The Alliance of Specialty Medicine urges Congress to act immediately to repeal the flawed Medicare physician payment system, known as the sustainable growth rate (SGR) formula, and to replace it with a system that accurately reflects the cost of medical practice and incentivizes quality improvement in a meaningful and clinically relevant manner.

Snapshot of the Issue – Unless Congress acts, the SGR formula will trigger a massive cut to physician reimbursement, slashing payments by more than 24% despite Medicare rates that are already well below market rates. These deep cuts, paired with other potential cuts from the Independent Payment Advisory Board (IPAB) and the Budget Control Act, threaten the viability of many physicians’ practices and imperil patient access to specialty care.

The Bottom Line – In order to transform care delivery, Medicare’s flawed SGR system must be repealed, the accumulated SGR debt eliminated, and the SGR formula replaced with a stable and fair mechanism for updating Medicare fees that ensures beneficiary access to high quality care.

Key Principles of Medicare Payment Reform – As Congress considers alternative payment models that would tie physician reimbursement to quality, the Alliance encourages Congress to adhere to the following principles:

• Ensure that all physicians receive adequate reimbursement. Physician shortages are looming in many specialties, not just primary care. Payment differentials will further exacerbate shortages of specialty physicians.

• Repeal of the SGR should be followed by a minimum 5-year period of payment stability. This period will give physicians time to invest in Electronic Health Records (EHR) and other quality reporting infrastructure, and should include annual updates equal to the Medicare Economic Index (MEI) to recognize the inflationary cost of practice.

• Maintain a viable fee-for-service (FFS) option. As other payment systems are explored, it is important to maintain flexible criteria that allow physician participation in delivery and payment models that are most meaningful to their practice and that preserve patient access to specialty care. This includes FFS, which may work best for patients with serious illnesses or in underserved areas where provider choice is already limited.

• Incentivize meaningful, physician-led quality improvement, rather than penalize arbitrary indicators of performance. In linking physician payment to quality care, Congress should use positive financial incentives rather than penalties and withholds. Physicians should be given the flexibility to choose among quality improvement activities that are most relevant to their practice and deemed appropriate by medical specialties/societies.

• Limit unnecessary regulatory requirements. Congress should not expand upon what are already administratively burdensome programs that rely on metrics of questionable value and include future penalties that, when combined, could reduce physician reimbursement by almost ten percent. Existing programs, such as the Physician Quality Reporting System (PQRS), the EHR Incentive Program and the Value-based Payment Modifier and associated penalties should be replaced with more meaningful programs or maintained only as an option for those who find them relevant.

• Legal protections for physicians who satisfy quality improvement program requirements. Physicians who adhere to best clinical practices deserve protections.

• Implement efficiency incentives cautiously and incrementally. Payment reforms, including those based on efficiency, should be developed by physicians and carefully tested in a variety of settings to minimize adverse consequences.

• Repeal of the IPAB. The IPAB will jeopardize Medicare patients’ access to care.

• Allow for voluntary private contracting between physicians and Medicare beneficiaries. Patients and physicians should be able to freely contract, in writing, for Medicare covered services without having to lose their Medicare benefits.

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Support Medical Liability Reform – Cosponsor H.R. 36 / S. 961, H.R. 1733 and H.R. 1473

The Alliance supports meaningful medical liability reform that reduces growth in healthcare costs, preserves access to specialty care, and encourages physician engagement in meaningful quality improvement activities.

**H.R. 36 / S. 961, the “Health Care Safety Net Enhancement Act of 2013”** was introduced in the House of Representatives by Reps. Charlie Dent (R-PA), Pete Sessions (R-TX), Jim Matheson (D-UT), and Jim Langevin (D-RI) and in the United States Senate by Senator Roy Blunt (R-MO). This legislation would extend Federal Tort Claims Act liability protections to on-call physicians. The inherently risky lifesaving care provided by on-call specialists exposes these providers to an increased likelihood of litigation because emergency and trauma patients are often sicker, have more serious complications, and usually have no pre-existing relationship with the treating physician. Unfortunately, the high-risk of being sued and the increased professional liability costs have reduced the pool of these providers to dangerously low levels. Please cosponsor this bipartisan bill by contacting Laura Kent (Rep. Dent) at 5-6411 or Laura.Kent@mail.house.gov, or Kristina Weger (Sen. Blunt) at 4-5721 or Kristina_Weger@blunt.senate.gov.

**H.R. 1733, the “Good Samaritan Health Professionals Act of 2013”** was introduced in the House of Representatives by Representatives Marsha Blackburn (R-TN) and Jim Matheson (D-UT). The legislation limits the liability of health care professionals who volunteer to provide health care services in response to a declared natural disaster. Such protections would not be extended in cases of willful or criminal misconduct, gross negligence, reckless misconduct, etc. To cosponsor this bipartisan bill, please contact Keith Studdard (Rep. Blackburn) at 5-2811 or Keith.Studdard@mail.house.gov, or Joel Bailey (Rep. Matheson) at 5-3011 or Joel.Bailey@mail.house.gov.

**H.R. 1473, the “Standard of Care Protection Act”** was introduced in the House of Representatives by Representative Phil Gingrey (R-GA). The legislation would help ensure that provisions of law regarding federal health care programs are not used, outside their intended purpose, to create new standards of care for medical liability lawsuits. This bill clarifies that lawsuits could not be based simply on whether medical providers followed the national guidelines or payment policies created in our federal health care laws. With so many changes occurring in the health care system, many people have concerns that misinterpretations of federal rules and regulations could result in new, and unwarranted, liability exposures. This legislation will help alleviate those concerns amongst health care providers, and will ensure that more unnecessary lawsuits, which increase the costs of health care, are not added to the medical liability system. To cosponsor H.R. 1473, please contact David Pulliam (Rep. Gingrey) at 5-2931 or David.Pulliam@mail.house.gov.

Going forward, meaningful medical liability reform should fully compensate patients for medical/economic damages, while placing a reasonable $250,000 limit on noneconomic damages and making a defendant liable only for damages equal to his/her share of responsibility; maximize patient awards and discourage frivolous lawsuits through sliding scale contingency fees; eliminate double recovery by accounting for evidence of collateral source benefits paid; and award punitive damages when there is clear and convincing evidence of malicious intent to injure or deliberate failure to avoid unnecessary injury.
**Repeal the Independent Payment Advisory Board (IPAB) – Cosponsor H.R. 351/S. 351**
The Alliance opposes the IPAB and urges you to cosponsor the bipartisan “Protecting Seniors’ Access to Medicare Act of 2013,” introduced in the House of Representatives by Representatives Phil Roe, MD (R-TN) and Allyson Schwartz (D-PA) and in the United States Senate by Senator John Cornyn (R-TX). The bill would eliminate the IPAB which was created under the “Patient Protection and Affordable Care Act” (PPACA) and will require a board of non-elected government officials to recommend Medicare cuts when spending exceeds a targeted growth rate.

**IPAB grants unprecedented “fast track” authority** over Medicare to an unaccountable, unelected body with minimal Congressional oversight, which could impact the quality of healthcare. IPAB’s recommendations automatically go into effect unless blocked by a Congressional three-fifths supermajority.

**The breadth of IPAB’s authority is unfairly focused on physicians.** Hospitals and Long Term Care Facilities comprise over one-third of Medicare spending, but are exempted until 2020 from IPAB cuts, which means further cuts for physicians, who make up less than 10% of total Medicare expenditures.

**IPAB subjects physicians to double jeopardy through multiple annual spending targets.** Physician reimbursement rates are already well below market rates. Coupling the IPAB and sustainable growth formula (SGR) will place further pressure on physicians to limit or stop seeing Medicare patients, further limiting access.

To cosponsor, please contact: John Martin (Rep. Roe) at 5-6356 or John.Martin@mail.house.gov, Charlene MacDonald (Rep. Schwartz) at 5-6111 or Charlene.MacDonald@mail.house.gov, or Laura Holland (Sen. Cornyn) at 4-2934 or Laura_Holland@cornyn.senate.gov.

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**Support the Medicare Patient Empowerment Act – Cosponsor H.R. 1310/S. 236**
The Alliance urges you to cosponsor the “Medicare Patient Empowerment Act,” introduced by Representative Tom Price, MD (R-GA) and Senator Lisa Murkowski (R-AK).

**Medicare limits patient choice.** The current structure of Medicare limits a beneficiary from accessing physicians who “opt out” of Medicare. If a doctor has “opted out” of Medicare in order to contract privately with even one patient, the physician is ineligible for Medicare reimbursement for two years.

**Beneficiaries must pay all costs out of pocket if they privately contract with a physician.** Under current law, beneficiaries who wish to privately contract with their physician are at a disadvantage, as they are responsible for paying for the entire service, despite paying into the program for many years. Medicare should reimburse what it would otherwise pay for a service.

**Physicians must “opt out” of Medicare if they privately contract with a Medicare patient.** The legislation removes the two-year ban from Medicare for physicians who privately contract, and allows patients who privately contract to recoup the amount Medicare would otherwise pay for the service.

To cosponsor, please contact: Amanda Street (Rep. Price) at 225-4501 or Amanda.Street@mail.house.gov, or Amanda Makki (Sen. Murkowski) at 224-6665 or Amanda_Makki@murkowski.senate.gov.
Graduate Medical Education (GME) – Cosponsor H.R. 1180/S. 577 and H.R. 1201

The Alliance of Specialty Medicine urges Congress to acknowledge the importance of specialty medicine and address the workforce shortages in many specialties that will jeopardize access to care for patients. We urge you to cosponsor the bipartisan “Resident Physician Shortage Reduction Act” (H.R. 1180/S. 577) introduced by Representatives Joseph Crowley (D-NY) and Michael Grimm (R-NY), and by Senators Bill Nelson (D-FL), Harry Reid (D-NV), and Charles Schumer (D-NY). In addition, we urge support of the bipartisan “Training Tomorrow’s Doctors Today Act” (H.R. 1201) introduced by Representatives Aaron Schock (R-IL) and Allyson Schwartz (D-PA).

Snapshot of the Issue – The United States will face an overall shortage of more than 130,000 physicians by 2025. However, one-half of this shortage will come from specialty physicians, including neurosurgeons, urologists, cardiologists, gastroenterologists, plastic and reconstructive surgeons, and orthopaedic surgeons. A 2008 report conducted by the Health Resources and Services Administration concluded that by 2020, ophthalmology and orthopedic surgery are each expected to need more than 6,000 additional physicians over current levels. Other specialties like urology are expected to see shortfalls of more than 4,000 physicians. This same report found that growth in future demand for physicians will be highest among specialties that predominantly serve the elderly (e.g., cardiology, rheumatology, and surgical specialties).

Unlike primary care physicians, whose residency training is only three years, specialty physicians require up to seven years of post-graduate residency training. By the time a true crisis is visible, we will be unable to quickly correct it. With 10,000 seniors aging into the Medicare program every day for the next 18 years, along with the impending influx of patients seeking access to care as a result of the Affordable Care Act (ACA), the need for specialist services will increase significantly. We need to take steps now to ensure a fully trained specialty physician workforce for the future.

Summary – Both the “Resident Physician Shortage Reduction Act,” and the “Training Tomorrow’s Doctors Today Act” will improve the nation’s GME system and help to preserve access to specialty care by:

- Increasing the number of GME residency slots by 15,000 over the next 5 years;
- Directing half of the newly available positions to training in shortage specialties;
- Specifying priorities for distributing the new slots (e.g., states with new medical schools); and
- Studying the needs of the U.S. healthcare system and to allocate residencies accordingly.

To cosponsor H.R. 1180/S. 577, the “Resident Physician Shortage Reduction Act,” please contact Nicole Cohen (Rep. Crowley) at 5-3965 or nicole.cohen@mail.house.gov; Jessica Talbert (Rep. Grimm) at 5-3371 or Jessica.Talbert@mail.house.gov; Sasha Albohm (Sen. Nelson) at 4-5274, Sasha_Albohm@nelson.senate.gov; or Meghan Taira (Sen. Schumer) at 4-6542 or Meghan_Taira@schumer.senate.gov.

To cosponsor H.R. 1201, the “Training Tomorrow’s Doctors Today Act,” please contact Margie Almanza (Rep. Schock) at 5-6201 or Margie.Almanza@mail.house.gov or Charlene MacDonald (Rep. Schwartz) at 5-6111 or Charlene.MacDonald@mail.house.gov.

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