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May 15, 2009

The Honorable Max Baucus
Chair
Committee on Finance
United States Senate
Washington, DC 20510

Dear Chairman Baucus:

On behalf of the American Gastroenterological Association (AGA), representing over 17,000 physicians and scientists who research, diagnose and treat disorders of the gastrointestinal tract and liver, I am pleased to provide our comments on the Committee's options paper, "*Transforming the Health Care Delivery System: Proposals to Improve Patient Care and Reduce Health Care Costs.*" We appreciate your leadership and share in your goal to expand health care coverage to the uninsured, improve coordination of care, and enhance quality.

Physician Payment Update. The AGA firmly believes that reforming the current Medicare physician payment formula and replacing it with a more stable and equitable payment system that reflects the costs of caring for Medicare beneficiaries must be an integral part of health care reform. Meaningful system reform cannot occur if the underlying payment system remains broken and fundamentally flawed. While the AGA appreciates the Committee's recognition that the scheduled cuts in physician payments must be averted, we are disappointed that the options included do not provide a permanent solution. Ignoring the need to fix the SGR is an omission that outweighs all other actions recommended by the package, and disregards the concerns expressed by physicians who have looked to this Congress to address the issue. The AGA continues to support removing the Part B drugs retroactively from the sustainable growth rate (SGR) formula and rebasing the Medicare spending baseline to eliminate debt from the current system to help transition to a more viable payment system.

Primary Care. The AGA recognizes the need to strengthen the role of primary care in health care reform and ensure patient access to primary care providers. We support incentives for medical students to choose primary care as a career, and other payment changes to address the significant workforce issues that currently exist. However, the AGA cannot support policies that make payment improvements for primary care in a budget neutral manner. A budget neutral bonus for primary care will not resolve the issues that plague primary care and will not improve patient access to services, regardless of specialty.

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Gastroenterology and other specialties have seen significant reductions in fees since the inception of the Resource-Based Relative Value Scale (RBRVS) beginning in 1992 and even greater reductions with the implementation of the practice expense changes as part of the Balanced Budget Act of 1997. Although modest increases may have been provided for physician services in recent years, they have not kept up with the rate of inflation, nor have all physicians seen increases. In addition, the ongoing 5-year review of the AMA / Specialty Society Relative Value Update Committee, movement of procedures from inpatient to outpatient settings, and the increasing impact of practice expense has resulted in cuts to procedural services to offset increases in evaluation and management (E/M) codes. During the period of 1992 through 2007, E/M wRVUs increased 45%, while surgical wRVUs increased 9%. Payments for new office visits increased 73%, established visits increased 67% and consults increased 32% during this time period. In comparison, there was a 24% decrease in endoscopy payments during this same time period. The practice costs for specialists continue to rise, like all physicians, yet those increases have not been reflected in the current payment system.

Gastroenterologists are principal care providers for the many Americans who suffer from chronic gastroenterological disorders and have assumed responsibility to coordinate their care because of our nation's deficit of primary care providers. Gastroenterologists have built the infrastructure needed to reduce colorectal cancer by building patient-centered endoscopy centers that are safe, convenient and cost-effective for patients and training specialists skilled at colonoscopy. We made these investments in the face of declining reimbursements and continue to invest in best practices and effective patient education to ensure that patients are screened. Continued reductions in reimbursement for colonoscopy would jeopardize this nation's fight against colon cancer, the second leading cause of cancer deaths for Americans.

Increasing payments for primary care could be accomplished by allowing shared savings across practice setting and breaking down current payment silos that exist in the Medicare program. The AGA firmly believes that physicians should benefit from savings that are generated in Part B from improved quality and efficiency. These savings could help finance enhanced payments to primary care as well as to those physicians who demonstrate quality and efficiency.

Physician Quality Reporting Initiative. The AGA has been actively engaged in developing evidence-based and clinically relevant quality measures for gastroenterological conditions. We have worked collaboratively with other societies encompassing primary care, procedural and diagnostic

services and the National Committee for Quality Assurance to develop measures through the American Medical Association's Physician Consortium for Performance Improvement, the AQA Alliance, the National Quality Forum that have been adopted by Medicare's Physician Quality Reporting Initiative (PQRI). We remain committed to providing the highest quality care to Medicare beneficiaries and providing our members with the tools to ultimately improve patient outcomes.

We appreciate your efforts to further improve the PQRI by ensuring providers have access to their data in a timely manner and establishing a reasonable appeals process. We agree with the creation of new options linked to continuing medical education and practice improvement, such as outlined in the Committee's proposal. These alternatives are more closely aligned with real medical practice and the kinds of challenges physicians face on a daily basis. However, we are concerned with the penalties included in both options for non-reporting within the PQRI beginning in 2012 especially when physicians will be facing cuts in reimbursement in those years.

We appreciate the Committee's interest in addressing concerns that have been expressed by physicians in the operations of the current PQRI system. We suggest that the penalty phase of the program be deferred for a longer period than is now suggested to allow all of the changes to be fully implemented. The AGA supports options that would provide alternatives to participate in PQRI through maintenance of certification (MOC) process. Currently, performance improvement modules (PIMs) for gastroenterological conditions such as gastroesophageal reflux disease (GERD) and procedures such as colonoscopy are part of MOC, and we believe this option could increase participation for gastroenterologists.

In addition, the AGA recommends that the Committee consider additional changes to PQRI, including verifying quality information before making it public and ensuring that the program has adequate funding. 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.

Comparative Effectiveness Research. The AGA appreciates the focus on transparency, public input, and patient safeguards in comparative effectiveness research (CER). The AGA believes that CER should assist patients and providers in helping to choose the best and most appropriate care, and should not be used to make decisions on a cost basis. In order for CER to be useful, we wish to stress the central role of transparency of methods in reducing bias and building trust in the process. CER 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 and should not be used to make centralized coverage and payment decisions or recommendations. CER researchers should pledge to reduce bias and to state in clear language the usefulness as well limitations of their findings. Research papers should disclose, in detail, the methods and metrics used, the assumptions behind statistical tests, the extent to which assumptions are met (or not met), and the comparability of populations compared, as well as the strengths and weaknesses of their results. The AGA prefers the option of the public-private funding partnership and independent structure of CER and urges the Committee to include medical liability protections for health care providers when they follow practice guidelines recommended by the CER entity.

The AGA appreciates the opportunity to provide input and looks forward to continuing to work with the Committee on improving quality and access to care for all Americans during this historical debate on health care reform. Should you have any questions or need additional information, please do not hesitate to contact Kathleen Teixeira, AGA Senior Director of Government Affairs, at 240.482.3222 or kteixeira@gastro2.org.

Sincerely,

A handwritten signature in black ink that reads "N. F. LaRusso". The signature is written in a cursive, flowing style.

Nicholas F. LaRusso, MD, AGAF
Chair

