



# AMERICAN COLLEGE OF GASTROENTEROLOGY

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June 1, 2007

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Dear Lou and Mike,

Thank you both for traveling out to Washington DC with me, Dr. Amy Foxx-Orenstein and Brad Stillman (executive director ACG). I found our conversations to be insightful and productive. Below are several points to summarize our perspectives from the meeting:

- 1) We were encouraged to hear the cardinal principles of commitment to quality, patient safety and optimization of clinical outcomes. As you could see from our discussion, the ACG is very much vested in the area of quality of patient care. As noted, we have been very much involved and continue to take leadership roles in gastroenterology for new quality based initiatives and clinical benchmarking.
- 2) We openly discussed the potential implications of site of service differentials for gastroenterology patients. We remain concerned that this has potential for serious unrecognized adverse outcomes. We discussed and agreed that patients should be seen and treated by the most competent and qualified health care providers. For endoscopic procedures this means physicians that have gone through both appropriate training to maximize their skill, but also who have had the appropriate cognitive training so that their technical interventions are most appropriately (and safely) delivered. We agreed in the majority of cases for gastrointestinal disease,

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this would typically mean that the care was provided best provided by a gastroenterologist.

- 3) We discussed the potential problems arising from SOS where gastroenterologists might not be able to perform the procedures in HOPD or ASC setting due to the financial cuts imposed which may necessitate those physicians to not be able to care for those patients. We agreed that if there was a suitable alternative for gastroenterologists to do these procedures in their office — in accordance with the same standards, quality and safeguards provided in HOPD and ASC certified facilities, this would be a viable option. Clearly if patients are not able to see the gastroenterologist for the procedure, there is clear risk that they may be seen by a non-gastroenterologist who might now have incentives to start doing endoscopic procedures in the office or by those who are already performing these procedures to increase their volumes — albeit not with the standards of quality, patient safety and training that we all agreed were cornerstones for UnitedHealthcare's priorities for their patients. Although recognizably, credentialing of physicians, performing a procedure is not the business of UnitedHealthcare, having procedures done in an ASC or HOPD does involve a credentialing process as well as a quality assurance program to insure that physicians performing these procedures are qualified in accordance with local and national standards — thereby insuring that the patients are receiving quality care by qualified care providers.
- 4) We found it extremely troubling that given the above issues, the UnitedHealthcare's SOS would use financial steerage of patients and may pose potential formidable risk of unforeseen consequences. We all agreed that we need to fully understand the downstream effects of such a policy. To do so, we agreed that the following is needed:

UnitedHealthcare will determine:

- a) What % of endoscopic procedures are being done in the office in each of the target areas. Some states such as NY and VA are doing high volume office endoscopy due to a certificate of need legislation issues precluding them from developing ASCs for endoscopic services. Hence a general number for the country would be potentially misleading but rather we need to see on a state-by-state basis to account for these areas.
- b) Who is currently performing endoscopy using GI diagnostic codes in the office — specifically the nature of practice (primary care, gastroenterologist, surgeon).
- c) Assess the logistics of transfer of patients from HOPD or ASC-specifically to assess if there is capacity in each area to be able to deliver GI endoscopic services in a timely and appropriate fashion and in accordance with present standards of care.

ACG will survey the membership on a number of issues to include:

June 7, 2007

Lewis Sandy, M.D.

Michael L. Ille

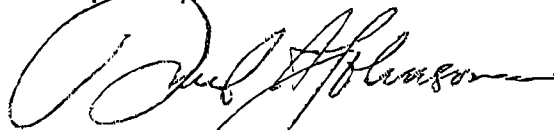
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- a) What % of physicians are currently doing office based procedures (outside of the areas where ASCs are not an option).
- b) What % of physicians who currently are doing endoscopic procedures in HOPD or ASC have the capacity to immediately start doing office based endoscopy at similar standards to the HOPD and ASC.
- c) What % of physicians currently doing procedures at HOPD and ASC would look to develop office endoscopy to provide for UnitedHealthcare patients as a result of this policy.

Although we recognize that the SOS policy is meant to apply globally to all types of physician specialties, it seems incumbent on UnitedHealthcare to appropriately assess all of the implications of this policy as it relates specifically to GI physicians and for the patients for whom they provide care. We believe the aforementioned issues strongly would suggest that at present, application of this SOS differential policy may have serious unforeseen consequences affecting access and quality. As such, we are encouraged that there may be some potential to re-evaluate this policy as it relates specifically to gastroenterology.

We will look forward to our next meeting and ask that you coordinate this through Brad Stillman to identify a mutually agreeable date. Many thanks again for your willingness to listen and for your commitment to provide the best care for the patients served by UnitedHealthcare.

Respectfully,



David A. Johnson, MD, FACG

President, American College of Gastroenterology

DAJ/lto

cc: Bradley C. Stillman, M.D.  
ACG Executive Director, ACG

Amy Foxx-Orenstein, D.O.  
President-Elect ACG