7075 Veterans Blvd.
Burr Ridge, IL 60527
tf (866) 960-6277 p (630) 230-3600 f (630) 230-3700
www.spine.org

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July 28, 2009

The Honorable Nancy Pelosi
235 Cannon House Office Building
Washington, DC 20515

Dear Speaker Pelosi:

The North American Spine Society (NASS) is a multidisciplinary medical organization dedicated to fostering the highest quality, evidence-based, and ethical patient care by promoting education, research, and advocacy. NASS is comprised of more than 5,500 physician and non-physician members from several disciplines including orthopedic surgery, neurosurgery, physiatry, neurology, radiology, anesthesiology, research, physical therapy and other spine care professionals. As patient and physician advocates, NASS appreciates your efforts to improve the health care offered to our citizens through the introduction of H.R. 3200, "America's Affordable Health Choices Act of 2009." NASS is concerned, however, that several elements within the overall package will fail to control costs, fail to improve quality and further diminish access to care for patients.

<u>Workforce issues:</u>
NASS recognizes the importance of primary and preventive care for Medicare beneficiaries. NASS believes efforts should simultaneously strive to maintain appropriate access to specialty care. <u>Cost effective preventive and maintenance care is routinely provided by specialists in a number of different venues.</u> Primary care providers received a large increase in reimbursement during the 2005 physician fee update. 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 for a second time during the last Five-Year Review because of an additional reduction in work values. Specialists are continuing to lose more ground in the fees they receive for serving Medicare beneficiaries while their practice costs steadily rise. H.R. 3200 offers variable payment rates towards primary and specialty care. <u>NASS believes that continued reductions in specialist reimbursement will result in dramatic specialist workforce shortages and further reduce access and delay access times for specialty care for Medicare beneficiaries.</u>

Data show that predicted workforce shortages for specialty care are similar to those expected for primary care. In its November 2008 report, *The Complexities of Physician Supply and Demand: Projections through 2025,* the Association of American Medical Colleges estimated that physician demand will outpace supply for the foreseeable future. The report estimates a physician deficit of 124,000 during the time period studied with workforce shortages between primary and surgical care varying only slightly—46,000 for primary care and 41,000 in the surgical disciplines. Additionally, the Bureau of Health Professions has cited significant workforce challenges across surgical specialties. Between 2005 and 2020, the Bureau projects significant decreases in a number of surgical specialties while expecting primary care physicians to increase by 19 percent.

Liability reform:

The medical liability climate in the U.S. prevents millions of patients each year from receiving the quality care they require; this is particularly a problem in rural areas where specialists are not readily available due to malpractice concerns. The lack of medical liability reforms adds billions to the nation's health care costs through widespread and deep defensive medicine practices. NASS is discouraged that H.R. 3200 fails to recognize the need to address our broken medical liability system as a strategy to achieve health system savings. NASS maintains that any serious effort at comprehensive health care reform must include medical liability reform. Further, NASS strongly urges that additional medical liability protections be specifically included in this bill when health care providers follow practice guidelines that may be established by any government mandated comparative effectiveness research (CER) entity. Additionally, NASS believes that physicians providing care in response to a national disaster should be covered under the Federal Tort Claims Act, as should physicians responding to call in emergency rooms located in underserved areas.

Sustainable Growth Rate (SGR) formula and decreasing physician reimbursement:

NASS appreciates the recognition that the current SGR formula is flawed, and values the efforts of H.R. 3200 to create a long-term solution. However, NASS does not support replacing the current formula with a new formula based on Gross Domestic Product. Given the deep reductions in specialty care reimbursement over many years, NASS does not support the further differential targets in the calculation of primary and specialty care physician reimbursement updates that the bill proposes. NASS believes that GDP does not accurately reflect the increasing costs and burdens of appropriate and required medical practice expenses, and recommends that any new formula be based on the Medicare Economic Index or similar index. Total spending under Medicare Part B increases annually secondary to increased costs of imaging, physician administered drugs, and multiple non-physician service category expenses. The inclusion of multiple service categories of Medicare beneficiary expenditure within Part B expenditure does not lend to fair or accurate physician payment update determination. NASS supports removing facility fees for imaging services from the current calculation of physician payment updates, and would further support multiple service category targets in the computation of annual updates to Medicare Part B payments.

NASS is deeply concerned with provisions that attempt to address suspected over-valued physician services by having the Center for Medicare and Medicaid Services (CMS) directly evaluate and adjust payment for these services. This mandate is redundant and duplicates the efforts of the American Medical Association (AMA) established 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 misvalued under the Five-Year Review of Work. In 2006, the RUC expanded its role by forming the Five-Year Review Identification Workgroup to identify, on an on-going basis, potentially misvalued services, as well as codes for consideration during future Five-Year Reviews. The Workgroup implemented several screens to facilitate an objective comprehensive review of potentially misvalued services. In addition to identifying codes with high volume growth, the Workgroup also screens for site-of-service anomalies, codes that are inherently performed together, and codes with high intra-service work per unit of time.

In fiscal year 2009, CMS issued a proposed rule to accelerate the review of the fastest growing higher cost procedures, including services with potentially unexplained high RVUs and procedures that have

not been reviewed by the RUC since the fee schedule was created. CMS has requested that the RUC begin reviewing the identified codes immediately but anticipates that this process may take a number of years due to the large number of services involved. There is already a process in place, which assures physician input from a variety of disciplines to examine potentially misvalued physician services. Therefore, NASS urges deletion of this language from H.R. 3200.

Public plan option:
Various concerns have been raised by multiple groups on funding mechanisms for any proposed public plan. The evolution of a public plan needs to be done in a transparent and deliberate fashion, with input from multiple stakeholders. NASS would like to point out that innovation has been the driver of progress and excellence in American healthcare, and the reason patients worldwide still travel to the US when they want the best health care. A government controlled payor system will stifle innovation, progress and free enterprise.

NASS feels that workforce issues for both primary and specialty care physicians must be addressed as part of the development of any public plan option. A public plan that does not account for adequate physician coverage of the insured group, or is not financially viable over the long term will ultimately increase costs for all and further reduce access for beneficiaries. Increase in the “insured” does not imply an increase in “access” to physicians. Additionally, NASS physicians feel that current Medicare physician payment rates do not account for the cost of providing care. NASS opposes required mandatory participation of Medicare providers in any public health insurance plan, and oppose linking reimbursement formulae for any proposed public plan to current Medicare physician payment rates.

Alternative healthcare delivery systems:
NASS supports the exploration of alternative healthcare delivery systems, including the proposals for both accountable care organizations and medical home pilot programs. Access to specialty care has been inadequately addressed in the current proposals. Currently, 60% of US physicians are specialists. Patients request and choose specialty care for many of their health conditions. For any alternative health delivery systems to succeed, NASS believes specialty medicine must be an integral part of the planning and execution of these various models. As alternative systems continue to be explored, NASS urges the consideration of the full cost of the treatment of disease and is against focusing on a single event.

Health Benefits Advisory Committee:
NASS is concerned with the proposed composition of a Health Benefits Advisory Committee or Independent Medicare Advisory Council with little to no physician input or oversight. Any such advisory body making decisions affecting patient care must include abundant representation by physicians actively involved in patient care. NASS is concerned with any proposal that would give extensive powers to this type of body with little oversight or accountability. The determinations of any such body should be made after due consultation with various specialty organizations and physicians involved in patient care.

Physician Quality Reporting Initiative (PQRI):
NASS appreciates the inclusion of changes to PQRI that would allow physicians to access their data in a timely manner, provide physicians with a reasonable appeals process, and ensure that PQRI is not punitive. Additionally, NASS believes that the PQRI program should reward physicians who report

clinical data to such registries. NASS encourages further consideration on the establishment of a public-private partnership to provide long-term financial support for clinical data registries and measure development currently undertaken solely through the limited resources of medical specialty societies.

Comparative Effectiveness Research (CER):

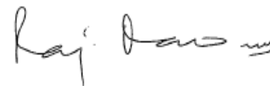
NASS is pleased that H.R. 3200 includes language to expand CER. CER findings or recommendations should not be binding in terms of patient care or intrude into the physician – patient relationship. In no way should findings or recommendations of a CER body be tied to reimbursement decisions. CER should augment information on treatment options and outcomes for patients and physicians, helping both parties choose the care that best meets the needs of an individual patient. NASS believes that CER must recognize a patient's individual characteristics (eg, co-morbidity, age, gender, race, potential for noncompliance with treatment and access to care) and communicate results in ways that reflect the differences in individual patient needs in order to be an effective tool for improving quality.

Relationships between physicians and industry:

NASS supports the physician/industry relationship disclosure language included in H.R. 3200. While relationships between physicians and industry are an important component of advancing medical technologies and improving patient care, NASS believes that uniform procedures must be in place for transparent disclosure to minimize confusion and misrepresentation. The proposals outlined will strengthen transparency in the medical profession and uphold professional medical society standards governing interaction between physicians and the pharmaceutical, biologics, and device industry. NASS encourages the adoption of language that would provide physicians with the ability to correct inaccuracies in their report and provide background information on their relationships with industry prior to the public release of this information. In addition, NASS is concerned with proposed restrictions 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 relationship has long helped support the advancement of cutting edge science, clinical innovation and continuing medical education.

Thank you for your continued commitment and leadership in reforming the nation's health care system. Please contact Nicholas Schilligo, Senior Manager of Advocacy, if you have any questions or would like additional information. Mr. Schilligo may be reached at 630-230-3671 or nschilligo@spine.org.

Sincerely,



Charles Branch, MD
President

Raj Rao, MD
Chairman, Advocacy Committee