

WRITTEN STATEMENT FROM THE

AMERICAN GERIATRICS SOCIETY

**FOR THE SUBCOMMITTEE ON HEALTH OF THE
WAYS AND MEANS COMMITTEE**

UNITED STATES HOUSE OF REPRESENTATIVES

HEARING ON REFORMING MEDICARE PHYSICIAN PAYMENTS

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May 20, 2011

The Honorable Wally Herger

Chairman, Ways and Means Health
Subcommittee
United States House of Representatives
Washington, D.C. 20515

The Honorable Fortney Pete Stark

Ranking Member, Ways and Means Health
Subcommittee
United States House of Representatives
Washington, D.C. 20515

RE: American Geriatrics Society Recommendations on SGR Reform

Dear Sirs:

On behalf of the 6,000 multidisciplinary geriatrics health professionals that comprise the American Geriatrics Society (AGS), we thank you for the opportunity to submit our comments and recommendations regarding a new payment framework that will replace the unworkable Sustainable Growth Rate (SGR) system.

AGS members are the geriatricians and other health professionals specializing in the care of the elderly, including advanced practice nurses and physician assistants, who are responsible for furnishing and directing care for our nation's growing number of elderly patients with multiple and complex conditions. The population of Americans aged 65 and older is expected to nearly double, to more than 70 million, by 2030. Of added significance is the phenomenal growth of the population of adults aged 85 and over. This segment is growing at four times the rate of the rest of the population and encounters greater overall disability, as well as need for medical and other support services. In fact, frail elders and those with multiple chronic conditions account for the highest percent of Medicare expenditures.

We believe it is imperative that a new payment system recognizes that these frail elderly with multiple conditions are the patients who will benefit the most from transformation of Medicare into a patient-centered system focused on primary geriatric care, chronic care management and coordination of care across settings.

A new payment framework should incorporate the following principles:

- Define "sustainable growth" in terms of total health care expenditures.
- Support and properly value primary care services, geriatrics expertise and care coordination.
- Replace volume-based payment structure with a value-based payment model that rewards quality and takes into account differences in the complexity of patients' health care needs.

- Use payment mechanisms to promote optimal use of clinicians and support staff, promote the efficacy of care transitions between settings and reduce preventable hospital readmissions.
- Establish stable and predictable updates that accurately reflect increases in provider expenses.

Background

The current Medicare program with its “siloeed” payment systems, has contributed to fragmented care delivery, resulting in health care that is provider-centric, not patient-centric.

The SGR formula relies upon national spending patterns across many different provider types. It creates a budget with accountability enforced by updates, yet completely fails to create or foster organizational capacity to manage expenditures. The current system has incentivized increasing the volume of care rather than improving outcomes. If anything, the SGR rewards excessive utilization as providers seek to take what they can before cuts are imposed. But the imposition of penalties is indiscriminate with respect to current efficiency.

It also significantly under-pays primary care physicians, especially geriatricians, because it does not take into account the needs of older adults with multiple illnesses or the cost of providing coordinated patient-centric care. In June 2008, the Medicare Payment Advisory Commission (MedPAC) noted that nonprocedural “evaluation and management (E&M) services - the hallmark of primary care - are undervalued, potentially creating an imbalance relative to procedurally-based services.” This disproportionately affects geriatrics health care professionals -- physicians, advanced practice nurses, and physician assistants alike -- because the vast majority of their patients are Medicare beneficiaries. According to the report, 65% of geriatricians’ payments are derived from nonprocedural primary care services, and this percentage was the highest among all primary care specialties.

Also, MedPAC recently assessed the current physician payment system and the current SGR formula for updating payments annually (which penalizes all physicians when aggregate spending exceeds a spending target in a given year) and determined that the current system does not differentiate by provider. While the SGR formula was designed to constrain growth, MedPAC described it as “strictly budgetary” with no tools for improving quality or efficiency, such as care coordination. Certainly, some growth is necessary and to be expected; but Congress should consider approaches to change the current system in order to constrain the growth of health care costs to a level that is fundamentally sound from an economic standpoint. Such an approach (or potentially multiple approaches) should consider total costs of health care (*e.g.*, including lost productivity for caregivers) and not just the costs associated with health care delivery.

A new payment system needs to fully recognize the importance of geriatrics in the care of the sickest Medicare patients - the patients who cost the system the most money. The kind of high-quality care provided by geriatricians and the interdisciplinary geriatrics care team requires that Medicare changes how it pays for services. We need innovative models for financing care that pays for value, not volume. These innovative models should create systems that incent and provide coordinated, patient-centered care -- the kind of care which is most likely to result in savings or, at minimum, reduced growth. This means properly compensating geriatricians and other geriatrics health professionals for the type of care provided and for the value added by improving functional outcomes and reducing the number of hospitalizations and unnecessary tests and procedures that are performed on patients. It also means increasing Medicare’s investment in the development of performance standards, metrics and

measurement methodologies as well as establishing additional incentives to use electronic health records and data collection tools.

Also, without a focus on the importance of geriatric care, younger physicians will continue to pursue training in more financially rewarding interventional medical specialties rather than in geriatric medicine. This could further exacerbate the fragmentation of care and increase health care costs that could be avoided, or at least mitigated, through the type of care provided by health professionals with skills and training to meet the needs of older, frail adults. Our nation already faces a shortage of geriatrics health professionals across disciplines. For example, in 2010, there were 7,029 certified geriatricians -- one geriatrician for every 2,699 Americans 75 or older. Due to the projected increase in the number of older Americans, this ratio is expected to drop to one geriatrician for every 5,549 older Americans in 2030 unless the payment system is reformed to correct long-standing payment inequities for primary care services delivered by geriatrics providers and other primary care professionals.

Recommendations for Payment Reform

We recommend a process involving steps that will achieve comprehensive payment reform that reduces costs, pays providers fairly, and rewards value and quality care delivered to Medicare beneficiaries. While the SGR must be repealed and permanently replaced with a new payment model, such fundamental reform may not be feasible before the end of 2011.

The first objective should be to stabilize current payment for the short-term so as to ensure continued physician participation in Medicare. In the long term, we believe that the system should provide options (in the most expeditious manner) for providers to voluntarily choose to be paid under other newly created payment systems. This will support migration away from the physician-fee-schedule by clinicians. The transition could be done in a way that reduces total spending while actually increasing reimbursement to physicians who provide high quality cost effective care in these other payment systems.

Short-Term: Concrete Steps to Phase Out the SGR

If Congress must adopt an interim approach, it should be one that begins the transition by modifying the current physician payment formula as a prelude to replacing it with a permanent solution. In the short-term, improvements in primary care payments are needed (1) to stabilize the current payment environment under the SGR; and (2) to attract and retain primary care clinicians.

As a first step toward value based purchasing, and to concurrently identify how money is being spent on physician services, we propose considering replacing the single update for all physicians with separate updates for different types of services and or specialties. Congress could consider establishing five separate updates for: (1) evaluation and management (*i.e.*, office visit) services furnished by primary care and geriatrics physicians; (2) evaluation and management services furnished by other specialties; (3) diagnostic/imaging services; (4) minor surgical services; and (5) major surgical services, each with a different conversion factor based on utilization, growth and other factors.

Based on past analysis, it is likely that primary care/geriatrics services would receive higher annual updates than diagnostic or imaging services. Such a system would create incentives for primary care and geriatrics providers in the short term, and the existence of five “pools of money” would facilitate the migration of physicians away from the current payment system. This would allow Congress to

accurately score the cost of that migration because it could allow an accurate reduction of the money in each pool as physicians begin to provide services under other payment systems while also identifying the savings provided by that migration. We believe it is likely that this approach will reduce the “cost” of eliminating the SGR system because the dollars being moved would be vastly more cost-effective in the other systems and those savings could be recognized.

During this time period, the primary care provider bonus for primary care clinicians should remain in place, or be extended for a number of years past its current 2015 expiration date. An extension would help create a more stable environment and provide an incentive for new physicians, advanced practice nurses and physician assistants to enter and stay in primary care, including geriatrics. Moreover, creation of a specific pool and update for primary care evaluation and management services will allow the continuation of the 10% primary care bonus beyond 2015 in a targeted, cost effective way because it will be easy to define both the services and providers who are eligible for the bonus.

We understand that creating a system with separate updates and conversion factors is a complex undertaking. In developing a new or revised system to begin transitioning away from the current SGR system, it is important that the old formula is not replaced with a similar flawed formula. Significant and meaningful discussion will have to take place regarding spending targets and growth rate formulas to ensure that the goals of promoting primary care, inclusive of geriatrics, are achieved. Again, these are complex issues that will require a great deal of serious thought and discussion.

Long-Term

At the same time that Congress establishes short-term revisions to the SGR system, it should further facilitate the phase-out of the physician-fee-schedule by enacting new payment systems into which physicians and other providers could opt in a budget neutral way with respect to the current fee schedule (*i.e.*, as physicians migrate to other payment systems, money is moved from the physician-fee-schedule into the new systems).

These new payment systems could include bundled payment (*e.g.*, for all items and services furnished over defined episodes of care); partial, risk adjusted capitation; and shared savings options. All options would incent care coordination and the provision of high quality, evidence-based medical care. This would mean higher payments for providers, including physicians and hospitals, that furnish the most effective and efficient care. Under the direction of Congress, the Centers for Medicare & Medicaid Services (CMS) has tested and even begun implementing some of these concepts, such as bundling, gainsharing, medical homes, and beginning in January of 2012, accountable care organizations (ACOs). The new Center for Medicare and Medicaid Innovation will soon begin testing a variety of new and innovative health care delivery and payment models that promote care coordination and cost efficiency, which, if successful, could swiftly be expanded to the broader Medicare program. Additionally, Congress could enact new programs or direct CMS to test other promising models.

The challenge will be to define sustainable growth in a way that is economically feasible and promotes high quality care. Importantly, while physician services make up a relatively small portion of total health care costs, physicians (and other professionals) direct or influence a greater portion of costs by admitting patients to the hospital, writing prescriptions, ordering services, *etc.* In the long-term, physician payment should recognize this and provide incentives for managing high quality, cost-effective, well-coordinated patient care.

The biggest question is not what needs to be done, but how best to get there. As an organization that represents health care professionals who specialize in the care of the oldest and most frail members of society, we understand the complex issues that face Congress as it works to reform SGR. We are ready to work closely with Congress on specific approaches that can be implemented now and in the future to improve health care payment and delivery, and to make the growth of health care spending sustainable over the long-term.

We look forward to working with you. Please do not hesitate to contact Alanna Goldstein, Assistant Director of Public Affairs and Advocacy, at agoldstein@americangeriatrics.org or 212-308-1414, should you have any additional questions.

Best Regards,



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President



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CC:

The Honorable Dave Camp
Chairman, Committee on Ways and Means, U.S. House of Representatives

The Honorable Sander Levin
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