April 15, 2013

The Honorable Dave Camp
Chairman
House Ways & Means Committee
Washington, D.C. 20515

The Honorable Fred Upton
Chairman
House Energy & Commerce Committee
Washington, D.C. 20515

The Honorable Kevin Brady
Chairman
Ways & Means, Health Subcommittee
Washington, D.C. 20515

The Honorable Joseph Pitts
Chairman
Energy & Commerce, Health Subcommittee
Washington, D.C. 20515

Dear Representatives Camp, Upton, Brady, and Pitts:

We welcome the opportunity to provide comment on the revised framework put forward by the House Committee on Ways & Means and the House Energy & Commerce Committee. Our organizations are committed to advancing the health and economic well-being of people with Medicare and their families. On behalf of the 50 million older adults and people with disabilities for whom Medicare provides a financial and health lifeline, we submit this statement in response to the Committees' revised framework.

We agree the SGR formula is fundamentally flawed and permanent changes to the Medicare reimbursement system are long overdue. Under the current system, Congress must act on an annual basis to avert dramatic cuts to Medicare physicians and other providers. The threat of looming cuts creates uncertainty and needless stress for beneficiaries about their ability to see the doctor of their choice.

We believe SGR reform must gradually replace the current volume-based payment system with a value-driven model. New payment models must reward quality, safety, value and coordination of care, as opposed to the number of services provided. At the same time, SGR replacement must strengthen primary care. Payment models which emphasize team-based care coordination, effective care transitions, and preventive care can lead to better care, better health and lower costs for Medicare beneficiaries.

On the whole, people with Medicare have multiple and significant health needs — 40% of beneficiaries have three or more chronic health conditions, and more than one quarter of beneficiaries (27%) report being in fair or poor health. Nearly one in four people with Medicare lives with a cognitive or mental impairment, requiring extensive, ongoing care. The health needs of the Medicare population demand a payment system that appropriately values primary care, care coordination and preventive services.[1]

[1] Kaiser Family Foundation, An Overview of the Medicare Program and Medicare Beneficiaries' Costs and Services Use (Statement by J. Cubanski before the Senate Special Committee on Aging, February 2013)

We appreciate the Committees' willingness to address the long-standing need to revisit the SGR. Yet, we believe any attempt to repeal and replace the SGR must adhere to the following principles not currently reflected in the revised framework:

1. Protect people with Medicare from cost shifting. A legislative proposal to repeal or replace the SGR must not be paid for by shifting costs to Medicare beneficiaries. Half of all Medicare beneficiaries — nearly 25 million people — live on annual incomes of $22,500 or less. People with Medicare already contribute a significant amount towards health care. As a share of Social Security income, Medicare premiums and cost-sharing has risen steadily over time. In 2010, Medicare premiums accounted for 26% of the average monthly Social Security benefit compared to 7% in 1980.[2]

Given this economic reality, a permanent SGR solution must ensure beneficiaries are held harmless from payment adjustments that would increase Medicare premiums and cost sharing. To accomplish this, a new system must reduce overpayments and compensate for quality care, rather than the quantity of services provided. In short, a proposal to repeal and replace the SGR must not worsen the already tenuous economic circumstances facing many people with Medicare.

Proposals shifting costs to Medicare beneficiaries, such as by raising the Medicare age of eligibility, redistributing the burden of Medicare cost sharing through increased deductibles, coinsurances or copayments, and further income-relating Medicare Part B and D premiums, must be rejected as offsets to pay for a permanent SGR solution.

2. Extend the 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 these benefits, including therapy cap exceptions and the Qualified Individual (QI) program.

We urge repeal of the annual Medicare therapy caps which harm low-income and chronically ill beneficiaries. If this is not done, we request that you make the exceptions process permanent. Therapy cap exceptions at least help ensure access to critical, medically necessary services that allow beneficiaries to live with independence and dignity each day.

Additionally, we urge you to make permanent the QI program. The QI benefit pays Medicare Part B premiums for individuals with incomes that are 120% to 135% of the federal poverty level, amounting to about $13,800 to $15,500 per year. This benefit is essential to the financial stability of people with Medicare living on fixed incomes.

3. Promote quality care. First and foremost, payment policies must address the imbalance between primary and specialty reimbursement, as reflected in recommendations by MedPAC.[3] Medicare beneficiaries often need extra attention from their health care providers. Time spent explaining treatment options or following up with patients is not adequately valued by current reimbursement policies. Reimbursement rates which appropriately reflect the demand for primary care services will strengthen the primary care workforce. Therefore, replacement payment models must build a strong primary care foundation to meet the current and future needs of the beneficiary population.

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[2] Kaiser Family Foundation, Policy Options to Sustain Medicare for the Future (January 2013)
[3] MedPAC, Re: Moving forward from the sustainable growth rate (SGR) system (Letter to Congress, October 2011)

In addition, new payment approaches must encourage promising delivery models, such as Patient Centered Medical Homes and Accountable Care Organizations, to coordinate and better manage care. In order to provide reliable, useful data to practitioners, quality measures must be consensus based, and endorsed by such organizations as the National Quality Forum. Allowing non-consensus-based measures undermines the current measure-selection process used by other programs and limits the ability to share quality data across programs. Moreover, a multi-stakeholder process ensures acceptance of and confidence in the measures which are ultimately selected for payment and other purposes.

Any process to enact a permanent SGR solution must involve the beneficiary community, including people with Medicare, family caregivers, consumer advocates and other health and service providers. 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 on the Committees' revised framework.

Sincerely,

Joe Baker
President
Medicare Rights Center

Judith A. Stein
Executive Director
Center for Medicare Advocacy, Inc.