Medicare Physician Payment

The repeal of Medicare’s flawed payment formula, known as the sustainable growth rate (SGR) formula, is one of the American Academy of Dermatology Association’s (AADA) top legislative advocacy priorities. Due to severe flaws in Medicare’s SGR formula, mandatory physician payment cuts have been scheduled to occur every year since 2002. After payments were cut 5.4 percent in 2002, only congressional action has prevented further cuts from occurring, and these cuts, if they had taken effect, would have threatened patient access to care across the country. Recent developments on Capitol Hill have made significant progress toward repeal of the SGR, but there are still concerns about what reforms might be put in its place. The AADA continues to advocate for repealing the SGR and replacing it with reforms that bring much needed stability, improve patient access to care, and preserve physicians’ ability to care for their patients.

What is the Sustainable Growth Rate?

Medicare uses the sustainable growth rate (SGR) formula to determine how much Medicare payments will be increased from one year to the next. While many factors are used to determine reimbursement for particular services within the Medicare physician fee schedule, the SGR is important because it determines what the largest component, the Medicare conversion factor, will be from one year to the next. Congress enacted the SGR as part of the Balanced Budget Act in 1997 as a new formula for calculating Medicare payments. This new formula established an annual target for Medicare spending on physician services by linking the allowed growth in the spending on these services, and thereby reimbursement, to the growth in the Gross Domestic Product (GDP). When Medicare physician spending exceeds the SGR’s target levels, Medicare is required to recoup those funds through payment cuts in future years.

After enactment in 1997, the SGR first resulted in a few years of payment increases, but in 2002, the SGR required payment cuts of 5.4 percent and only Congressional intervention in the years following has stopped cuts from occurring in every year since 2002. While the temporary fixes provide temporary relief to physicians facing the looming Medicare cuts, the fixes fail to adjust the spending target, leading to the threat of substantial cuts in later years that ultimately raise the long-term cost of repealing the SGR formula and enacting a permanent solution. In fact, Congress has acted on 15 separate occasions to stop SGR cuts from taking effect.

In 2013, the SGR was scheduled to cut Medicare payments by an estimated 26.5 percent. Given a combination of factors surrounding the “fiscal cliff” which was scheduled for January 1, 2013, Congress and the White House struggled to find an agreement to address the confluence of scheduled spending cuts, tax increases and several expiring provisions—one of those “expiring” provisions was the relief from scheduled cuts under the SGR. Ultimately, on January 1, the Senate and House cleared the American Taxpayer Relief Act (H.R. 8), which prevented the SGR cuts from occurring.

113th Congress: Developments on SGR Reform

While lawmakers have regularly stated their support for repealing the SGR, the high cost of repeal associated with repeal has prevented Congress from reaching agreement on a larger bill to repeal the SGR. Earlier this year, the Congressional Budget Office (CBO) announced that the estimated cost or score associated with repeal had been reduced to $138 billion from a previous estimate of
$245 billion in August 2012. In May, the CBO modified its estimate slightly to $139 billion, but this reduced score has provided increased optimism regarding the possibility of reform. In addition, Congress has been more active in its consideration of legislation to repeal the SGR than ever before. In fact, on July 31, the House Energy & Commerce Committee cleared legislation, the Medicare Patient Access and Quality Improvement Act of 2013 (H.R. 2810), which would repeal the SGR and implement several reforms.

H.R. 2810, the Medicare Patient Access and Quality Improvement Act of 2013, came after many months of collaboration with physician and associated healthcare stakeholders. As the Energy & Commerce Committee has moved forward, the AADA responded to SGR draft legislation proposals and inquiries from both the House and Senate, and most recently sent a letter on July 9 to the Energy & Commerce Committee in response to their legislative draft released on June 28. On July 18, the Committee released a draft bill to reform Medicare physician payment and on July 23 the bill advanced through the Committee’s Health Subcommittee with just one technical amendment. While the legislation does raise some concerns, it does help the physician community move closer to the goal of full SGR repeal. The AADA’s response letter to the bill is attached, outlining our concerns and our appreciation for the positive aspects of the legislation. The AADA’s additional letters are also available on the AADA website. In a 51-0 vote, H.R. 2810, was passed out of the Committee with unanimous bipartisan support on July 31, 2013. A summary of the bill prepared by the Committee is also attached.

Other legislation related to the SGR:

- Congressmen Phil Gingrey (R-GA) and Henry Cuellar (D-TX) recently introduced H.R. 1473, the Standard of Care Protection Act. This legislation aims to protect physicians and other health care providers from new liability exposure resulting from practice standards or guidelines set by the Affordable Care Act (ACA) by creating a rule of construction that those guidelines which were not specifically designed to establish a standard of care should not be interpreted as creating a standard of care. H.R. 1473 also states that those ACA guidelines cannot supersede state liability laws. Earlier this year, the AADA joined the Health Coalition on Liability and Access (HCLA), which is a coalition of organizations and companies committed to medical liability reform. The AADA joined the HCLA in sending a letter of support to Congress asking that H.R. 1473 be included in any SGR reform legislation. The language was successfully added to the SGR bill that passed out of Energy & Commerce Committee on July 31.

- Reps. Allyson Schwartz (D-PA) and Joe Heck, DO, (R-NV) reintroduced the Medicare Physician Payment Innovation Act of 2013, which would permanently repeal the SGR formula and offer yearly increased payment updates for physicians for 4 years. It would seek to increase payments for primary care, identify new payment and delivery models which focus on quality measurements, including for different specialties, practice types, and geographic regions. With the Committee consideration of H.R. 2810, this legislation is not expected to receive consideration.
Related Issues:

**Dermatology & Pathology Services**

With support from the Alliance for Integrity in Medicare (AIM), Rep. Jackie Speier (D-CA), along with Rep. Jim McDermott (D-WA) and Rep. Dina Titus (D-NV), recently introduced H.R. 2914, “Promoting Integrity in Medicare Act of 2013,” a bill that threatens a dermatologist’s ability to prepare and interpret the pathology slides within their dermatological practice. Specifically, the bill repeals the In-Office Ancillary Services Exception (IOASE) to the Stark Law for advanced imaging, anatomic pathology, physical therapy, and radiation therapy. This would effectively require dermatologists to refer their pathology slides to an outside laboratory, and hinder their freedom to choose dermatopathology consultants. Members of AIM include the American Clinical Laboratory Association, American College of Radiology, American Physical Therapy Association, Association for Quality Imaging, American Society for Radiation Oncology (ASTRO), American Society for Clinical Pathology, College of American Pathologists, and Building the Business of Radiology.

Dermatology is unique in that it devotes a significant portion of its residency curriculum to pathology training, providing substantive knowledge and skills in the performance of pathology services. This extensive core training in dermatopathology, which is required for board-certification, highlights the importance of pathology within the specialty of dermatology. Dermatopathology is a critical component of dermatologic care, ensuring that skin biopsy specimens receive accurate, reliable, and timely diagnosis for the purpose of delivering quality patient care. At the Annual Meeting in March of this year, the AADA took a strong stance against certain inappropriate uses of dermatopathology services, and will continue to promote the highest quality, most efficient care for our patients.

**Legislative Advocacy and the Government Accountability Office (GAO)**

AIM is advocating for the elimination of the IOASE to the Stark Law in the larger context of Medicare reform being considered by Congress this year. The AADA, other specialty provider groups, and industry stakeholders have been regularly meeting with congressional committee staff, House and Senate Leadership, and rank and file members of the House and Senate to advocate for preserving the IOASE to the Stark Law. In addition, the 17 members of the “House Doc Caucus” sent a letter to Speaker John Boehner (R-OH) and Minority Leader Nancy Pelosi (D-CA) that calls for the preservation of the IOASE and explains the importance of the exemption for physicians and their patients. The AADA joined the AMA and 30 other specialty groups and stakeholders in a letter to all members of the House of Representatives opposing Rep. Speier's bill, H.R. 2914, “Promoting Integrity in Medicare Act of 2013.”

This July, the Government Accountability Office (GAO) issued a report on anatomic pathology services that found self-referring physicians utilized these services at a higher rate than those who referred to pathology services to an outside reference lab. Similar findings were reported in GAO reports related to imaging and radiation therapy. The AADA expressed deep concern with the anatomic pathology report’s findings and reiterated its strong position against the inappropriate use of ancillary services. However, the AADA maintains it is important to preserve the ability of both board-certified dermatologists and dermatopathologists to provide pathology services to their patients.
President’s FY 14 Budget and Congressional Budget Office

The President’s proposed FY 14 Budget includes a provision to exclude certain services from the IOASE, including radiation therapy, physical therapy, and advanced imaging, claiming it saves the U.S. government $6.1 billion over 10 years. However, it does not include anatomic pathology. The Congressional Budget Office did its own analysis claiming a savings of $1.8 billion over 10 years. Neither the President’s budget office nor the Congressional Budget Office has publicly shared how these calculations were determined or explained the discrepancies.

Our Dermatology & Pathology Message to the Hill

The AADA opposes H.R. 2914 and will continue to strongly support dermatologists’ ability to read their own slides – as it is consistent with their training – to meet the needs of patients and to provide more integrated patient care.
Dear Representatives Upton, Pitts, Burgess, Waxman, Pallone and Dingell:

The American Academy of Dermatology Association (Academy), which represents more than 12,000 dermatologists nationwide, appreciates your efforts to develop H.R. 2810, the Medicare Patient Access and Quality Improvement Act of 2013, to repeal the Sustainable Growth Rate (SGR) and reform the Medicare payment system. The Academy believes that any legislation or changes made to the Medicare program should protect Medicare beneficiaries, pay physicians fairly, and ensure sustainability of the program for future generations. We are grateful for being given the opportunity to offer input during the legislative process and hope to continue working with you moving forward. To that end, the Academy is pleased to offer the following comments regarding the legislation.

The Academy is appreciative of your bipartisan efforts to update the Medicare physician payment system is encouraged by the following provisions in the bill language:
• The permanent repeal of the flawed SGR formula and the replacement of the formula with a five-year period of stability, which will provide for positive updates while new alternative payment models can be developed and tested. While the Academy is pleased with the five year period of stability, the Academy would encourage the consideration of the rising costs of medical inflation as measured by the Medicare Economic Index (MEI) when developing updates for physician payments.
• The opportunity for physician practices and specialties that do not fit into alternative payment models to continue to participate within the fee-for-service system.
• The incorporation of language from H.R. 1473, the Standard of Care Protection Act, which protects physicians from new forms of liability by simply clarifying that federal healthcare guidelines or regulations which were not designed to establish a standard of care should not be interpreted as a creating a standard of care.

As this process moves forward to consideration in the full Energy and Commerce Committee, the Academy also looks forward to addressing our concerns and working to improve the legislation, including addressing the following:

• The Academy is concerned with provisions to include a “reporting group” of physicians who will be reimbursed for reporting on the amount of time it takes to perform various procedures and the accuracy of relative values. Between 2016 and 2018, reductions of up to 1% in Relative Value Units (RVUs) resulting from this process would not be subject to the longstanding practice of budget neutrality; instead, these dollars would be removed from the Medicare pool rather than being redistributed to other codes for other physician services. This policy would be greatly concerning as funds within the fee schedule are already limited and many services have already seen cuts in recent years—these provisions would only exacerbate these cuts. The Academy is also concerned that collectively these provisions would further the increasingly common practice of the Centers for Medicare and Medicaid Services to reduce the value and reimbursement for particular services often with little transparency as to the rationale that CMS used to arrive at its decision.
• In addition, the Academy is concerned about the additional administrative burden, which would result under the new Quality Update Incentive Program (QUIP) as it is added to the Physician Quality Reporting System (PQRS) and Value Based Modifier (VBM). Further, the Academy is also concerned that the QUIP will be punitive in nature and that the bottom third of physicians will be subject to a negative update even if all physicians improve quality and meet benchmarks.
• The Academy is also concerned regarding the bill’s provision to recognize the American Board of Physician Specialties (ABPS) as a professional organization
authorized to develop clinical practice improvement activities. This is very troubling as the Academy, and other physician specialties, have concerns regarding the inadequacy of ABPS’ board certification requirements. In addition, the ABPS is not recognized as a group permitted to provide board certification of physicians in many states. The Academy is concerned that their inclusion in this legislation would provide them greater validation and potentially pose challenges regarding the delivery of quality care and protecting patients.

The Academy is thankful for the dedication of the Committee towards reforming the Medicare payment system and promoting the delivery of high quality healthcare in the most effective manner possible. We appreciate your continued leadership on these issues and would like to work with you to address our areas of concern so we can reach a point where we can fully support the legislation. Please feel free to address any comments to Shawn Friesen, the Academy’s Director of Legislative, Political and Grassroots Advocacy, at sfriesen@aad.org or (202) 712-2601.

Thank you,

[Signature]

Dirk Elston, MD, FAAD
President, American Academy of Dermatology Association
H.R. 2810, the “Medicare Patient Access and Quality Improvement Act of 2013”

Section-by-section

The SGR repeal and replace policy laid out in H.R. 2810 has two basic components: the Fee for Service Program (FFS) and the Payment Model Choice Program. Additionally, it contains policy language on Medicare data, care coordination, relative values, and standards of care. The following summarizes each section:

Section 1: Short title
This section provides the short title of “Medicare Patient Access and Quality Improvement Act of 2013.”

Section 2: Reform of sustainable growth rate (SGR) and Medicare payment for physicians’ services

Fee for Service

- Stabilizing Fee Updates (Phase I, 2014 - 2018)—The provision would repeal the SGR and replace it with a 5-year period of stable payments with annual inflationary baseline adjustments of 0.5%. This 5-year transition away from the SGR coupled with payment stability, is based on feedback from the medical community and other stakeholders. They expressed a need to have 3 to 5 years in order to develop and test quality measures and clinical practice improvement activities, which will be used for performance assessment during Phase II.

- Quality Update Incentive Program (QUIP) (Phase II, 2019)—The period of transition would end with the implementation of an enhanced Physician Quality Reporting System (PQRS), which would link payments to provider excellence in the delivery of high quality care. All providers who meet or exceed their specialty specific benchmark could receive a positive update of 1.5% per year.

Advancing Alternative Payment Models: Payment Model Choice Program

- Eligible professionals at any time could choose to opt-out of the FFS program and participate in alternative payment models (APMs). These APMs would include, but would not be limited to, the following: Patient-Centered Medical Homes, specialty models, and bundles or episodes of care. Providers would submit proposals on an ongoing basis for innovative payment APMs through a newly developed, streamlined process that encourages high quality, high value healthcare.

Section 3: Expanding availability of Medicare Data

Medicare Data

- Greater access to Medicare claims data would be made available to qualified entities to facilitate development of APMs and to facilitate quality improvement initiatives of qualified clinical data registries.
Section 4: Encouraging Care Coordination and Medical Homes

Care Coordination

- Additional codes would be developed to promote better care coordination for patients with complex chronic care needs. These codes would apply to physicians who are certified as a medical home by achieving certain accreditation status.

Section 5: Miscellaneous

Solicitations, Recommendations, and Reports

- The Centers for Medicare and Medicaid Services (CMS) would solicit recommendations from the medical community on episodes of care and payment bundles for high volume, high cost services. Not later than January 15, 2016, biannual progress reports on the QUIP and APM’s would be submitted to Congress. GAO and MedPAC also would evaluate the QUIP and APM’s and submit reports to Congress annually, corresponding with the performance years.

Relative Values

- This policy would improve the accuracy of relative values under the Medicare Physician Fee Schedule. It would do so by establishing a mechanism for representative physician cohorts to report on data relating to service volume and time, accounting for differences in specialties, practitioner types, services, and patient populations.

Standards of Care

- Under this provision, guidelines or standards developed, recognized, or implemented in conjunction with this legislation could not be construed to establish the standard of care in any medical malpractice or medical product liability claim.

CQ NEWS
Aug. 27, 2013 – 1:54 p.m.

Physician Groups Hope for Agreement by Ways and Means, Energy and Commerce on Payment Fix

By Emily Ethridge, CQ Roll Call

The House Ways and Means Committee plans to release its own proposal this fall for replacing Medicare’s physician payment system, and stakeholders hope it will be close to the bill the Energy and Commerce Committee approved unanimously in July.

“We’re really hopeful that regardless of what Ways and Means does, that it’s either complementary to what Energy and Commerce has done or it’s very similar,” said Ray Quintero, director of government relations at the American Osteopathic Association. “The last thing that we want is for the two policies to be far apart and then take us back to square one, especially this late in the year.”

Ways and Means Committee spokeswoman Sarah Swinehart said in an email that “we are working on a bipartisan proposal and are using the August recess to gather more feedback to shape the proposal. We are working to have a comprehensive proposal to provide a permanent solution sometime in the fall.”

The Senate Finance Committee also is expected to release its plan to replace Medicare’s sustainable growth rate formula with a new payment system this fall. That could leave lawmakers with three different proposals to choose from as they push to reach their goal of repealing the SGR this year.

One major element the Ways and Means Committee could add that is lacking from the Energy and Commerce bill (HR 2810) is a provision offsetting the bill’s cost. The Congressional Budget Office scored the cost of repealing the SGR at $139.1 billion over 10 years — much lower than it has been in previous years.

Lawmakers have shied away from discussing how to cover that cost, although committee leaders have pledged that the final bill will be fully paid for. The Ways and Means Committee has jurisdiction over several potential relevant offsets.

Ardis Hoven, president of the American Medical Association, noted that Congress has already spent $146 billion on temporary patches to block the payment cuts called for under the formula. She also said that moving physicians to better care delivery models can result in cost savings and better outcomes for patients.

“We can’t tell them how to do the pay-fors, and I realize this is going to be an issue no matter what the conversation is,” Hoven said. “I think the way to tee up this conversation is to talk about future cost savings. ... One of the ways to recognize that this is the right pathway is the cost savings that we’re going to be seeing across the system, and which we’re already beginning to see.”
According to stakeholders, lawmakers on all three committees seem to agree on a basic layout for a bill: repealing the SGR, instituting a multi-year period of payment stability and then transitioning providers to new payment and delivery models.

“Whoever’s doing it, it needs to have in it the repeal, the stabilization updates for five years, and then the ability for physicians to go into models of care and get rewarded for doing the type of work that they want to do and can do,” Hoven said.

Quintero said it was crucial for his group that physicians have different options of payment models because practices vary greatly depending on the types of patients they see, their location, the services they provide and other factors.

“The SGR was one size fits all,” said Quintero. “We all saw how that played out.”

A senior representative for another physician organization said his group has been talking with all three committees, and he felt that the committees shared a high level of agreement on policy.

He added that the Energy and Commerce bill could serve as a template for the other committees to work off of — one that already has strong bipartisan support.

Hoven mentioned one thing her group would like to change in the Energy and Commerce bill — the 0.5 percent annual payment updates that physicians would receive during the five-year transition period. Hoven said that amount is too low and the issue needed to be negotiated.

Still, she said she was encouraged that the timing was right to repeal the SGR this year, thanks to “SGR fatigue” in Congress, the lower CBO score, and evidence that alternative payment models are working.

“This is much more likely to happen that has ever happened before,” she said.

Rebecca Adams contributed to this report.

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Source: CQ News

Round-the-clock coverage of news from Capitol Hill.

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Letter Sent to All Members of the U.S. House of Representatives

August 12, 2013

Dear Representative:

The undersigned organizations strongly urge you to oppose H.R. 2914, the Promoting Integrity in Medicare Act of 2013, which would limit patient access to in-office services that physicians provide under the physician self-referral or Stark law. If enacted, this bill would limit access to life-saving services for many patients and stifle new innovative reforms already underway to improve care delivery and quality improvement. It would raise the costs to Medicare beneficiaries and the Medicare program by driving patients to more costly facilities thereby requiring additional expenditures.

The Stark law currently allows physicians to provide some services in the office setting, including advanced diagnostic imaging (MRI, PET, and CT scans), radiation therapy, anatomic pathology, and physical therapy, when complex and detailed supervision, location, and billing requirements are met. Integration of these medical services facilitates the development of coordinated clinical pathways, improves communication between specialists, offers better quality control of ancillary services and enhances data collection – all of which improves patient care and maximizes efficiencies. In addition, in-office patient access to these services can facilitate immediate diagnosis, physician communication with other members of the care team, and rapid, appropriate treatment of the disease condition.

H.R. 2914 would prohibit all these services in an office setting, force patients to receive services in a new and unfamiliar setting, increase costs, present significant barriers to appropriate screenings and treatments, and make health care less accessible. In its June 2011 Report to Congress, the Medicare Payment Advisory Commission (MedPAC) recommended against limiting the Stark law exception for ancillary services, citing potential “unintended consequences, such as inhibiting the development of organizations that integrate and coordinate care within a physician practice.” The General Accounting Office (GAO) recently issued a series of reports on self-referral and flatly rejected the recommendation to limit the Stark exception.

Over the years, the medical profession has taken significant steps to develop tools to promote the medically necessary and appropriate use of ancillary services. These steps include accreditation, as well as the development and implementation of training guidance, appropriate use criteria, practice guidelines, and clinical decision support tools which assist physicians in delivering the most appropriate care.

Our organizations seek to protect Medicare beneficiaries and taxpayers alike by providing high quality, ethical care in a setting that benefits patients and facilitates care...
coordination. We strongly urge you to oppose H.R. 2914, legislation that would only limit patient access, undermine competition in the healthcare market, force patients to receive care in more expensive settings and contravene new innovative reforms already underway.

Sincerely,

American Academy of Dermatology Association
American Academy of Neurology
American Academy of Ophthalmology
American Academy of Otolaryngology—Head and Neck Surgery
American Association of Clinical Urologists
American Association of Neurological Surgeons
American Association of Neuromuscular & Electrodagnostic Medicine
American Association of Orthopaedic Surgeons
American College of Cardiology
American College of Gastroenterology
American College of Mohs Surgery
American College of Rheumatology
American College of Surgeons
American Gastroenterological Association
American Medical Association
American Medical Group Association
American Society for Dermatologic Surgery Association
American Society for Gastrointestinal Endoscopy
American Society for Mohs Surgery
American Society of Echocardiography
American Society of Neuroimaging
American Society of Nuclear Cardiology
American Urological Association
Association of Black Cardiologists
Association of Freestanding Oncologists
Cardiology Advocacy Alliance
Large Urology Group Practice Association
Medical Group Management Association
National Association of Spine Specialists
Society for Cardiovascular Angiography and Interventions
Society for Vascular Surgery
US Oncology Network
In-office ancillary services exception and the GAO report

As members of Congress seek ways to reduce the federal deficit and pay for a fix to the Sustainable Growth Rate formula, whether temporary or permanent, one of the items frequently on the table as a proposed “pay-for” is the in-office ancillary services, or group practice, exception to the Stark law. The exception is what allows dermatology groups to provide dermatopathology in-house without facing penalties for violating regulations that forbid self-referral within practices. Unfortunately, abuse of this exception by some now threatens its existence for all.

Actuaries have long believed that closing the exception would save the Medicare program money, with varying estimates depending on how such a closure is implemented. The Congressional Budget Office says closing part of the exception would save $1.6 billion over 10 years, while the Office of Management and Budget flips the digits, estimating the closure in the president’s proposed budget for 2014 would save $6.1 billion. Recently, the Government Accountability Office (GAO) gave supporters of closing the exception a boost with a report that became public on July 15 and indicated that when dermatologists, urologists, and gastroenterologists start referring anatomic pathology in-house, they immediately begin referring significantly more pathology to their own ancillary services, or group practice, exception to Stark had not yet attracted congressional sponsor. But in its wake, a bill introduced in the House. It would be a terrible irony for us to finally achieve long-sought Medicare payment stability, only to have it paid for in part by gutting our ability to use the full spectrum of our training to provide the best possible care for our patients.

However, if Congress closes the exception, the data suggest that dermatologists may, in part, be culpable. While the GAO report’s methodology was imperfect, its conclusions are all but irrefutable: on average, dermatologists, gastroenterologists, and urologists who brought their pathology in-house during the study period referred more pathology to themselves than they had previously referred out. In aggregate, 918,000 more specimens were read in-house in 2010 by self-referrers than would have been referred out. After searching for any other explanation for this change, the GAO concluded that the financial incentives for self-referring were to blame, and said this behavior cost Medicare an extra $69 million in 2010 alone, not to mention additional co-pays made by patients.

What is at risk may be no less than our scope of practice and our right as dermatologists to read slides and run labs.

The AADA issued a strong response to the GAO report, noting that we are “committed to working to ensure that pathology services are utilized in the most appropriate and cost-effective manner.” We call upon all Academy members to evaluate their practices and help us fulfill this commitment. We can, and we must, guarantee that we use pathology services in only the most appropriate and cost-effective manner, which is that which best serves the needs of our patients.

Prior to the release of the GAO report, the push to eliminate the in-office ancillary services exception to Stark had not yet attracted a congressional sponsor. But in its wake, a bill that would close the exception for anatomic pathology, as well as advanced imaging, radiation therapy, and physical therapy, was introduced in the House. It would be a terrible irony for us to finally achieve long-sought Medicare payment stability, only to have it paid for in part by gutting our ability to use the full spectrum of our training to provide the best possible care for our patients.

Signed by the Officers, Board of Directors (current and incoming), and Board Observers

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Dermatology World September 2013