May 31, 2013

Chairman Max Baucus
Ranking Member Orrin Hatch
Senate Committee on Finance
Washington, DC 20510

Dear Chairman Baucus and Ranking Member Hatch:

The American Academy of Neurology (AAN), representing more than 26,000 neurologists and neuroscience professionals, appreciates the opportunity to submit comments in response to the Senate Committee on Finance request for feedback on the repeal and reform of the Medicare Sustainable Growth Rate (SGR) formula. The AAN strongly supports repeal of the SGR formula and reform of the physician payment system. We believe these steps are essential to ensure better access to care for all Medicare beneficiaries.

Each year, neurologic disorders strike an estimated 50 million Americans and cost hundreds of billions of dollars in medical expenses and lost productivity. It takes significant time and skill to provide ongoing cognitive care to manage complex chronic conditions for people with neurologic diseases like Alzheimer’s disease, Parkinson’s disease, stroke, epilepsy, traumatic brain injury, ALS, multiple sclerosis, and headache. Often, these diseases represent the highest-need, highest-cost Medicare beneficiaries.

Because of the aging baby boom population, the demand for neurologic services is expected to grow by 63% by 2025 for people age 65-74 and by 47% for people age 75 and older. However, a recent study found that there will be 19% fewer neurologists by 2025 than will be needed by our aging population. The AAN believes that reform of the Medicare payment system is critical to ensuring a balanced physician workforce and protecting access to cognitive specialists. Maintaining a balanced workforce is critical to the dual goals of improved patient outcomes and lower costs.

The Academy’s responses to questions raised by your Committee follow:

What specific reforms should be made to the physician fee schedule to ensure that physician services are valued appropriately?

The current Medicare physician fee schedule is flawed in large part due to inherent biases that favor procedures and testing over non-procedural care. These biases persist in spite of data showing inequity of provider reimbursement and the rapid growth of these services without a...
corresponding increase in medical need. The AAN has long believed that a complete revision of the Medicare fee schedule that narrows the payment gap between evaluation and management (E/M) services and procedures is necessary to ensure access to all health care services. In research conducted by the University of Cincinnati, specialties—surgeons, internists, family medicine physicians and neurologists—reported similar levels of work intensity, although the specific dimensions of work intensity were more variable. Yet varying “intensity” of physician services is used in the current fee schedule to justify reimbursing procedures at higher rates than face-to-face or cognitive care.

As quality measures and value increasingly factor into physician payments, it is important to acknowledge that there are many conditions where patient outcomes currently cannot be improved significantly (e.g., neurodegenerative disease). Specialists like neurologists, however, can make a significant difference in maintaining and prolonging quality of life. We therefore contend that fee schedules of the future should better reflect the effect a cognitive service has on the patient’s quality of life. Cognitive care services that improve the care and well-being of patients should be valued at levels commensurate with their benefit to the patient. Instead, the current system devalues cognitive care while greatly rewarding procedures and technologies. A total knee replacement, for example, is reimbursed at a much higher level than the diagnosis and treatment of an acute stroke. Similarly, Medicare pays four times as much for an MRI scan of the brain (which shows damage or disease) than it does for an office visit with a physician who takes time to sit down with patients to inform them of their diagnosis and begin a discussion of their treatment options. The new fee schedule should factor in value to the patient and the importance of the service when determining reimbursement rates.

The retention of fee-for-service (FFS) in a new fee schedule seems all but inevitable; however, the Academy supports efforts to reform FFS to capture more of the services patients expect from their physicians (such as routine care coordination, phone and email communication, review of medical records, obtaining test results from other facilities, etc.). This could be accomplished by providing reimbursement for existing codes that describe chronic care coordination services and the creation of additional codes similar to the new transitional care management code. Alternatively, the new fee schedule could incorporate monthly or quarterly billing on a per patient basis for ongoing patient care coordination and communication. It is essential that coordination payments not be restricted—any physician that provides these services should be eligible to receive care coordination incentives regardless of specialty designation. This would streamline the patient experience and reduce arbitrary lines between providers. Medicare beneficiaries should be able to expect fully coordinated care across the spectrum of providers they see.

What specific policies should be implemented that could coexist with the current FFS physician payment system and would identify and reduce unnecessary utilization to improve health and reduce Medicare spending growth?

Fundamentally changing the financial incentives to reward in-person cognitive care over procedures and tests also would go a long way toward changing behavior. Current FFS incentivizes more care, intervention, and services regardless of quality or medical need. The needs of the patient should be paramount. Physicians who keep Medicare beneficiaries out of
hospitals and skilled nursing facilities should be rewarded—perhaps through shared savings programs or other quality-related bonuses.

Diagnostic testing is another area of increasing expense and growing use. It may be practical to require consultation before the ordering of certain tests (or restrict the ordering of such tests to subspecialists). There are many instances where consultation with the appropriate specialist/subspecialist would provide better patient care while avoiding the need for costly tests.

Consider eliminating outdated reimbursement packages like surgical global periods (or, at a minimum, requiring audits to determine the actual visits performed). In 2005 and 2012, the Office of the Inspector General published reports concluding that the RVUs for the global surgical package are too high because they include the work of E/M services that are not typically furnished within the global period for the reviewed procedures. Now that mature information technology can capture and store data on individual services more easily than in the past, a resource-based payment system might better pay for services individually as medically necessary and as provided.

Additionally, the widespread implementation of decision support programs in electronic medical record systems could help guide utilization. Physician-directed programs to encourage wise allocation of finite health care resources (similar to the Choosing Wisely campaign) would also draw attention to the role of providers in controlling expenses.

Within the context of the current FFS system, how specifically can Medicare most effectively incentivize physician practices to undertake the structural, behavioral, and other changes needed to participate in alternative payment models?

To encourage physician participation in alternative care models, incentives need to be meaningful and cover the costs associated with implementing the necessary structural changes. It will take time for individual providers and communities to determine which alternative care models are the best fit for their patient populations. During this period of transition, allow physicians to have a trial period to participate in different models at the same time without incurring the risk of losing traditional payment models. Further, Medicare needs to provide more information on how these models work and share data demonstrating the merits of each model. It’s also important that those participating in alternative models receive timely feedback about performance at the individual and institution or community levels. New models should clearly promote performance and process improvements while focusing on delivering high quality patient- or population-centered care.

In addition, the AAN would like to see Medicare design alternative payment model demonstrations geared toward specialists, not just primary care. Medicare beneficiaries with complex chronic neurologic conditions often have very specialized needs that are frequently not met or efficiently managed by a traditional model. We believe participation in alternative payments models would improve if demonstrations for specialists were more widely incorporated.
The AAN appreciates the opportunity to provide comments on this important topic and looks forward to assisting your committee in its deliberations on Medicare payment reform.

Sincerely,

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President, American Academy of Neurology

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\footnote{Horner RD, Szafarski JP, Ying J, et al. Physician Work Intensity Among Medical Specialties. Emerging Evidence on its Magnitude and Composition. \textit{Medical Care} 2011.}