Identical letters were also sent to Chairman/Ranking Member of the House Ways and Means Committee and House Energy and Commerce Committee

October 15, 2012

The Honorable Max Baucus
Chairman
Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Orrin Hatch
Ranking Member
Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Baucus and Senator Hatch:

The United States health care system is in the midst of profound change, and we now have a unique opportunity to improve and restructure how we deliver and pay for care in this country. Many ground-breaking innovations, including many led by physicians, are already underway in Medicare and the private sector that can guide the development of a new and improved Medicare physician payment system. These models include patient-centered medical homes, accountable care organizations, an array of approaches to bundled payments and shared savings arrangements as well as new initiatives designed by regional health improvement collaboratives.

The sustainable growth rate (SGR) formula is an enormous impediment to successful health care delivery and payment reforms that can improve the quality of patient care while lowering growth in costs. Physicians facing the constant specter of severe cuts under the SGR cannot invest their time, energy, and resources in care re-design. The first step in moving to a higher performing Medicare program must be the elimination of the SGR formula. The status quo is bad for patients, physicians, and taxpayers.

Physicians face yet another steep payment cut of 27 percent on January 1, 2013. For more than a decade, average payment rates under the SGR have remained stagnant and today are barely higher than their 2001 levels. Each year, patient access to care is eroded because the threat of steep physician payment cuts and last-minute congressional action to avoid these cuts create an environment where new Medicare patients have difficulty securing physician appointments. Congress must stop this vicious cycle now so that a transitional framework can be put in place that will provide some stability and predictability for seniors and physicians, along with needed delivery innovations.

Although the SGR must be eliminated, the physician community recognizes that this is only one-half of the equation. Therefore, the undersigned organizations have developed the attached principles and core elements that can form the basis for new federal policy on a transition from the SGR to a higher performing Medicare program.

New payment models are needed that can offer physicians opportunities and allow them to lead changes in care delivery while being rewarded for improving the quality of patient care and lowering the rate of growth in costs. Currently, physicians who want to improve care can face major hurdles, as those who lower total health care costs through delivery improvements are not rewarded and may actually lose revenue.

Further, these physician-led, patient-centered models must be developed and implemented during a defined and robust transition period that can fill in the gap between elimination of the SGR formula and implementation of a new system nationwide. Physician practices of every size and specialty must be supported and encouraged to develop the needed infrastructure and begin adopting the most appropriate model for their patients and their practice.

The undersigned organizations look forward to working with Congress to develop and implement policies to improve the Medicare program. We offer the attached principles and core elements as a foundation for a new system that supports physicians in improving the delivery of care with payment options that are good for patients, physicians, and the Medicare program overall.

Sincerely,

American Medical Association
AMDA – Dedicated to Long Term Care Medicine™
American Academy of Dermatology Association
American Academy of Family Physicians
American Academy of Home Care Physicians
American Academy of Hospice and Palliative Medicine
American Academy of Ophthalmology
American Academy of Otolaryngology—Head and Neck Surgery
American Academy of Pain Medicine
American Academy of Physical Medicine & Rehabilitation
American Academy of Urgent Care Medicine
American Academy of Neurology
American Association of Clinical Endocrinologists
American Association of Neurological Surgeons
American Association of Orthopaedic Surgeons
American College of Cardiology
American College of Chest Physicians
American College of Emergency Physicians
American College of Gastroenterology
American College of Osteopathic Family Physicians
American College of Osteopathic Internists
American College of Osteopathic Surgeons
American College of Phlebology
American College of Physicians

American College of Radiology
American College of Rheumatology
American College of Surgeons
American Congress of Obstetricians and Gynecologists
American Gastroenterological Association
American Osteopathic Academy of Orthopedics
American Osteopathic Association
American Psychiatric Association
American Society for Clinical Pathology
American Society for Dermatologic Surgery Association
American Society for Gastrointestinal Endoscopy
American Society for Radiation Oncology
American Society of Anesthesiologists
American Society of Cataract and Refractive Surgery
American Society of Clinical Oncology
American Society of Hematology
American Society of Nuclear Cardiology
American Society of Plastic Surgeons
American Society of Transplant Surgeons
American Thoracic Society
American Urological Association
Association of American Medical Colleges
College of American Pathologists
Congress of Neurological Surgeons
Heart Rhythm Society
Infectious Diseases Society of American International
Society for the Advancement of Spine Surgery
International Spine Intervention Society
Joint Council on Allergy, Asthma and Immunology
Medical Group Management Association
National Medical Association
North American Spine Society
Renal Physicians Association
Society of Critical Care Medicine
Society of Gynecologic Oncology
Society of Interventional Radiology
Society of Thoracic Surgeons
The Endocrine Society

Medical Association of the State of Alabama
Arizona Medical Association
Arkansas Medical Society
California Medical Association
Colorado Medical Society
Connecticut State Medical Society
Medical Society of Delaware

Medical Society of the District of Columbia
Florida Medical Association Inc
Medical Association of Georgia
Hawaii Medical Association
Idaho Medical Association
Illinois State Medical Society
Indiana State Medical Association
Iowa Medical Society
Kansas Medical Society
Kentucky Medical Association
Louisiana State Medical Society
Maine Medical Association
MedChi, The Maryland State Medical Society
Massachusetts Medical Society
Michigan State Medical Society
Minnesota Medical Association
Mississippi State Medical Association
Missouri State Medical Association
Montana Medical Association
Nebraska Medical Association
Nevada State Medical Association
New Hampshire Medical Society
New Mexico Medical Society
North Carolina Medical Society
North Dakota Medical Association
Ohio State Medical Association
Oklahoma State Medical Association
Oregon Medical Association
Pennsylvania Medical Society
Rhode Island Medical Society
South Carolina Medical Association
South Dakota State Medical Association
Tennessee Medical Association
Texas Medical Association
Utah Medical Association
Vermont Medical Society
Medical Society of Virginia
Washington State Medical Association
West Virginia State Medical Association
Wisconsin Medical Society
Wyoming Medical Society

Attachment

cc: Senate Finance Committee

Transitioning from the SGR to a High Performing Medicare Program
DRIVING PRINCIPLES AND CORE ELEMENTS

Eliminating the SGR formula is essential to developing a high performing Medicare program. In conjunction with SGR repeal, the following driving principles can provide a foundation for a transition plan that organized medicine can support:

- Successful delivery reform is an essential foundation for transitioning to a high performing Medicare program that provides patient choice and meets the health care needs of a diverse patient population.

- The Medicare program must invest and support physician infrastructure that provides the platform for delivery and payment reform.

- Medicare payment updates should reflect costs of providing services as well as efforts and progress on quality improvements and managing costs.

The transition plan must include core elements that:

- Reflect the diversity of physician practices and provide opportunities for physicians to choose payment models that work for their patients, practice, specialty and region;

- Encourage incremental changes with positive incentives and rewards during a defined timetable, instead of using penalties to order abrupt changes in care delivery; and

- Provide a way to measure progress and show policymakers that physicians are taking accountability for quality and costs;

In addition, the plan needs to be structured in a way that will:

- Reward physicians for savings achieved across the health care spectrum;

- Enhance prospects for physicians adopting new models to achieve positive updates;

- Tie incentives to physicians' own actions, not the actions of others or factors beyond their influence;

- Enhance prospects to harmonize measures and alter incentives in current law;

- Encourage systems of care, regional collaborative efforts, primary care and specialist cooperation while preserving patient choice;

- Allow specialty and state society initiatives to be credited as delivery improvements (deeming authority) and recognize the central role of the profession in determining and measuring quality; and

- Provide exemptions and alternative pathways for physicians in practice situations in which making or recovering the investments that may be needed to reform care delivery would constitute a hardship.