July 7, 2011

The Honorable Barack Obama
The White House
Washington, D.C. 20500

The Honorable Joe Biden
The White House
Washington, D.C. 20500

The Honorable John Boehner
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Nancy Pelosi
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Eric Cantor
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Steny Hoyer
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Harry Reid
U.S. Senate
Washington, D.C. 20510

The Honorable Mitch McConnell
U.S. Senate
Washington, D.C. 20510

The Honorable Dick Durbin
U.S. Senate
Washington, D.C. 20510

The Honorable Jon Kyl
U.S. Senate
Washington, D.C. 20510

The Honorable Paul Ryan
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Kent Conrad
U.S. Senate
Washington, D.C. 20510

Dear Sirs and Madame:

On behalf of the American College of Physicians, representing 130,000 internal medicine physician specialists in primary and comprehensive care of adults and adolescents and medical student members, I am writing to share our views on enactment of legislation to increase the debt ceiling linked to an agreement on policies to reduce the federal budget deficit. ACP is the largest physician specialty society and second-largest physician membership organization in the United States.

The College believes that:

- It is essential Congress and the Administration reach agreement on an increase in the debt ceiling in time to prevent any disruption for patients who depend on Medicare and Medicaid and for physicians and hospitals that provide services to them.
- A credible and fiscally responsible agreement should eliminate the Medicare Sustainable Growth Rate (SGR), instead of counting savings from cuts that Congress has no intention of allowing to go into effect.
- Spending growth on Medicare and Medicaid must be reduced as part of a broad agreement, but not by cutting funding for essential programs to improve access, quality and ensure a sufficient supply of physicians, especially primary care physicians.

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- Instead, Congress and the Administration should partner with physicians to support bold initiatives to address the real cost drivers behind increased federal spending, including providing physicians and patients with information on the comparative effectiveness of different treatments, taking such research into consideration in making Medicare and Medicaid coverage decisions, reforming payment and delivery systems to align incentives with the value of care provided, and encouraging innovation at both the federal and state levels in delivery services to Medicaid patients while preserving the existing guarantee of coverage for all lower-income persons.

More specifically, the College offers the following four principles that we believe are critical to developing a credible plan that would have the support of physicians and their patients:

1. **A debt ceiling agreement must be reached in time to avert an unprecedented suspension of funding for the millions of patients who rely on Medicare, Medicaid and other federal health programs.** According to the Bipartisan Policy Center, unless an increase in the debt ceiling is enacted and signed into law by early August 2, the federal government would immediately experience a cash flow shortfall of $20 billion on August 3 (obligated spending in excess of revenue collected). The gap between cash on hand and obligated spending would increase each day and become a whopping $74 billion by August 15. As a result:

    - The U.S. government would immediately have to cut spending by 44%, creating enormous "economic disruption" and day-to-day uncertainty.
    - The Treasury Department would effectively have to choose among 80 million monthly payments so that 40–45% of bills are NOT paid.
    - "Handling all payments for important and popular programs (e.g., Social Security, Medicare, Medicaid, Defense, active duty pay) will quickly become impossible."

    If the federal government fails to reimburse physicians for their services, physicians would be put in the untenable position of striving to provide uninterrupted care to Medicare and Medicaid patients -- but without any payment for their services, and with no certainty when and if payments would resume. The government's cash flow shortfall would become a critical cash flow shortfall for physician practices, causing some of them to lay off staff, limit how many Medicare and Medicaid patients they can see, or even go under and close their doors. This will be especially true of specialties, like internal medicine, which typically have 40% or more of their patients enrolled in the Medicare program. Similarly, training programs will be at great risk if the federal government lacks the cash to distribute Graduate Medical Education (GME) and Indirect Medical Education (IME) funds for teaching, resident stipends and other costs incurred in training physicians.

2. **For a debt ceiling agreement to be credible -- and to ensure Medicare patients' access to care in a fiscally responsible manner -- it must result in a permanent solution to the Medicare SGR formula, instead of continuing the misleading practice of counting "savings" from scheduled SGR cuts that Congress has no intention of allowing to go into effect.** Last week, ACP joined more than 100 national and state physician membership organizations in signing a letter that urged President Obama and Congress to include a permanent solution to the SGR in any agreement on the debt ceiling legislation. The letter points out that:

    > "Bypassing this issue or passing another short-term fix simply drives up the cost of a long-term solution. Had Congress acted as recently as 2005, the ten-year cost of preventing future cuts would have been $48 billion. Today, it is estimated that averting currently scheduled cuts would cost nearly $300 billion over the next ten years. Furthermore, a credible budget agreement can not include a Medicare budget baseline that assumes draconian physician payment cuts of almost $300 billion. The final report released by the National Commission on Fiscal Responsibility and Reform on December 1, 2010 included funding to permanently reform the SGR while also

achieving nearly $4 trillion in overall deficit reductions. While we do not support all of the specific elements of that report, the basic framework provides a good starting point and demonstrates that significant deficit reduction and the elimination of the SGR are compatible."

3. **Reduction in the rate of growth of federal spending on Medicare and Medicaid is necessary, but should not be accomplished through cuts in essential health programs that will undermine needed improvements in health care.** ACP recognizes that Medicare and Medicaid spending will need to be reduced as part of a fiscally-responsible agreement on the debt ceiling. We are concerned, though, that a debt ceiling agreement may mandate cuts in programs that are clearly designed to improve access, quality, and ensure a sufficient physician workforce.

    - Specifically, we believe the debt ceiling agreement must provide for continued funding of mandatory and discretionary programs to ensure a sufficient supply of primary care physicians and other specialties facing shortages, including sufficient funding for GME training programs. Cutting funding for programs to support the training of primary care physicians and to ensure improved payment for their services would be penny-wise but pound foolish, since more than 100 studies show that primary care is positively associated with better outcomes and lower costs of care.

4. **As an alternative to across-the-board cuts in essential health programs, Congress should partner with physicians to support bold efforts to reduce per capita health care spending and promote innovation in payment and delivery systems.** Studies show much of health care spending in the United States is on marginal or ineffective treatments that have no value to the patient. In addition, current payment and delivery systems create incentives for higher volume of services, rather than better value (better outcomes achieved efficiently) for patients. To address the true "cost-drivers" that result in unsustainable health care spending by the federal government, the College recommends Congress and the Administration:

    - Support comparative effectiveness research including funding for CER through the Patient-Centered Outcomes Research Institute and the Agency for Health Care Research and Quality.
        - Patients and physicians should be provided with objective and understandable information about the benefits and costs of different treatments to enable them to make informed choices, in consultation with their physicians (shared decision-making), on the best treatment options.
        - To encourage patients to use health care resources wisely, public and private health insurers could vary patient cost-sharing levels so that services with greater value, based on a review of the evidence, have lower cost-sharing levels than those with less value.
    - Authorize the use of comparative effectiveness research, with consideration of cost, in Medicare and Medicaid coverage decisions, through a transparent process that allows for broad public participation in such coverage decisions.
    - Support efforts by the medical profession to encourage judicious and appropriate use of health care resources, such as ACP's High Value, Cost Conscious Care initiative, which will provide physicians with guidelines on appropriate use of diagnostic and treatment options based on a review of the evidence of their effectiveness.
    - Support the development, testing, evaluation and broad adoption of new payment and delivery systems aligned with value, such as the Patient-Centered Medical Home, including support for the Center for Medicare and Medicaid Services' Center for Medicare and Medicaid Innovation.
    - Establish a definitive timeline to transition to new payment and delivery systems linked to the value of services provided. Such a timeline should provide a period of at least five years of stable Medicare payments, with updates set by statute instead of by the SGR formula, during which the new models will be tested on a voluntary basis and the most effective ones then selected for broad adoption.
    - Establish better processes to address the mis-valuation of physician services.
    - Allow the federal government to negotiate drug prices under the Medicare Part D program, as the Veterans Administration does for its drug benefit programs.

- Reform the medical liability system to reduce the costs of defensive medicine, including caps on non-economic damages and a national pilot of no-fault "health courts" as an alternative to the current adversarial tort system.
- Improve the Medicaid program by encouraging innovation at the federal and state levels while preserving the commitment to provide coverage to all persons up to 133% of the Federal Poverty Level.
    - Federal and state stakeholders should work together to streamline and improve the Medicaid waiver process, ensuring timely approval or rejection of waiver requests and sufficient transparency to allow for public consideration and comment.
    - In the case of long-term care, Medicaid beneficiaries should be offered more flexibility to choose among alternatives to nursing home care, such as community or home health care, since these services could be less costly and more suitable to the individual's needs. States and the federal government should collaborate to ensure access to home and community-based, long-term care services. Individuals with long-term care needs should be able to supplement their Medicaid coverage with long-term care insurance products.
    - Medicaid programs should ensure access for Medicaid enrollees to innovative delivery system reforms, such as the Patient-Centered Medical Home, a team-based care model that emphasizes care coordination, a strong physician-patient relationship, and preventive services.
    - Medicaid program stakeholders should consider alternative financing structures to ensure solvency, high quality of care, and uninterrupted access for beneficiaries, while alleviating the program's financial pressure on states. Particularly, financing and delivery of care for dual eligible beneficiaries must be reformed.

In conclusion, the College believes Congress and the Administration must reach agreement on raising the debt ceiling in time to avert disruption in the care provided to millions of patients who rely on Medicare, Medicaid and other health programs; that results in a permanent solution to the Medicare SGR formula, instead of continuing the misleading practice of counting "savings" from scheduled SGR cuts that Congress has no intention of allowing to go into effect; that reduces the rate of growth in federal spending on Medicare and Medicaid while ensuring sufficient funding for essential programs to improve access and quality and ensure a sufficient physician workforce; and that partners with physicians on bold initiatives to address the true "cost-drivers" that result in unsustainable health care spending.

We stand ready to assist you in achieving such an historic agreement.

Yours truly,

Virginia Hood, MBBS, MPH, FACP
President