specialty physicians will not be able to take advantage of the enhanced payments to purchase HIT because of the ambitious timelines and the fact that current specialty systems lack certification and interoperability standards. Further, the current certified HIT systems have been developed for primary care settings and have not yet been fully adapted for specialty care.

However, there are a variety of quality provisions which, if enacted, would have detrimental effects on patient care. . As you move the bill forward in the legislative process and examine the differences between the House and Senate bills **we strongly urge you to STRIKE the following provisions from any final bill:**

- **Physician Compare Website** (section 10331 of HR 3590) which will provide patients with confusing and conflicting information.
- **Hospital Readmissions** (section 1151 of HR 3962 and section 3025 of HR 3590) which fails to ensure that measures used to report readmission data are evidence based. At this juncture, the measures are not fully developed, approved or validated. The measures could penalize the specialties that have been at the forefront of measurement development and discourage the future development of similar measures. Additionally, the

legislation requires payment reductions even if all unnecessary admissions are eliminated. There needs to be an agreed upon acceptable rate of readmissions.

MEDICAL LIABILITY REFORM

We urge you to STRIKE section 10607 of HR 3590 and ACCEPT section 2531 of HR 3962 with an expansion of eligible State options. While the Alliance firmly believes that federal medical liability reform based on the California or Texas models, which include, among other things, reasonable limits on non-economic damages, is the gold standard, we appreciate and **support section 2531 of HR 3962 because it provides stronger incentives for appropriately designed State medical liability demonstration projects with measureable results.** As you further refine the proposal, we strongly encourage you to **expand the State options as originally proposed in the House Committee on Energy and Commerce** to provide a full range of solutions to this drastic problem.

OTHER KEY ITEMS

Physician Sunshine Act – We urge you to **STRIKE section 1421 of HR 3962 and ACCEPT section 6002 of HR 3590.** The Alliance believes that while relationships between physicians and industry are an important component of advancing medical technologies and improving patient care, uniform procedures for transparent disclosure must be in place to minimize confusion and misrepresentation. Due to key differences within the proposals, the Alliance supports section 6002 of HR 3590, given that section 1421 of HR 3962 will have a detrimental impact on funding of continuing medical education (CME) courses.

Health Benefits Advisory Committee – If this provision (section 123 of HR 3962) is maintained, **we strongly support explicit language that guarantees that a minimum of three practicing physicians** devoting at least one third time to direct patient care and representing different specialties will serve on the Committee.

We urge you NOT TO INCLUDE the following provisions in any final conference agreement:

- **National Medical Device Registry** (section 2571 of HR 3962) which could be subject to subpoena or FOIA requests and exacerbate the medical liability crisis. We are concerned that there are no protections for any physician level data and it would duplicate current post-market programs including those authorized, but not yet implemented, by the Food and Drug Amendments Act of 2007.
- **Physician-Owned Hospitals** (section 1156 of HR 3962 and section 6001 of HR 3590) which focus referrals on ownership and not overall quality of care.
- **Medical Residency Training** (section 1505 of HR 3962). Given Medicare's \$9 billion annual investment in graduate medical education (GME), the Alliance appreciates the need for accountability in this system. However, we are very concerned about the provisions of HR 3962 that would (1) establish in statute the goals of medical education and (2) require a GAO study to evaluate residency training programs.

We applaud many of the provisions in HR 3962 and HR 3590 that improve access to health insurance and believe a number of provisions must be included in any meaningful health reform package to improve access to affordable health insurance and assure access to specialty medicine. Those provisions that we believe should be maintained include eliminating pre-existing condition exclusions, providing adequate access to specialty care through the benefit package, addressing rescission of health coverage, ensuring continuity in Medicaid coverage for children who go in and out of the system, and prohibiting annual and lifetime coverage limits.

We would also like to thank you for changes in the legislation in response to our previously stated concerns. We appreciate that you **addressed our concerns related to imaging services** and clarified that the definition of advanced imaging does not include ultrasound as it relates to the increase in the utilization rate for imaging services. In addition, we applaud the **removal of the excise tax on certain elective medical procedures.**

Thank you for your commitment and leadership on this issue. If you would like further information about our specific policy positions, please see the enclosed attachment. If you have any questions or would like additional information, please e-mail us at info@specialtydocs.org.

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

Cc: Chairmen and Ranking members of health committees in House and Senate



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Attachment: Health Care Reform Policy Side by Side

Topic	HOUSE: HR 3962, "Affordable Health Care for America Act"	SENATE: HR 3590, "Patient Protection and Affordable Care Act"	Alliance position
INDEPENDENT PAYMENT ADVISORY BOARD			
Independent Payment Advisory Board	Not included	Included	Prefer House
MEDICARE PAYMENT POLICY PROVISIONS			
Sustainable Growth Rate (SGR) fix	Not included	Not included	Prefer a permanent fix
Primary care bonuses that are NOT budget neutral	Included	Included	Like both House and Senate
Inclusion of specialties in accountable care organization demo	Included	Included	Like both House and Senate
Center for Medicare and Medicaid Innovation	Included	Not included	Prefer House
Value-based purchasing	Included	Included	Request a deletion of these provisions
Mis-Valued Physician Payment Services	Included	Included	Request a deletion of these provisions
Geographic variation	Included	Included	Request a deletion of these provisions
QUALITY PROVISIONS			
Comparative Effectiveness Research	Included	Included	Prefer Senate version
Physician Quality Reporting Initiative	Included	Included	Prefer House version
Health Information Technology	Not included	Not included	Request a delay in ARRA timelines
Physician compare website	Not included	Included	Prefer House
Hospital readmissions	Included	Included	Request a deletion of these provisions
MEDICAL LIABILITY REFORM			
Medical liability reform	Some provisions included	Some provisions included	Prefer House with an expansion of State options
OTHER KEY ITEMS			
Physician Sunshine	Included	Included	Prefer Senate version
Health Benefits Advisory Committee	Included	Not included	If included, ensure physicians added
National Medical Device Registry	Included	Not included	Prefer Senate
Physician-owned hospitals	Included	Included	Request a deletion of these provisions
Medical residency training	Included	Included	Prefer Senate version
Imaging	Included	Included	Thanks for changes
Excise tax on certain elective procedures	Not included	Not included	Thanks for changes



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Attachment: Health Care Reform Policy Statements

INDEPENDENT PAYMENT ADVISORY BOARD

Independent Payment Advisory Board (Sections 3403 and 10320 of HR 3590). As the Alliance has stated before, Congress should retain proper oversight of the process that determines how services are provided under Medicare and not relegate it to another entity. If the goal of a new Advisory Board is to find new ways to eliminate spending in the Medicare program, the end result may well be detrimental to patient care for our nation's elderly. With the establishment of this body, we are also concerned that care and services for Medicare beneficiaries will be rationed to cut costs without examining the clinical need and efficacy of treatments. Already, Medicare reimbursement rates are well below market rates for similar services, and by requiring coordination with other payers), it will likely only get worse. And yet, the solution is further ratcheting down the costs, without oversight, without care taken to ensure that our seniors receive the care that they need and deserve. Further, the construct of the Board seems to selectively exempt certain providers from its purview – placing more pressure to cut Medicare in those areas under its jurisdiction. There is no question we need to improve the Medicare program to make it sustainable well into the future. However, Medicare cannot be “fixed” when we do not look at the whole program, but rather, chop it up and force program savings into specific areas, such as provider reimbursement. We certainly understand and appreciate concerns with the rising costs of health care. But this is not the way approach this problem. If we go forward with this process, there will be myriad unintended consequences, including restricting access to important interventions and services for Medicare patients. A recent example of this situation is the Mayo clinic, which is seen as a model for the delivery of quality care. The Mayo Clinic recently announced that an affiliated clinic is no longer accepting new Medicare patients due to reimbursement inadequacies. Physicians cannot afford to continue to see Medicare patients, a problem that will be further compounded if reimbursements are based on outcomes and treatments and services are rationed to limit patient access to the care needed to achieve quality outcomes. You should not allow important health care decisions to be made with little clinical expertise, resources or oversight required to ensure that seniors are not placed in jeopardy.

MEDICARE PAYMENT POLICY PROVISIONS

Sustainable Growth Rate (SGR). For the health care system to move forward with important system delivery reform and to continue to assure Medicare beneficiary access to high quality care, a stable physician reimbursement system must be enacted. Therefore, we strongly support legislative initiatives that replace Medicare's sustainable growth rate (SGR) formula with a stable mechanism for updating Medicare fees, and we are very discouraged that neither HR 3962 nor HR 3590 address this issue. Ideally any system that replaces the SGR would update payments based on the Medicare Economic Index, which would allow reimbursements to be based on the actual cost of providing care to our nation's elderly.

Protecting access to specialty care. We appreciate your efforts to maintain appropriate access to specialty care while you shift health care delivery toward greater preventive care. Preventive care is routinely provided by specialists in a number of different venues and should be rewarded in the same way as preventive care provided by any physician. We also believe these efforts should NOT be distributed in a budget neutral fashion, which is why we support the changes outlined by section 5101 of HR 3590 section 1303 of HR 3962. Budget neutral funding does not take into account significant reductions specialists have seen in their fees over time for the services they provide. Since the introduction of Medicare's Resource-Based Relative Value Scale (RBRVS) in 1992, specialists have seen significant reductions in the

fees they received for procedural services. Many specialty medical services were cut in 2008 because of an additional reduction in work values. Specialists continue to lose more ground in the fees they receive for serving Medicare beneficiaries while their practice costs steadily rise.

Accountable Care Organizations (section 1301 of HR 3962 and section 3002 of HR 3590). The Alliance appreciates the Committee's efforts to allow groups of providers to voluntarily work together to improve quality and save costs. We support exploration of alternative payment systems, including your proposal for Accountable Care Organizations and appreciate that the legislation retains the amendment to ensure inclusion of all physicians regardless of specialty. As you explore these alternative systems, we urge you to consider the full cost of the treatment of disease and not focus on a single event. Our vision should remain long term and not result in pressure to save money in the short term for a single event or procedure, only to require additional interventions down the road because of choices made in a vacuum. Congress needs to ensure that alternative systems must be fully tested to understand their implications on quality of care and determine whether they achieve their stated goals.

Center for Medicare and Medicaid Innovation (sections 3021 and 10306 of HR 3590). The Alliance cannot support the currently outlined Center for Medicare and Medicaid Innovation. While the Alliance appreciates the need for stronger innovation in developing new payment methodologies, we remain concerned with the underlying proposal to establish the Center for Medicare and Medicaid Innovation without additional oversight. Given the potential negative impacts on patient care, any new payment methodology should be thoroughly evaluated, posted for public comment as required by law, and approved by Congress before being fully implemented. Therefore, we strongly urge you not to eliminate Congress's oversight responsibility.

Value Based Purchasing (sections 1159 & 1160 of HR 3962 and sections 3007 and 10301 of HR 3590). As a general concept, value-based purchasing (VBP) has great merit. However, the Department of Health and Human Services (HHS) is still working to determine the best way to do so, with the various demonstration projects that have already been authorized. We are concerned that the timeline for an Institute of Medicine study, recommendations and implementation plan will short-circuit a process that will completely revamp the Medicare payment system. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) requires the Secretary to submit a report to Congress next year with a VBP program for Medicare payment. Congress should allow HHS to further examine how to make this work best by allowing the value based purchasing demonstration projects already underway to finish. There is widespread agreement that the current SGR process results in arbitrary and damaging cuts to Medicare physician payment. We cannot achieve a reliable or stable incentive for quality care by modifying arbitrarily – and arbitrarily changing – reimbursement rates. Additionally, the new modifier in Section 3007 of HR 3590 would be budget neutral, resulting in some providers facing the dual blow of arbitrary SGR cuts and neutrality-imposed value-based purchasing cuts.

While the Center for Medicare and Medicaid Services (CMS) has been testing various models for value-based payment, CMS does not currently have the capability to implement such a plan for value-based purchasing among ambulatory surgical centers. CMS has no valid methodology that incorporates appropriate risk adjustment factors and outcome measures, given that CMS has not even begun to report on quality measures for ambulatory surgical centers let alone base payments off of such measures. While CMS has required quality measure reporting for other entities (such as physicians), CMS has no experience with requiring quality reporting for ambulatory surgical centers. As CMS has learned from the Physician Quality Reporting Initiative, it takes several years to develop fully validated quality measures relevant to specific providers. Furthermore, there are many reasons for geographic cost variation, including differences in population demographics that merit significantly more study before such a measure could be implemented. Therefore, this proposal would create yet more instability with an unrealistic and unachievable timeline. CMS should be allowed to fully test models for value-based payment and determine which system would achieve maximum benefit before the Agency is required to arbitrarily develop a plan for requiring a value-based purchasing program for ambulatory surgical centers.

Mis-Valued Physician Payment Services (section 1122 of HR 3962 and section 3134 of HR 3590). The Alliance is very concerned about the proposal to address over-valued physician services by having the Center for Medicare and Medicaid Services (CMS) directly evaluate and adjust payment for potentially mis-valued physician services because this

proposal is unnecessary. We believe this proposal is unnecessary and redundant of 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 mis-valued under the Five-Year Review of Work. This process assures physician input from a variety of disciplines to examine potentially mis-valued physician services, and we believe is a more effective than a concurrent CMS process. Therefore, we urge you to delete this section.

Geographic Variation (sections 1157-1159 of HR 3962 and section 3102 of HR 3590). The Alliance is disappointed that the geographic variation provisions in the legislation are focused on costs and cost reduction rather than first examining treatment quality. A better focus would be to determine root causes for noted discrepancies in utilization rates in different parts of the country, including understanding the difference in patient demographics, patient access to care and the difference in physician supply and mix. Attention should be paid to 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 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.

QUALITY PROVISIONS

Quality Measurement (section 1441 of HR 3962 and section 3011-3015 of HR 3590). Your proposal provides additional authority to the Secretary of Health and Human Services, working in conjunction with AHRQ, to further strengthen and improve quality measurement and development processes. The Alliance welcomes this proposal and recommends that these resources be used to fill gaps in clinical research that will allow us to build a better supply of evidence-based clinical practice guidelines, to fund clinical data registries and other innovative quality improvement activities, to develop valid risk adjustment mechanisms that will allow us to take full advantage of clinical outcomes data, and to conduct studies on whether currently used measures have any impact on quality and cost.

Prior to developing efficiency measures, there should be studies on the impact of the current quality measures. We appreciate that the proposal recognizes the need for measures to focus on a range of important areas, including patient outcomes, functional status, patient experience or satisfaction, and care coordination. Unfortunately, such measures have not been shown to improve health care quality. Therefore, we urge the committee to carefully consider the implications of measuring efficiency, given the lack of necessary studies. Cost should not trump quality, and information accrued from studies on the impact of measures should be presented in a manner that is meaningful and actionable to both physicians and patients.

We have concerns about the proposal's continued heavy reliance on NQF-endorsed measures, but appreciate the changes thus far. The National Quality Forum (NQF) is certainly the most balanced and, structured of all the current multi-stakeholder groups. However, NQF's ever-expanding size and scope often make it difficult to focus on vital quality improvement activities that are most relevant to smaller specialties and their patients, such as outcomes measures that rely on clinical data sources. Specific measures areas chosen by NQF for review and endorsement understandably require commitment of limited resources and therefore must be prioritized. As a consequence, measures of vital importance to some specialties often do not merit timely review, thereby seriously delaying the availability of endorsed measures for some specialties. Moreover, it still takes significant time to convene a technical review panel and move its recommendations through the membership and NQF oversight committees for approval. It is for these reasons that many specialties feel the need for access to alternative sources of approved measures.

Comparative Effectiveness Research (CER) (sections 1401, 1802 & 2401 of HR 3962 and sections 6301 and 6302 of HR 3590). The Alliance is pleased that both the House and Senate bills includes a provision to expand comparative effectiveness research (CER). The Alliance believes appropriately designed CER conducted by an independent entity (as outlined in HR 3590) with full participation of all relevant stakeholders should enhance information about treatment options and outcomes for patients and physicians, helping them to choose the care that best meets the individual needs of the patient. The success of CER relies on appropriate input from specialty physicians providing the treatments being evaluated. Further, Congress must establish an independent CER structure to limit the inherent conflict of interest

associated with this research and to ensure results provide valuable information for patients and physicians. CER also needs to recognize the diversity, including racial and ethnic diversity, of patient populations and subpopulations and communicate results in ways that reflect the differences in individual patient needs. It should not be a vehicle for making centralized coverage decisions or recommendations. The Alliance is also pleased with the specific revisions to the CER provisions in HR 3590 that would add additional physicians to the CER panel. Finally, the Alliance also strongly urges you to include medical liability protections for health care providers when they follow practice guidelines recommended by the CER entity.

Physician Quality Reporting Initiative (PQRI) (section 1124 of HR 3962 and section 3002 of HR 3590). All member organizations of the Alliance are actively engaged in the process of developing evidence-based and clinically relevant quality measures and establishing data registries through initiatives within their own specialty and/or through the AMA's Physician Consortium for Performance Improvement. The commitment is to provide the highest quality specialty care to Medicare beneficiaries in a transparent health care system so as to improve patient outcomes. We appreciate your efforts to further improve and refine the Physician Quality Reporting Initiative (PQRI). In particular, we urge you to maintain the changes in section 1124 of HR 3962 that would physicians to access their data in a timely manner, provide physicians with a reasonable appeals process, and ensure that PQRI is not punitive.

We encourage the Committee to consider establishing a public private partnership to provide long-term support for clinical data registries and measure development currently undertaken solely through the limited resources of medical specialty societies. Additionally, the PQRI program should reward physicians who report clinical data to such registries.

Health Information Technology (section 1124 of HR 3962 and section 3002 of HR 3590). The Alliance is pleased that the bill ensures clinical reporting on quality measures for PQRI and that the "meaningful use" definition included within the "American Recovery and Reinvestment Act of 2009" (ARRA) (P.L. 111-5) will be more fully integrated. However, we would like to take this opportunity to urge you to consider amending the current HIT timelines. Many specialty physicians will not be able to take advantage of the enhanced payments to purchase HIT because of the ambitious timelines and the fact that current specialty systems lack certification and interoperability standards. Further, the current **certified** HIT systems have been developed for primary care settings and have not yet been fully adapted for specialty care. The financial incentives and penalties are based on the adoption and "meaningful use" of certified HIT systems and will have a profound impact on our members and their ability to adopt and become meaningful users. Physicians are hesitant to make the considerable investment until certified systems that meet their unique needs are available. Therefore, we urge you to consider amending the current HIT timelines included in the ARRA.

Physician compare website (section 10331 of HR 3590). The Alliance is extremely concerned by the creation of a physician compare website and incentives for Medicare beneficiaries to choose specific "high performing" providers. In fact, there currently is no consensus definition of what determines a "high performing" physician, and the actual selection of an appropriate physician is generally dependent on personal preferences. The legislative language is unclear regarding how quality outcomes will be determined and whether appropriate risk adjustment would be included. Many specialists care for extremely ill patients with co-morbidities. It is imperative to take all this information into consideration when trying to compare one physician to another. Without consensus about an appropriate outcome or various risk-adjustment factors, this amounts to an arbitrary label that could be misinterpreted by patients seeking quality care. In addition, it seems impossible to appropriately describe a doctor-patient relationship with just a few arbitrary measures focused only on the physician's characteristics. Further, by providing financial incentives to Medicare beneficiaries who are furnished services by high performing physicians, without appropriate testing of these incentives (including testing for statistical validity), this amendment would likely result in confusing and conflicting information for our seniors. This amendment does not provide an appropriate selection process for those critical measures nor an appropriate testing of such measures.

Hospital Readmissions (section 1151 of HR 3962 and section 3025 of HR 3590). We have concerns about the proposal to reduce net hospital payments of some hospitals based on measures of readmissions for just three procedures. The measures are not fully developed, approved or validated at this point in time. They penalize the specialties that have been at the forefront of measurement development thereby discouraging future development of such measures.

Additionally, the legislation requires payment reductions even if all unnecessary admissions are eliminated. There needs to be an agreed upon acceptable rate of readmissions.

MEDICAL LIABILITY REFORM

Medical Liability Reform (section 2531 of HR 3962 and section 10607 of HR 3590). While the Alliance firmly believes that federal medical liability reform based on the California or Texas models, which include, among other things, reasonable limits on non-economic damages, is the gold standard, we appreciate and support the inclusion of a proposal which seeks to encourage states to adopt liability reforms. We urge you to strengthen this provision because we believe these modest medical liability reforms will not fully alleviate the patient access crisis faced in many states and specialties or the exorbitant costs of defensive medicine that add billions in health care spending each year. As you are aware the Congressional Budget Office recently scored comprehensive and proven medical liability reforms, as outlined above, as saving the federal government \$54 billion over the next decade. In addition to this savings, these reforms will also improve patient access to specialty care, particularly in rural and underserved areas.

OTHER KEY ITEMS

Physician Sunshine (section 1421 of HR 3962 and section 6002 of HR 3590). The Alliance believes that while relationships between physicians and industry are an important component of advancing medical technologies and improving patient care, uniform procedures for transparent disclosure must be in place to minimize confusion and misrepresentation. The proposals outlined in both bills will strengthen transparency in the medical profession and uphold the professional standards that professional medical societies have in place to govern interaction between physicians and the pharmaceutical, biologics, and device industry. We appreciate that both H.R. 3962 and H.R. 3590 clarifies the physician role regarding the accuracy of information and envisions a system to allow physicians to bring inaccuracies to the attention of those reporting.

Unfortunately, section 1421 of HR 3962 contains additional problematic provisions. We remain extremely concerned with the impact the provision in its current form will have on funding of continuing medical education courses, which already are managed for conflict of interest through the accreditation process overseen by the American Council for Continuing Medical Education (ACCME). There is a legitimate place for ethical partnerships between industry and medical associations and this support has long helped support the advancement of cutting edge science, clinical innovation and continuing medical education.

Health Benefits Advisory Committee (section 123 of HR 3962). The Alliance is concerned that the composition of the Health Benefits Advisory Committee does not require greater physician representation. We strongly support explicit language that guarantees that a minimum of three practicing physicians devoting at least one third time to direct patient care and representing different specialties will serve on the Committee.

National Medical Device Registry (section 2571 of HR 3962). The Alliance is strongly opposed to the inclusion of this section due to concerns that the National Medical Device Registry (NMDR) could be subject to subpoena or FOIA requests by personal injury attorneys and then used to exacerbate the medical liability crisis. There are no protections for any physician level data in this language which is ill-advised at a time when the public overwhelmingly supports comprehensive medical liability reform. Additionally, the NMDR would duplicate several post-market programs including those authorized but not yet implemented in the Food and Drug Amendments Act of 2007. We urge you to not include this section in the final health care reform legislation. If this section remains in the final bill, we advise a much more cautious approach and would prefer a very limited pilot project to assess the utility and ramifications of capturing this data.

Physician-Owned Hospitals (section 1156 of HR 3962 and section 6001 of HR 3590). The Alliance believes that physicians should have the ability to treat patients in whichever setting they feel offers patients the highest quality of care available. Ethical referral under the current "Stark laws" provides physicians and their patients the opportunity to determine together which setting is most appropriate for the treatment they require. The requirements laid out in the legislation that are not related to patient referral or disclosure of ownership interest are overly prescriptive and not currently required of other non-physician owned health care entities. We urge the Congress not to discriminate against physician-owned hospitals.

Medical Residency Training (section 1505 of HR 3962). Given Medicare's \$9 billion annual investment in graduate medical education (GME), the Alliance appreciates the need for accountability in this system. However, we are very concerned about the provisions of HR 3962 that would (1) establish in statute the goals of medical education and (2) require a GAO study to evaluate residency training programs. The Accreditation Council for Graduate Medical Education (ACGME) has a very dynamic and robust system for ensuring that our nation's training programs are meeting the needs of the 21st Century health care delivery system. The six core competencies that must be incorporated into the curriculum of every residency training program – patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice – demonstrate that the profession and medical educators are satisfying the goals of this provision of the draft bill. In addition, the individual specialty societies are also evaluating and reevaluating, on an ongoing basis, GME curricula. Medical education should remain in the purview of the profession and medical educators, and the Alliance firmly believes that the ACGME and specialty societies are doing a superb job in educating and training our Nation's future physicians. We therefore urge you to delete this entire section of the bill.

Imaging. We thank you for making changes to your provisions which would alter the utilization rates for imaging services. Specifically, we appreciate the changes to ensure that ultrasound and X-ray are not included so that your current provision focuses on more advanced, expensive imaging services and not catalog all imaging services into one category. As you know, the MedPAC recommendation only applied to advanced imaging equipment, with a cost of one million dollars or more. Ultrasound equipment cost on average \$40,000 -- far less than MedPAC's recommendation.

Excise tax on certain elective medical procedures. Physicians strongly oppose taxes on distinctive physician services to fund health care programs or to pay for health care reform and we therefore are extremely concerned by the last minute addition of the tax on elective cosmetic surgery and medical procedures. This is a dangerous precedent to set as it places physicians in the role of tax collector, compromises patient safety by encouraging individuals to circumvent the tax by seeking procedures from non-medical personnel or providers in other countries, and jeopardizes patient privacy by opening physician practices up to IRS audits. Furthermore, once in place, we fear that this tax could easily be expanded to other health care services. As demonstrated by New Jersey's experience with a similar tax, the application of such a tax is arbitrary and confusing to administer.