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COMMITTEE ON THE BUDGET
COMMITTEE ON FOREIGN AFFAIRS
MIDDLE EAST AND SOUTH ASIA
TERRORISM, NONPROLIFERATION, AND TRADE

# Congress of the United States
## House of Representatives
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November 16, 2011

Honorable Patty Murray
U.S. Senate
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Honorable Max Baucus
U.S. Senate
Washington, DC 20510

Honorable John Kerry
U.S. Senate
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Honorable John Kyl
U.S. Senate
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Honorable Rob Portman
U.S. Senate
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Honorable Patrick Toomey
U.S. Senate
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Honorable Jeb Hensarling
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Honorable Dave Camp
U.S. House of Representatives
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Honorable Fred Upton
U.S. House of Representatives
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Honorable James Clyburn
U.S. House of Representatives
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Honorable Chris Van Hollen
U.S. House of Representatives
Washington, DC 20515

Honorable Xavier Becerra
U.S. House of Representatives
Washington, DC 20515

Dear Colleagues:

Last month, I sent a letter to members of the Joint Select Committee on Deficit Reduction – signed by 117 Members of Congress – urging you to include a long-term solution to the broken Medicare physician payment system as an integral component of your deficit reduction proposal. As the Committee concludes its deliberations, I respectfully request your consideration of the *Medicare Physician Payment Innovation Act* proposal, which repeals the flawed Sustainable Growth Rate (SGR) formula and sets out a clear path toward comprehensive reforms of Medicare payment and delivery systems.

As you know, on January 1, 2012, physicians face a scheduled reduction in Medicare payments of more than 27 percent. We owe it to seniors across the country to end this perennial threat to Medicare beneficiaries' access to medical services once and for all. The *Medicare Physician Payment Innovation Act* proposal ensures patient access to physicians while promoting efficiency, quality and value in health care delivery by:

- Permanently repealing the Sustainable Growth Rate;
- Stabilizing the current payment system and providing positive payment updates for primary and specialty providers;
- Instituting measures to ensure access to primary care;
- Aggressively testing and evaluating new payment and delivery models;
- Identifying best practices and developing a menu of delivery model options;
- Establishing a transition period for practice transformation;
- Rewarding providers for high-quality, high-value care;
- Ensuring long-term stability in the Medicare physician payment system; and
- Containing the rising growth in health care costs through delivery system reform.

The SGR has created uncertainty and instability in the health care system and the federal budget for over a decade. True deficit reduction cannot be achieved without measures to address the Medicare program's $300 billion debt that has resulted from this failed policy.

Through this process, Congress has an historic opportunity to implement sound fiscal policy in the Medicare program in the context of broad fiscal reforms. I urge you to seize this opportunity and incorporate the broad reforms to the Medicare physician payment system contained in the *Medicare Physician Payment Innovation Act* proposal in your forthcoming recommendations.

Sincerely,

Allyson Y. Schwartz

Allyson Y. Schwartz
Member of Congress

C: The Honorable John Boehner, Speaker, House of Representatives
The Honorable Harry Reid, Majority Leader, United States Senate
The Honorable Mitch McConnell, Republican Leader, United States Senate
The Honorable Eric Cantor, Majority Leader, House of Representatives
The Honorable Nancy Pelosi, Democrat Leader, House of Representatives
The Honorable Kevin McCarthy, Republican Whip, House of Representatives
The Honorable Steny Hoyer, Democrat Whip, House of Representatives

**Representative Allyson Y. Schwartz**

***MEDICARE PHYSICIAN PAYMENT INNOVATION ACT OF 2011***

**November 2011**

The *Balanced Budget Act of 1997* created the sustainable growth rate formula (SGR) in an attempt to control spending in the Medicare program. For ten years, this payment formula has consistently produced unrealistic expenditure targets, which subsequently trigger untenable reductions in payment rates. Annual Congressional overrides of these scheduled cuts have averted immediate crises in access to physician services for Medicare beneficiaries—while exacerbating a longer-term crisis in Medicare financing. On January 1, 2012, physicians face a scheduled reduction in Medicare payments of more than 27 percent.

The current approach to payment levels based on overall physician expenditure targets, which punishes individual physicians for systemic dysfunction, is the wrong approach to reducing costs. The existing fee-for-service model, particularly with the threat of SGR cuts, rewards overutilization as providers seek to compensate for insufficient payments. It is time to end SGR and replace it with a system of reimbursement that will reduce costs in Medicare by changing the way we pay physicians to incentivize timely, evidence-based, coordinated care to Medicare beneficiaries. Payment reforms that reimburse providers on the basis of efficiency, quality and patient outcomes are essential to slowing the rate of growth in health care spending while ensuring access to services.

The *Medicare Physician Payment Innovation Act of 2011* fully repeals the SGR, stabilizes current payment rates to ensure beneficiary access in the near-term, and sets out a clear path toward comprehensive payment reform.

## SUMMARY

### 1. PERMANENTLY REPEAL THE SUSTAINABLE GROWTH RATE.

*The existing Medicare physician payment system is unsustainable and the SGR must be repealed immediately. Real progress toward a quality-based, fiscally sound payment system cannot begin without eliminating the uncertainty and instability resulting from the SGR that has persisted for a decade.*

This legislation permanently repeals the "sustainable growth rate" (SGR) formula. By eliminating the $300 billion debt to the Medicare program, this provision restores stability and fiscal transparency to the payment system, and sets out a clear path to comprehensive payment reform.

### 2. STABILIZE THE CURRENT PAYMENT SYSTEM.

*First and foremost, Congress must take action to avert the 27.4% cut to physician reimbursements scheduled for January 1, 2012 and stabilize the current payment system.*

In order to ensure a workable transformation of the Medicare payment system over the long-term and provide short-term stability in the Medicare program, an immediate one year freeze at 2011 payment levels would be effective January 1, 2012. Thereafter, a five year transition period begins which gradually modifies the current physician payment formula, before a new payment system is fully implemented.

### 3. INSTITUTE MEASURES TO ENSURE ACCESS TO PRIMARY CARE.

*At present, more than 1.3 million Medicare beneficiaries have difficulty finding a primary care physician due to a severe shortage of primary care physicians. A major factor in the supply of these physicians is the income disparities between primary care and specialty physicians. Nonprocedural services, which constitute the majority of primary care services, are undervalued under the current system, while care coordination is rarely reimbursed at all. During the transition period to more patient-centered, primary care-based delivery models, short-term measures to attract and retain primary care physicians are needed to ensure beneficiary access to care.*

The *Medicare Physician Payment Innovation Act* would implement temporary differential updates to payments for physician services. For years 2013 to 2016, the bill provides an annual increase of 2.5% for primary care services provided by primary care providers, and a .5% update for all other physician services. This provision addresses the failure of recent updates to keep pace with the rising cost of providing health care services, as well as the undervaluation of essential primary care services relative to procedural services.

### 4. AGGRESSIVELY TEST AND EVALUATE NEW PAYMENT AND DELIVERY MODELS.

*Under the Patient Protection and Affordable Care Act, the Center for Medicare and Medicaid Innovation (CMMI) was established to test new health care delivery and payment models in-tended to*

*reduce costs while improving quality. Increasingly, providers are also independently embracing the opportunity to pursue innovative changes to the way they deliver care effectively and improve patient outcomes while reducing costs. These ongoing activities in both the public and private sector have the potential to transform the health care delivery system and contain the rising growth of growth of costs.*

CMMI's ongoing demonstration projects will inform the development of payment models to replace the SGR. This legislation directs CMMI to expand upon its current charge and identify, test and evaluate multiple models that can be successfully replicated in more than one geographic region taking into account the need to identify workable options for both primary care providers and specialists. In addition to the quality and spending components required under the Affordable Care Act, the Secretary's evaluation of models would include an estimate of the per-physician cost of implementation.

This legislation also directs the Government Accountability Office to conduct a meta-analysis of CMMI's evaluations and report to Congress by April 1, 2015 on CMMI's activities to date and provide recommendations to CMS to address any problem areas identified in the report.

**5. IDENTIFY BEST PRACTICES AND DEVELOP A MENU OF DELIVERY MODEL OPTIONS.**

*Under the existing Medicare Physician Payment System, the SGR imposes a singular payment formula in a wide array of health care settings, irrespective of the physician's practice model, specialty or role within the community's larger health care system. Comprehensive reforms to the payment system must provide flexibility by offering the choice of multiple options with various levels of risk and integration to ensure maximum participation and successful implementation of new payment models in diverse practice settings.*

By October 1, 2015, the Centers for Medicare and Medicaid Services (CMS) must issue a menu of no less than four health care delivery and payment model options based on an analysis of CMMI evaluations and input from the provider community. CMMI will also have the option of selecting models under development outside CMS that have demonstrated success in containing costs while improving quality. In addition, CMS must publicly release guidance to providers as to best practices for transitioning from their current practice model to new models based on factors including practice size, specialty mix, health care infrastructure in the region, demographics, case mix and variations in cost of living.

**6. ESTABLISH A TRANSITION PERIOD.**

*While delivery system reforms offer providers the opportunity to reap benefits in the long-term, the period of physician practice transformation will initially be time and resource intensive for many. Sufficient time will be necessary to allow providers to evaluate the appropriateness of the CMMI models for implementation in their own practices and seek external guidance as needed.*

In order to minimize disruption in the transition to new delivery models in 2017, fee-for-service payments will be frozen at 2016 levels for one year. Recognizing the unique challenges facing solo and small group providers seeking to transform established business models, this legislation provides funding for existing Regional Extension Centers, established under the American Recovery and

Reinvestment Act, to provide guidance to physicians on alternative health care delivery model options and best practices for practice transition.

**7. REWARD PROVIDERS FOR HIGH-QUALITY, HIGH-VALUE CARE WHILE DISINCENTIVIZING FRAGMENTED, VOLUME-DRIVEN CARE.**

*Coordinated care models are the future of the Medicare physician payment system and wide-spread adoption will be central to the success of comprehensive reforms. Incentives for physicians to change their practice models will ensure a comprehensive transformation of the current delivery system. While financial incentives among the various CMMI approved models will vary, resistance to change cannot be rewarded. A straight fee-for-service system updated annually on the basis of overall spending relative to an expenditure target, however designed, cannot substitute for fundamental delivery system reforms.*

Beginning, January 1, 2017, physicians practicing within a CMMI-approved health care delivery model will continue to receive stable reimbursements consistent with their specified payment system. For those practicing in CMMI-designated coordinated care models with underlying fee-for-service payments, all services will continue to be reimbursed at 2016 levels through 2021.

Providers who retain the straight fee for-service-model will be subject to disincentives in the form of reduced updates to both primary and procedural services. Annual updates in years 2018 to 2021 for those in this category will be: -2% in 2018, -3% in 2019, -4% in 2020 and -5% in 2021.

The legislation contains a limited exemption from negative fee-for-service updates to be granted annually by CMS on a case-by-case basis for providers who, after demonstrating a good faith effort, are deemed incapable of transitioning to an established model.

**8. ENSURE LONG TERM STABILITY IN THE MEDICARE PHYSICIAN PAYMENT SYSTEM.**

*Predictable updates that accurately reflect the cost and value of providing health care services in coordinated care models while containing health care spending will be essential to a sustain-able payment system over the long-term.*

This legislation directs the Secretary beginning in 2022 to update fee-for-service payments under coordinated care models between one percent and the Medicare Economic Index (MEI) annually based on beneficiary access to health care services, provider participation in CMMI models and the overall rate of growth in spending in the Medicare program – not limited to Part B.

Payments in straight fee-for-service models will be permanently frozen at 2021 levels.