

## **Eliminate Medicare’s Sustainable Growth Rate and Transition to Improved Payment Models for Patients and Physicians**

Medicare’s Sustainable Growth Rate (SGR) formula is fatally flawed and should be replaced with a framework that creates stable and positive updates for all physician services; provides incentives for primary, preventive and coordinated care; accelerates development and testing of new models developed with physicians input; and establishes a transition to the most effective new payment models.

The unworkable SGR formula determines the annual payment updates to physicians for the services they provide under the Medicare and TriCare programs. (TriCare, the health insurance program for military families, uses the same flawed SGR formula as Medicare.) Every year since 2001, the SGR has resulted in annual scheduled payment cuts that jeopardize access to care for our nation’s Medicare beneficiaries and military families. The scheduled cuts also act as a barrier to physicians investing in health information systems and in acquiring other practice capabilities to improve the value of care provided to patients. While Congress typically enacts short-term “patches” to avert payment reductions, its repeated inability to agree on a permanent solution has resulted in a ballooning of the budget cost of SGR repeal – from \$40 billion only a few years ago to almost \$300 billion today to an estimated \$600 billion by 2016. If Congress does not intervene, the estimated cut scheduled for Jan. 1, 2013 is nearly 30 percent.

There is bipartisan recognition in Congress that now is the time to replace the SGR. On March 28, 2011, the bipartisan leadership of the House Energy & Commerce Committee sent a letter to physician groups asking for proposals on “how to reform the physician payment system and move to a system that reduces spending, pays providers fairly, and pays for services according to their value to the beneficiary.” On April 27, 2012, the House Ways & Means Committee majority leadership sent a letter to physician groups addressing the Medicare physician payment system and asking for data on “value-based measures and practice arrangements that can improve health outcomes and efficiency in the Medicare program.” And, on May 10, 2012, Senate Finance Chairman Max Baucus (D-MT) asked all members of his committee to attend a roundtable discussion that day on ways to reform the Medicare physician payment system.

### **If the SGR is repealed, what should replace it?**

ACP has provided Congress with specific proposals to eliminate the SGR and transition to better models:

- In April, 2011, ACP sent a proposal to the House Energy and Commerce Committee that outlined our principals on reforming physician payments and moving to new models of care that pay physicians fairly and provide value-based care. ACP’s proposal would repeal the SGR, provide stable updates for physicians, increase payments for primary care services, establish robust testing of new payment models, and implement a transition period for physicians to participate in new models of care.
- In September, 2011, ACP provided the House and Senate members of the Select Committee on Deficit Reduction, established by the Budget Control Act of 2011, with its proposal to eliminate the SGR and transition to new models.
- In May, 2012, ACP sent a letter to the Ways and Means Committee with specific information on initiatives being undertaken by the College to promote high value and cost conscious care, and on new models of payment and delivery—including Patient-Centered Medical Homes (PCMH)—that are demonstrating the potential to improve outcomes and reduce the costs of care.
- Also in May, 2012, ACP endorsed a new, bipartisan bill—the *Medicare Physician Payment Innovation Act of 2012, H.R. 5707*—that would permanently replace the SGR, provide stable and positive updates for all physician services with incentives for primary, coordinated, and preventive care, and transition to new payment models—as ACP itself has recommended.

### ***The Medicare Physician Payment Innovation Act of 2012 (H.R. 5707)***

On May 9, 2012, Representatives Allyson Schwartz (D-PA) along with Representatives Joe Heck (R-NV), Donna Christenson (D-VI) and Joe Courtney (D-CT) introduced H.R. 5707, the *Medicare Physician Payment Innovation Act (MPPIA)*. This legislation, consistent with ACP’s own proposal, would:

- **Permanently Repeal the SGR:** Repeals the SGR formula by eliminating the \$300 billion debt to the Medicare program, restores stability and fiscal transparency to the payment system, and sets out a clear path to comprehensive payment reform. The cost of repeal is fully offset using the savings from the reduction in military operations in Iraq and Afghanistan.
- **Stabilize Current Payments:** Continues 2012 physician payment levels through December 31, 2013—preventing the nearly 30 percent cut scheduled for January 1, 2013. Establishes a five year transition period during which all physician services would get positive updates, with additional needed incentives for critically important primary, coordinated and preventive care services.
  - ✓ **Positive updates for all physician services:** Establishes positive annual updates of 0.5 percent for all physician services each year for four years starting in 2014.
  - ✓ **Creates incentives for care coordination, prevention and primary care:** Provides for annual higher updates of 2.5 percent for designated primary care, preventative and care coordination services from 2014 to 2017. *Physicians, without regard to their specialty designation, would qualify for the higher update if those same designated services constitute 60 percent of their Medicare allowable charges.*
- **Accelerate Testing and Evaluation of New Payment and Delivery Models:** Ongoing initiatives to evaluate new payment and delivery models, under CMS and in the private sector, will inform the development of new models. CMS, in ongoing collaboration with physician membership organizations, would be required to identify, test, and evaluate multiple care models that can be successfully replicated in more than one geographic region.
- **Identify Best Practices and a Menu of Delivery Model Options:** By October 1, 2016, CMS must issue a menu of no fewer than four health care delivery and payment model options based on an analysis of its relevant evaluations and input from physician organizations. These models will have demonstrated success in containing costs while improving quality. The GAO would conduct a meta-analysis of CMS's evaluations and make recommendations to Congress by April 1, 2017.
- **Establish a Transition Period:** Physicians will have until 2018 to transition to new CMS-approved models. In order to minimize disruption in the transition to new delivery models, fee for service payments in 2018 will be continued at 2017 payment levels.
- **Establish an Alternative Fee-For-Service System:** In addition to the menu of new models described above, the bill provides an alternative fee-for-service option for physicians who choose to participate in approved quality improvement programs (maintenance of specialty board certification, successful participation in Medicare's quality reporting program and meaningful use of electronic health records), or who demonstrate high value based on a new value modifier being developed by CMS.
- **Reward Clinicians for High-Quality, High-Value Care While Dis-incentivizing Fragmented, Volume Driven Care:** Beginning January 1, 2018, physicians practicing within a CMS-approved health care delivery model *will continue to receive stable and positive reimbursement updates consistent with their specified payment system, with opportunities* to earn higher reimbursements for achieving gains in quality, effectiveness and cost of patient-centered care. The goal of the bill is for there to be enough validated models, with enough positive payment incentives, so that all physicians will have a model that will work for them. However, effective January 1, 2019, penalties would apply to clinicians who choose to retain the current fee-for-service model rather than participating in any one of the new coordinated care models or in the alternative fee-for-service system. The penalties, should they apply to some physicians, are much less than the scheduled SGR cuts that will be eliminated by H.R. 5707. A limited hardship exemption is provided. Congress will need to hold CMS accountable to ensuring that a viable model is available for all physicians in all specialties.

### **What are ACP members asking Congress to do?**

- ✓ Repeal the SGR and avert the nearly 30 percent SGR payment cut scheduled for January 1, 2013.
- ✓ House members should cosponsor and pass in the *House H.R. 5707, the Medicare Physician Payment Innovation Act.*
- ✓ Senate members should introduce and pass in the Senate the companion legislation to H.R. 5707.

For more information on ACP's positions, please visit the Advocacy section of ACP Online, <http://www.acponline.org/advocacy/>.