Statement

of the

American Medical Association

to the

Committee on Energy & Commerce
Subcommittee on Health
United States House of Representatives

Re: Permanent Solution to the SGR: The Time is Now

Presented by Barbara L. McAneny, MD
Chair, AMA Board of Trustees

January 22, 2015

Division of Legislative Counsel
(202) 789-7426

STATEMENT

of the

American Medical Association

to the

Committee on Energy & Commerce
Subcommittee on Health
United States House of Representatives

Re: A Permanent Solution to the SGR: The Time is Now

Presented by Barbara L. McAneny, MD
Chair, AMA Board of Trustees

January 22, 2015

On behalf of the American Medical Association (AMA), I commend the Energy & Commerce Committee Subcommittee on Health for conducting this hearing to address "A Permanent Solution to the SGR: The Time is Now." As the largest professional association for physicians and the umbrella organization for state and specialty medical societies, the AMA is dedicated to promoting the art and science of medicine and the betterment of public health. We commend the Subcommittee for taking the first step in the 114th Congress to address this matter.

The time is past for Congress to move forward with a legislative solution that resolves a longstanding and fundamental problem facing Medicare by repealing the statutory formula known as the Sustainable Growth Rate, or SGR, and replacing it with payment reforms that enhance and support patient care. Congress should act expeditiously to enact the policies in the comprehensive, bipartisan, bicameral "SGR Repeal and Medicare Provider Payment Modernization Act," (H.R. 4015/S. 2000 in the 113th Congress).

We now have a unique opportunity to improve and modernize Medicare by enacting into law legislation based upon H.R. 4015/S. 2000. This bill represents significant Medicare reform, and the Subcommittee

should continue to build on this effort by addressing outstanding barriers to its successful passage. There should be no preconditions, other than the commitment to a bipartisan and workable solution that can withstand scrutiny and be passed by both houses of Congress, signed by the President, and become law.

In 1997, Medicare law was amended to include the SGR formula, which requires cuts in payment for physician services when annual spending under the Medicare Physician Fee Schedule exceeds certain targets that are tied to economic growth. These "physician services"—which also include services by non-physician practitioners who are paid under the Medicare Physician Fee Schedule/Part B—are the only Medicare services subject to these kinds of cuts. There is no SGR formula or other comparable ceiling that triggers cuts in Medicare reimbursement for hospitals, ambulatory surgical clinics, home health, hospice, pharmaceuticals, medical devices and supplies, or any other category of Medicare provider or supplier.

Everyone agrees that we need to contain Medicare spending and ensure the most efficient and effective use of Medicare resources. Unfortunately, the Medicare SGR formula was never the solution, and in fact has now added to the problem. Physicians are not solely responsible for Medicare spending levels. Physicians order and recommend health care services and treatments, but they do not establish (or sometimes even know) the prices of those services. A wide array of factors and services contribute to Medicare spending levels, including patient choices and decisions. In 2013, Medicare spending on Part B Physician Fee Schedule services was $69 billion, or 12 percent of total Medicare spending.[1] And many physician services are designed to keep patients out of the hospital. Cuts produced under the SGR affect payment and compensation for over a million health care professionals, including physicians, non-physician practitioners (such as nurse practitioners and physician assistants), and the nurses and other staff they employ.

[1] 2014 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, at 11.

This Medicare formula has undermined and destabilized the practice of medicine and prevented physicians from focusing on their patients. It also has prevented physicians from engaging in payment and delivery reforms, and it has taken time and energy away from innovations that can improve the quality of care. If not remedied soon, access to care will be threatened. For example, the number of psychiatrists accepting Medicare patients has plummeted in recent years, to just over 50 percent, while the growing numbers of patients with dementia and depression are facing a severe shortage of mental health providers.[2]

Physicians already face an enormous gap between what Medicare pays and the actual cost of caring for seniors and the disabled. From 2001 to 2015, government data show that the cost of caring for patients by medical practices has gone up by 27 percent. At the same time, the average annual Medicare physician payment update has been only about 0.3 percent per year. Adjusting for inflation, the physician payment rate has actually fallen by 18 percent. With enormous debt burdens for graduating medical students,[3] and increasing regulatory burdens for electronic health records, physician quality reporting programs, ICD-10, etc., we continue to hear from physicians who are retiring early, choosing to go into administration or business instead of seeing patients, or advising their children not to become physicians. The Medicare SGR formula adds to this problem by threatening steep payment cuts year after year, and AMA members have repeatedly identified SGR reform as our highest priority. Physicians are also facing a tsunami of penalties from the various overlapping Medicare programs. The cumulative effect of these programs, when combined with a two percent payment sequester reduction, would produce penalties totaling 11 percent in 2017 and grow to 13 percent by the end of this decade.

[2] *JAMA Psychiatry*. 2014; 71(2):176-181. doi:10.1001/jamapsychiatry.2013.2862.
[3] The AMA estimates the average debt burden for medical school graduates at approximately $180,000.

The current fee-for-service payment system creates major barriers for physicians who want to redesign care in ways that benefit patients and save money for Medicare:

- **Financial penalties for delivering higher-value care**: Today, physicians are financially penalized for reducing unnecessary services and improving quality. Under the current Medicare payment system, physicians lose revenue if they perform fewer procedures or lower cost procedures, even if their patients are healthier as a result. Most fundamentally, under Medicare, physicians are not paid at all when their patients stay well.
- **Failure to pay for high-value services**: In the Medicare program, some high-value services are not paid for adequately or at all. Medicare does not pay physicians to respond to a patient phone call about a symptom or problem, even though those phone calls can avoid far more expensive visits to the emergency room. Medicare will not pay primary care physicians and specialists to coordinate care by telephone or email, yet it will pay for duplicate tests and the problems caused by conflicting medications.

Physicians all over the country have proven that they can both improve care for patients and save money for Medicare if they can get the resources they need to deliver services that Medicare does not pay for. For example, primary care physicians, cardiologists, oncologists, and others have used grant funding in demonstration projects to pay for nurses to help patients manage their health problems. These projects have dramatically reduced the rate at which their patients have had to go to an emergency room or be hospitalized for complications, saving Medicare far more than the cost of the services supported by the grants. But in most cases, the improvements in care and the savings achieved in the demonstration projects end when the demonstration ends, because there is no way to sustain the projects under the current payment system. The payment reforms adopted by the Committee last year would help remove these barriers and promote adoption of new payment models that will improve patient care and lower costs.

On 17 separate occasions in the past 12 years, Congress has agreed that the Medicare SGR formula is not working. Seventeen temporary "patches" have been enacted since 2003 to prevent SGR cuts from taking effect. But every time a patch is enacted, the cut is simply postponed and added to the following year. As a result, the projected cut that is scheduled to take effect on April 1, 2015, is 21.2 percent, unless Congress intervenes. Due to nearly flat utilization growth in physician services for several years, the SGR "cliff" has dropped from almost 30 percent a few years ago to 21.2 percent effective in April 2015. If we could ignore the accumulated 21 percent cliff, the Medicare SGR formula would actually trigger an increase in payment for physician services, as recent spending has actually been running below SGR targets. Per enrollee, SGR spending has averaged less than one percent in recent years, and for 2013 SGR spending was six percent below the target amount.

There has long been widespread support for repealing the Medicare SGR formula, including from the Medicare Payment Advisory Commission. Just last week at the Commission's January meeting, Chair Glenn Hackbarth "exhorted lawmakers" to put a permanent end to the SGR formula that "routinely threatens to slash doctors' pay from the big government health program." Mr. Hackbarth pointed out that Congress has frequently used savings from Medicare to offset budget deals and temporary SGR patches. "Yet we never seem to have enough to pay for an appropriate payment system for physicians," he said.

The House of Representatives is in session only 28 days before SGR Patch Number 17 expires on March 31. Unless Congress takes action now, there will again be scrambling at the last minute to enact yet another "Band-Aid" patch. Even the Congressional Budget Office (CBO) agrees that the patches have cost Medicare more over time (not even counting the work of Congress and other stakeholders) than if Congress had acted quickly to repeal the Medicare SGR formula. In November 2014, the CBO estimated the 10-year cost of enacting H.R. 4015/S. 2000 at $144 billion. By contrast, the cumulative cost of the patches since 2003 is estimated at $169.5 billion.

The AMA commends the members and staff of the House Energy & Commerce, House Ways & Means, and Senate Finance Committees for developing comprehensive bipartisan, bicameral legislation—with input from stakeholders—to enact permanent Medicare reform and permanently repeal the Medicare formula. We encourage this Committee and the new Congress to move this legislation forward as quickly as possible. H.R. 4015/S. 2000 provides a pathway forward to achieving meaningful Medicare reform. It represents a historic achievement in this effort. There has long been strong bipartisan agreement that the Medicare SGR formula must be repealed and replaced with an alternative, more viable system. After working for over a year, Republican and Democratic members and staff of these three committees were able to come to agreement on a single bill, and each committee approved the bill. The House Energy and Commerce Committee approved H.R. 4015 unanimously, 51 to zero.

H.R. 4015/S. 2000 is a detailed, thoughtful, and workable solution. It represents a major improvement over current law, and it is widely supported by physician specialty organizations. In addition to permanently repealing the SGR, it would provide positive payment updates of 0.5 percent for the first five years, and then freeze payments at that level for an additional five years to allow for the development and adoption of new, innovative payment and delivery models. Payments in subsequent years would be determined by many factors, including performance in the newly created Merit-Based Incentive Payment System (MIPS) for those who choose to remain in the fee-for-service payment system. Physicians in qualifying alternative payment models would receive a five percent bonus for a five-year period. The MIPS program would harmonize the various Medicare quality reporting programs: the Physician Quality Reporting System (PQRS), Electronic Health Record Incentive Program/Meaningful Use (MU), and the Value-Based Payment Modifier (VBM). The distinct requirements of these individual programs are often contradictory and duplicative, and together impose an unreasonably high burden and unduly high penalties on physicians, without clear evidence that they actually improve the quality of care. The bill streamlines key features of these programs into one single, more workable and practical program that offers greater flexibility and more opportunities for physicians to be rewarded for providing quality care.

Performance scoring under the MIPS program has several advantages over the current penalty programs:

- Unlike the VBM, the MIPS would not require both winners and losers. In the MIPS, physicians who meet the performance threshold would avoid a penalty, and those who exceed it would earn bonuses.
- Performance assessment under the MIPS program would be according to a "sliding scale"—versus the current "all or nothing" approaches used in PQRS and MU. Credit would be provided to those who partially meet the performance metrics.
- The bill has guidelines for the weighting of the four performance categories, yet specifically allows administrative flexibility for those in practices or specialties that are at a disadvantage in meeting quality or MU requirements.
- At the start of each performance period, physicians would know the threshold score for successful performance, and they would receive quarterly feedback on their individual performance.
- Physicians could receive substantial credit for clinical practice improvement activities and for improving (and achieving) quality of care.
- Physicians with a low level of Medicare claims, and those who are in alternative models, would be exempt from the MIPS requirements and payment adjustments.

The MIPS also presents the first real opportunity for physicians to earn substantial bonuses for providing high quality of care. For exceeding the performance threshold, physicians could earn bonuses of up to four percent the first year, with the maximum increasing by one percent each year until reaching nine percent in year six and beyond. Additional funding is provided for exceptional performance, up to $500 million per year, in years eight through ten. So even if all physicians score above the threshold, some will still receive incentive payments. Unlike current law, the MIPS penalties provide greater certainty, and have a maximum range in future years.

The bill provides incentives and a pathway for physicians to develop and participate in new models of health care delivery and payment. Physicians participating in patient centered medical homes, widely recognized to lower costs of care, would not be required to assume downside financial risk. Other models would require some degree of downside risk in addition to opportunities for increased revenues if the physician practice generates savings. To encourage physicians to take on this risk, and provide a financial cushion, the legislation provides five percent bonus payments for five years for those who join new models. This provides a transition period to support successful implementation of new models. Another advantage is that physicians would only be subject to the quality reporting requirements for their model of care; they would be exempt from the new MIPS quality program. The bill also supports the use of telemedicine in new models of care and creates an advisory panel to consider physicians' proposals for new models.

New payment and delivery models can make Medicare services more effective and more efficient, thereby saving money while improving care. Many of these savings are difficult to demonstrate, and occur in the long-term, beyond the period reviewed by the CBO. But the leading experts in health care payment and efficiency embrace alternative payment models as the best way to make Medicare a stronger, more efficient program, and present an alternative to the current fee-for-service approach which inherently rewards quantity of services, over quality and effectiveness of services. Moreover, the Centers for Medicare & Medicaid Services (CMS) recently reported there are now 424 accountable care organizations (ACOs) serving over 7.8 million beneficiaries under the Medicare Shared Savings Program and the Pioneer ACO Model, producing total savings of $417 million.[4]

The Committee's proposal has the broad support of providers, patients, and other stakeholders. More than 600 state, specialty, and national medical societies signed a letter to Congress urging its passage. A

[4] Sean Cavanaugh, Deputy Administrator and Director, Center for Medicare. The CMS Blog: ACOs Moving Ahead. Dec. 22, 2014. http://blog.cms.gov/.

broad array of patient and other groups, from AARP to Easter Seals to the U.S. Chamber of Commerce, also wrote to Congress in November 2014, in support of the bill.

The AMA stands ready to support this process. Now is the time to move toward a Medicare program that supports physicians for providing high-quality care that helps keep their patients out of the hospital. A 21st Century health care system focuses on patients, not just payments.

The AMA appreciates the opportunity to provide our comments on this critical health policy matter, and we look forward to working with the Subcommittee and Congress to repeal the flawed SGR formula and assist in the transition to a new health care payment and delivery system that provides more coordinated care, improves health outcomes, and slows the growth of costs in the Medicare program.