November 12, 2013

U.S. House of Representatives
Committee on Ways & Means
Washington, D.C. 20515

U.S. Senate
Committee on Finance
Washington, D.C. 20515

Re: SGR Repeal and Medicare Physician Payment Reform Discussion Draft

Dear Chairman Camp and Chairman Baucus:

The undersigned organizations welcome the opportunity to submit written comments in response to the discussion draft released by the U.S. House Committee on Ways & Means and Senate Finance Committee to repeal and replace the sustainable growth rate (SGR) formula. Our organizations share a commitment to advancing the economic and health security of older adults, people with disabilities and their families.

We agree the SGR formula is fundamentally flawed and permanent changes to the Medicare reimbursement system are long overdue. We are encouraged by this bipartisan, bicameral effort to repeal and replace the current volume-based payment system with one that rewards quality, efficiency and innovation.

While this policy proposal represents a significant step towards needed reform, we remain concerned about issues unaddressed in the discussion draft. First, the discussion draft does not account for how the SGR repeal and replacement policy will be paid for. Second, as acknowledged in the draft text, the proposal does not incorporate critical Medicare extenders traditionally included as part of an annual, year-end SGR patch. Our comments on these key issues as well as feedback on the draft proposal are detailed below.

Protecting people with Medicare from higher health care costs

We appreciate the Committees' commitment to securing consensus on an SGR repeal and replacement framework. Yet, we remain deeply concerned about potential offsets raised by some policymakers. A legislative proposal to repeal and replace the SGR **must not be paid for by shifting added health care costs to people with Medicare**.

We are grateful for the Committees' commitment to devising an efficient, low-cost SGR solution. However, we know the policy will come at a significant expense, with estimates ranging from $139 to $175 billion over 10 years.[1] We are opposed to proposals such as further income-relating Medicare Part B and Part D premiums; prohibiting or discouraging "first dollar" Medigap coverage; raising the age of Medicare eligibility; or redistributing the burden of Medicare cost sharing through increased deductibles, coinsurances or copayments to pay for a permanent SGR solution.

[1] Congressional Budget Office (CBO), "Medicare's Payments to Physicians: The Budgetary Impact of Alternative Policies Relative to CBO's May 2013 Baseline," (May 2013); Congressional Budget Office (CBO), "H.R. 2810, Medicare Patient Access and Quality Improvement Act of 2013," (September 2013)

Half of all Medicare beneficiaries—nearly 25 million older adults and people with disabilities—live on annual incomes of $22,500 or less. People with Medicare already contribute a significant amount towards their health care costs. Medicare premiums and cost sharing have risen steadily over time. In 1980, Medicare premiums and cost sharing accounted for 7% of the average monthly Social Security benefit compared to 26% in 2010.[2] In 2011, older adults averaged out-of-pocket health care costs of nearly $4,800, an increase of 46% since 2000.[3] Given this economic reality, a permanent SGR solution must ensure Medicare beneficiaries are held harmless from payment adjustments that would increase premiums and cost sharing.

Extending a permanent fix to critical Medicare benefits

We urge Congress to **extend a permanent fix to critical Medicare benefits**. Averting steep cuts to physician payments is not the only Medicare policy revisited on an annual basis. Any permanent SGR solution must also account for the Qualified Individual (QI) program and therapy cap exceptions. We are very concerned that a permanent SGR fix could significantly diminish the prospects for continued bipartisan agreement on extenders packages, which traditionally include these two critical provisions.

We urge you to make the QI program permanent. The QI benefit pays Medicare Part B premiums for individuals with incomes that are 120% to 135% of the federal poverty level—about $13,800 to $15,500 per year. This benefit is essential to the financial stability of people with Medicare living on fixed incomes. Additionally, in the absence of full repeal of Medicare therapy caps, we request that you make the exceptions process permanent. Therapy cap exceptions ensure access to critical, medically necessary services that allow beneficiaries to live with independence and dignity in their homes and communities.

Addressing the imbalance between primary care and specialty care

We urge Congress to **correct the imbalance between primary and specialty reimbursement** through an SGR repeal and replacement policy, as reflected in recommendations by MedPAC.[4] This provision is absent in the Committees' discussion draft. Medicare beneficiaries often have multiple chronic conditions, may have cognitive impairments, and need extra attention from their health care providers. Time spent explaining treatment options, following up with patients and coordinating care—activities regularly engaged in by primary care physicians and geriatricians—is not adequately valued by current reimbursement policies.

Reimbursement rates that appropriately reflect the demand for primary care services are needed to strengthen the primary care workforce and to meet the care needs of current and future Medicare beneficiaries. We encourage the Committees to incorporate concepts along these lines in subsequent proposals.

We appreciate that the Committees attempted to partly address these concerns through the inclusion of payment codes for complex chronic care management, building on already successful patient-centered medical homes and comparable specialty practice models. We strongly support paying for non-face-to-face activities to improve beneficiary quality of care. To improve on this proposal, we urge the Committees to better facilitate access to this service for low- and moderate-income beneficiaries by eliminating the Part B coinsurance.

Implementing a value-based performance payment system

We applaud the Committees for developing a value-based performance payment system, through which Medicare physicians and other providers are incentivized to participate in alternative payment models (APMs).

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[2] Cubanski, J. "An Overview of the Medicare Program and Medicare Beneficiaries' Costs and Service Use," (Kaiser Family Foundation: February 2013)
[3] Administration on Aging (AoA), "A Profile of Older Americans: 2012," (DHHS: 2012)
[4] MedPAC, Re: Moving forward from the sustainable growth rate (SGR) system (Letter to Congress, October 2011)

We are encouraged by the streamlined approach adopted in the draft framework, and we are glad to see that it aims to both build on and improve existing systems. Still, the proposal is silent on critical issues concerning the development of new quality measures and the administration of APMs.

With respect to these issues, additional detail is needed on the annual process by which the Secretary will solicit and approve new quality measures. We ask that Congress **ensure newly-developed quality measures are consensus based.** In order to provide reliable, useful data to practitioners, quality measures must be endorsed by organizations such as the National Quality Forum (NQF) that include consumers, employers and other purchasers. A multi-stakeholder process ensures acceptance of and confidence in the measures ultimately selected for payment and other purposes.

Furthermore, we strongly suggest that the Committees **include clear criteria for individual measures**, including documentation of clinical importance, evidence base, transparency, reliability, validity, feasibility, ability to act on results and rigorous auditing, in subsequent SGR policy drafts.

In addition, we support and appreciate the proposal to commit meaningful funding toward the creation of new quality measures. We **encourage that the development of measures that fill current gaps be emphasized**, particularly for vulnerable and frail older adults with multiple chronic conditions, outcome-based and patient experience measures. These areas should be identified as measurement development priorities for physicians both within and outside of APMs.

We thank the Committees for the inclusion of existing value-based APMs, including accountable care organizations, medical homes and bundled payment systems, in the discussion draft. However, more detail is needed on the process by which APMs will be administered. We strongly encourage Congress to **build on existing capacities within the Centers for Medicare & Medicaid Services (CMS),** rather than create needless bureaucracy and allow for costly duplication.

It is important to **ensure that APMs do not allow for changes to Medicare beneficiary cost sharing**. In particular, balance billing, wellness incentive-based programming and value-based insurance design that increases beneficiary costs should not be allowed APM practices. Congress has traditionally taken responsibility for decisions about beneficiary cost sharing, and this should not be delegated to CMS or another body. Language in the final bill should prohibit changes to beneficiary cost sharing.

Making Medicare data readily available

We appreciate that the Committees seek to make Medicare data available to physicians and other stakeholders to facilitate quality improvement, while also making physician and practitioner data on utilization and payment available to people with Medicare. We urge the Committees to **ensure appropriate safeguards are adopted to limit the sale of beneficiary-related data and to protect patient privacy**. At the same time, we ask the Committees to reflect carefully on how to ensure that data incorporated into Physician Compare is provided in an accessible, streamlined and simple format for Medicare beneficiaries.

In closing, we believe that any process to enact a permanent SGR solution must **involve the beneficiary community, including people with Medicare, family caregivers and consumer advocates**. We applaud this bicameral, bipartisan effort to move towards a value-based health care system for people with Medicare. Our support of a final SGR package, however, hinges on Congress's decisions concerning offsets and extenders. Staying true to the principles outlined above is critical to designing a reformed payment system that provides economic stability and ensures access to high-quality care for people with Medicare.

Thank you for the opportunity to provide comment.

Sincerely,

AARP
AFL-CIO
AFSCME
Alliance for Retired Americans
Center for Medicare Advocacy, Inc.
Medicare Rights Center
Military Officers Association of America
National Association for Home Care & Hospice
National Association of Professional Geriatric Care Managers
National Association of States United for Aging and Disabilities
National Committee to Preserve Social Security and Medicare
National Consumer Voice for Quality Long-Term Care
National Council on Aging
National Organization for Women (NOW)
Services and Advocacy for GLBT Elders (SAGE)