June 30, 2009

The Hon. Charles Rangel
Ways & Means Committee, Chair
The Hon. Henry Waxman
Energy & Commerce Committee, Chair
US House of Representatives
Washington, DC 20510

Re: A Bill to provide affordable, quality health care for all Americans and reduce the growth in health care spending, and for other purposes.

Dear Congressmen Rangel and Waxman:

The American Academy of Neurology Professional Association (Academy), the premier specialty society for neurology, is dedicated to high-quality, patient-centered neurologic care. Neurologists are doctors with specialized training in diagnosing, treating, and managing complex disorders of the brain and nervous system such as epilepsy, Parkinson’s, Alzheimer’s disease, multiple sclerosis (MS), and traumatic brain injury (TBI). Significant time and skill are required to manage patients with neurologic conditions. Increasingly, neurologists have less time to spend with patients due to the declining compensation for cognitive care. As a result, patients may experience reduced quality care and have limited access to neurologic services.

While Congress has clearly heard the cry for help from primary care, it should not ignore the struggling specialties that care for patients with high-cost chronic conditions. Neurology faces many of the same challenges of primary care. As a result of high medical school debt and lower anticipated salary, many of the best and brightest medical students may be discouraged from going into neurology. Like family medicine, many neurology residency slots are now being filled with foreign medical graduates. A recent JAMA article shows a correlation between average starting salary and residency fill rate by US medical student graduates by specialty (see figure 1 and 2 in Appendix). Training fewer US graduates means there will be fewer physicians in these specialties who are able to remain in the US for the duration of their careers. In 2007, only 52% of neurology residency positions were filled by US seniors. Likewise, other primary care specialties like family medicine and internal medicine had similar challenges attracting US graduates.

People with disorders such as Parkinson’s disease, stroke, and dementia require advanced training and expertise to diagnose and treat them. Medicare beneficiaries especially need specialized physicians trained to care for many of the disorders that affect an aging population. Unfortunately, many primary care residencies include minimal training in neurology. Any legislation that singles out primary care for bonus
payments but disregards neurology could therefore have a devastating effect on patients with neurological disorders. Legislation must realign incentives to promote patient care over higher-paying procedural-based care.

Patients suffering from neurologic conditions who received care from neurologists received better outcomes at less cost. MS patients are more satisfied when their care is provided by a neurologist." In fact, studies show patients who receive care from neurologists tend to be discharged earlier from the hospital, receive more accurate diagnoses, and receive fewer unnecessary tests and procedures. Stroke patients have a lower mortality rate and less disability when treated by a neurologist.

Much of the available literature focuses on outcomes in stroke patients. A 2007 study about the impact of neurology consultations on inpatient care found that 65% of patients were discharged from the hospital earlier as a result of neurological consultation. Stroke patients seen by a neurologist were also less likely to die during hospitalization than those seen by a non-neurologist. Patients presenting with a transient ischemic attack (TIA)—a type of mini-stroke and indicator of impending larger stroke—were more likely to undergo testing, but were less likely to undergo more costly surgery when under the care of a neurologist compared with patients treated by physicians in other specialties. A study showed that stroke patients randomized to receive care in a neurology department were able to leave the hospital an average of 16 days earlier than patients randomized to receive care at general medical wards.

The Academy appreciates the work of the House Committees to move forward much-needed health care legislation. Comments on provisions in Division B—Medicare and Medicaid Improvements are below and the Academy’s proposal for a patient-centered payment model that addresses chronic disease is offered on pages 4–5.

DIVISION B – MEDICARE AND MEDICAID IMPROVEMENTS
TITLE I – IMPROVING HEALTH CARE VALUE, Subtitle B – Provisions Related to Part B
Part 1 – Physicians Services
Sec. 1121. Sustainable Growth Rate Reform.

The Academy strongly supports efforts to replace the SGR with a more appropriate measure based on the Medicare Economic Index (MEI).

The Academy supports establishment of a separate service category and conversion factor for evaluation and management (E/M) services. This provision recognizes the importance of patient-centered over procedure-centered care. The Academy urges the House committees to further define “evaluation and management services” so that any physician who provides these services would be included. If not, the Secretary, through regulations, could narrow its scope to E/M services furnished by primary care specialties only.

Sec. 1122. Misvalued Codes Under the Physician Fee Schedule.

The Academy has participated vigorously in the process of appropriately valuing codes through the AMA/RUC. The Academy believes in general that the process is effective but we appreciate CMS oversight in areas that need further review.
The Academy believes one of the principle weaknesses of valuing physician services is there is not a scientifically validated method to evaluate the intensity of physician work, which depends partly on the characteristics of the physician, the patient, the illness, and the care setting. The Academy applauds the apparent intention in this bill to develop scientifically validate methods to evaluate physician work elements (such as time, mental effort and professional judgment, technical skill and physical effort, and stress due to risk). Such a process requires appropriate resources but would go a long way towards reinvigorating the fairness of the relative value system.

Sec. 1124. Modifications to the Physician Quality Reporting Initiative (PQRI).

The Academy supports provisions that would provide timely feedback to participating professionals, offer an appeals process to correct errors, and extend incentive payments through 2012. The Academy supports integration of quality reporting with the meaningful use of electronic health records (EHR).

Section 1147. Payment for Imaging Services.

The Academy supports both provisions affecting payment for imaging services:
- adjusting the practice expense relative value units (RVUs) for imaging services to reflect a 75 percent rate of utilization of imaging equipment
- increasing the reduction on single-session imaging involving consecutive body parts from 25 percent to 50 percent

Subtitle F – Medicare Rural Access Protection
Section 1191. Telehealth Expansion and Enhancements.

The Academy supports efforts to expand and enhance Medicare beneficiary access to telehealth services. Neurologists practicing telemedicine could enhance care provision for patients with multiple important disabling neurologic conditions such as stroke, dementia/cognitive impairment, diseases requiring neuro-rehabilitation, Parkinson’s disease, multiple sclerosis, epilepsy, and others in rural, remote, and underserved communities.

Section 1194. Extension of Geographic Floor for Work

The Academy supports the extension of the geographic floor for work until January 1, 2012.

TITLE II – MEDICARE BENEFICIARY IMPROVEMENTS, Subtitle C – Miscellaneous Improvements
Section 1231. Extension of Therapy Caps Exceptions Process.

The Academy supports extending the therapy caps exceptions to ensure that patients receive necessary therapy.

Section 1235. Consultation and Information Regarding End-of-Life Planning.

The Academy supports a new benefit for consultations regarding an order for life sustaining treatment. Neurologists often must have these conversations with patients who have chronic, progressive illnesses and are facing death.

TITLE III – PROMOTING PRIMARY CARE, MENTAL HEALTH SERVICES, AND COORDINATED CARE
Section 1301. Accountable Care Organization Pilot Program.
The Academy is supportive of the voluntary pilot program. While the current payment system penalizes efficiency, neurologists participating in integrated networks may be able to provide higher quality care to their patients and have an opportunity to share in the savings that they generate. Physicians should be actively involved in the distribution of bonus payments.

Section 1302. Medical Home Pilot Program.
The Academy appreciates the inclusion of principal care physicians as eligible for the medical home pilot program and suggests that a portion of the funds allocated to this program be reserved for medical homes that are established by medical subspecialties.

Section 1303. Rate Increase for Selected Primary Care Services.
Since neurologists face many of the same challenges as primary care physicians, the Academy supports a 5–10 percent bonus payment that is applied to principal care physicians in addition to primary care physicians. Any physician groups who receive more than 50 percent of their total allowed charges from E/M services should also be eligible for the 5–10 percent bonus payment. Providing a bonus to primary care is not a solution for overutilization of procedures.

Furthermore, the Academy urges the House committees to reconsider this entire section and focus Medicare payment on patient need rather than physician specialty. The Academy proposes a payment model that provides the immediate institution of a bonus payment over the fee schedule for E/M services for patients with the chronic conditions identified by the Medicare Special Needs Plan Chronic Condition Panel (SNCCP). This would be in effect for a period of three to five years as a temporary solution until further analyses of comprehensive alternatives to the payment system are completed and new payment models are implemented.

Additional payment would be contingent upon adhering to quality measurement and reporting and care coordination. There are quality measures for many of the conditions on the list. The Academy has quality measures for stroke and epilepsy and will be developing measures for Parkinson’s disease and dementia this year. The Academy would look to CMS to define criteria for care coordination.

By using a patient-centered approach to determine eligibility, all physicians treating patients with the chronic conditions identified by the SNCCP would be rewarded for the provision of focused, ongoing care. Focusing solutions based on patient need is likely to bring added care management to these high cost, chronically ill patients. This model could function within the structure of a medical home as well.

This plan would be easier for CMS to administer than the rate increase for primary care physicians. Any provider could qualify by seeing patients with the appropriate ICD-9 diagnosis code for any of the conditions identified by the SNCCP (listed below). The SNCCP – authorized by the Medicare Improvements for Patients and Providers Act of 2008 – identified 15 conditions for inclusion in the 2010 Medicare Advantage Special Needs Plans. The panel considered the following inclusion factors: medically complex, substantially disabling, life threatening, a high risk of hospitalization, a high risk for adverse outcomes, and in need of specialized care delivery across several domains.

Adoption of this bonus payment will immediately begin to correct the misaligned incentives that reward procedure-based care at the cost of patient-centered care. Further, this shift will re-align incentives to deliver truly patient-centered care, enhance patient access, improve quality, and immediately lower costs.
2010 Medical Special Needs Plans Chronic Conditions

1. Chronic alcohol and other drug dependence
2. Autoimmune disorders, limited to: Polyarteritis nodosa, Polymyalgia rheumatic, Polymyositis, Rheumatoid arthritis, Systemic lupus erythematosus
3. Cancer excluding pre-cancer conditions or in-situ status
4. Cardiovascular disorders, limited to: Cardiac arrhythmia, Coronary artery disease, Peripheral vascular disease, Chronic venous thromboembolic disorder
5. Chronic heart failure
6. Dementia
7. Diabetes mellitus
8. End-stage liver disease
9. End-stage renal disease requiring dialysis (any mode of dialysis)
10. Severe hematologic disorders: Aplastic anemia, Hemophilia, Immune thrombocytopenic purpura, Myelodysplastic syndrome, Sickle-cell disease (excluding sickle-cell trait), Chronic venous thromboembolic disorder
11. HIV/AIDS
12. Chronic lung disorders: Asthma, Chronic bronchitis, Emphysema, Pulmonary fibrosis, Pulmonary hypertension
13. Chronic and disabling mental health conditions: Bipolar disorders, Major depressive disorders, Paranoid disorder, Schizophrenia, Schizoaffective disorder
14. Neurologic disorders: Amyotrophic lateral sclerosis (ALS), Epilepsy, Extensive paralysis (i.e., hemiplegia, quadriplegia, paraplegia, monoplegia), Huntington’s disease, Multiple sclerosis, Parkinson’s disease, Polyneuropathy, Spinal stenosis, Stroke-related neurologic deficit
15. Stroke

TITLE IV – QUALITY, Subtitle A – Comparative Effectiveness Research
Section 1401. Comparative Effectiveness Research.

The Academy is concerned that this legislation would not be setting up a true unbiased “evidence-based” manner for determining comparative effectiveness. The language leaves many questions about exactly who would make these determinations and how they would do it. The legislation could allow politically motivated determinations under the guise of evidence.

The Academy recommends that any comparative effectiveness research should follow these rules:
• In order to inform clinical practice, head-to-head studies must be large enough to be able to assess all the relevant subgroups who will ultimately be treated with the therapies in question.
• The therapies being assessed in the study must be well enough understood, that the optimal mode of treatment (route of administration, dose, titration) must be agreed upon in advance of the study.
• The endpoint of the study must have been agreed upon as the most relevant endpoints in clinical practice. In addition, the most relevant endpoints in practice must be addressable in the trial.
• There must be agreement in the community that a small and finite number of treatments are most commonly selected by clinicians, and are an obvious choice for the comparative effectiveness trial. In addition, these treatments must be so well established, that it is unlikely that they will be abandoned for novel therapies in the near future.
Conclusion

It is well recognized that health care faces major systematic problems with costs, uneven quality, and misaligned incentives. The current legislation does not effectively address these issues confronting the delivery of health care to constituents and patients. Former CMS Administrator Kerry Weems addresses the challenges CMS faces in running Medicare programs and implementing reform in a recent *Health Affairs* interview, concluding that one of the key solutions is to appropriately value E/M services. The Academy stresses that Congress needs to understand that the reference to “primary care services” is often synonymous with E/M services. Congress should not differentiate between the particular physicians providing the service, but focus on the patient being able to get the service from their preferred physician.

The Academy supports opportunities to improve patient outcomes through appropriate reimbursement of time spent managing complex chronic conditions, the use of health information technology, streamlining appropriate access to specialty care, improvements in coordination of care, and adherence to meaningful, evidence-based clinical guidelines and performance measures. To further discuss any of these points, please contact the Academy’s Legislative Counsel Michael Amery at mamery@aan.com or 202-349-4299.

Sincerely,

Robert C. Griggs, MD, FAAN
President
American Academy of Neurology
American Academy of Neurology Professional Association

CC: The Hon. Dave Camp, Joe Barton, Pete Stark, Frank Pallone, Wally Herger, and Nathan Deal

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Table. Salary and Residency Match Data, 2007

<table>
<thead>
<tr>
<th>Specialty</th>
<th>PGY-1 Positions Offered, No.</th>
<th>Starting Salary, Mean, $</th>
<th>Overall Salary, Mean, $</th>
<th>US Allopathic Graduates</th>
<th>Non-US IMG</th>
<th>Total Filled Positions, %</th>
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</thead>
<tbody>
<tr>
<td>Family medicine</td>
<td>2803</td>
<td>100,000</td>
<td>100,740</td>
<td>100,462 (1.1)</td>
<td>536 (12.9)</td>
<td>227 (5.7)</td>
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<td>Pediatrics</td>
<td>2199</td>
<td>105,000</td>
<td>105,000</td>
<td>105,000 (0.0)</td>
<td>113 (4.8)</td>
<td>196 (7.2)</td>
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<td>Internal medicine (all)</td>
<td>4704</td>
<td>155,000</td>
<td>155,162</td>
<td>155,162 (0.0)</td>
<td>355 (12.9)</td>
<td>258 (25.4)</td>
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<td>Psychiatry</td>
<td>1037</td>
<td>160,000</td>
<td>160,971</td>
<td>160,971 (0.0)</td>
<td>71 (6.7)</td>
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<td>Neurology</td>
<td>100</td>
<td>177,000</td>
<td>177,065</td>
<td>177,065 (0.0)</td>
<td>46 (5.6)</td>
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<tr>
<td>Pathology</td>
<td>513</td>
<td>NA</td>
<td>247,606</td>
<td>247,606 (0.0)</td>
<td>22 (4.3)</td>
<td>27 (5.3)</td>
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<td>Emergency medicine</td>
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<td>Obstetrics/gynecology</td>
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<td>76 (6.8)</td>
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<td>Otolaryngology</td>
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<td>220,000</td>
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<td>10 (0.4)</td>
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<td>General surgery</td>
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<td>235,000</td>
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<td>Anesthesiology</td>
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<td>Radiology</td>
<td>141</td>
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<tr>
<td>Orthopedic surgery</td>
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<td>10 (0.2)</td>
</tr>
</tbody>
</table>

Abbreviations: IMC, international medical graduate; NA, not available; PGY-1, postgraduate year 1.

Source: Ebell, M. H. JAMA 2008;300:1131-1132