

Developing a Viable Medicare Physician Payment Policy

Before the Subcommittee on Health
Committee on Ways & Means
United States House of Representatives
May 7, 2013

Written statement submitted jointly by:

AARP
AFL-CIO
AFSCME
American Federation of Teachers (AFT)
American Society on Aging
Center for Medicare Advocacy, Inc.
Families USA
Medicare Rights Center
National Academy of Elder Law Attorneys
National Association for Home Care and Hospice
National Committee to Preserve Social Security and Medicare
National Consumer Voice for Quality Long-Term Care
National Council on Aging
National Education Association (NEA)
OWL-The Voice of Midlife and Older Women
Services and Advocacy for GLBT Elders (SAGE)

Direct questions regarding this statement to:

Stacy Sanders
Federal Policy Director
Medicare Rights Center
1825 K Street NW, Suite 400
Washington, DC 20006
ssanders@medicarerights.org
202-637-0961

May 13, 2013

U.S. House of Representatives
Committee on Ways & Means, Subcommittee on Health
Washington, DC 20515

Re: Hearing on Developing a Viable Medicare Physician Payment Policy

Dear Mr. Chairman and Members of the Subcommittee:

The undersigned organizations welcome the opportunity to submit a written statement in response to the recent hearing conducted by the Subcommittee on Health of the U.S. House Committee on Ways & Means on developing a viable physician payment policy. 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. 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 physician 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 live 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

We appreciate the Subcommittee's commitment to addressing 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:

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—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

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)

cost-sharing has risen steadily over time. In 1980, Medicare premiums accounted for 7% of the average monthly Social Security benefit compared to 26% in 2010.²

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.

It is also important to note that current Medicare low-income protections are woefully insufficient. According to recent estimates from the Congressional Budget Office (CBO), only 33% of eligible beneficiaries were enrolled for Qualified Medicare Beneficiary (QMB) benefits and only 13% were enrolled for Specified Low-Income Medicare Beneficiary (SLMB) benefits. In addition, unreasonably low asset tests penalize beneficiaries by denying eligibility to those who set aside a modest nest egg of savings during their working years.

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 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 agreements on extenders packages, which always included extensions of these two critical provisions with expiration dates that correspond with the SGR.

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—about \$13,800 to \$15,500 per year. This benefit is essential to the financial stability of people with Medicare living on fixed incomes. Failure to make the QI program permanent alongside a permanent SGR solution raises the risk that vulnerable beneficiaries might be forced to drop Part B coverage outright, leaving them with significant, unaffordable out-of-pocket costs every time they need health care services.

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 each day.

3. Promote quality care. Payment policies must address the imbalance between primary and specialty reimbursement, as reflected in recommendations by MedPAC.³ 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 or following up with patients is not adequately

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)

valued by current reimbursement policies. These nonprocedural services provided by primary care physicians, including geriatricians, are undervalued because the current system does not take into account the needs of older adults with multiple illnesses or the cost of providing coordinated patient-centered care.

As such, the current payment system discourages providers from pursuing or continuing careers in primary care, including those with the training and skills needed to meet the unique care needs of our nation's growing population of older adults. Reimbursement rates which appropriately reflect the demand for primary care services will strengthen the primary care workforce. Replacement payment models must build a strong primary care foundation to meet the current and future needs of the beneficiary population.

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.

In recent years, considerable energy has been focused on the development of quality measures. Yet, these efforts are largely specific to a single disease or condition, with little attention paid to developing measures for those with multiple chronic illnesses. Further, some measures specifically exclude those age 65 and over (and people with diabetes age 75 and over) from being measured precisely because of the complexity they present. Any new payment system must include quality measures constructed for vulnerable and frail older adults, so that multiple chronic illnesses are accounted for and providers are rewarded for treatment that improves quality of life.

Any process to enact a permanent SGR solution must involve the beneficiary community, including people with Medicare, family caregivers, and consumer advocates. 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,

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