ACP
American College of Physicians
Internal Medicine | Doctors for Adults®

October 25, 2013

The Honorable Patty Murray
United States Senate
154 Russell Senate Office Building
Washington, D.C. 20510

The Honorable Paul Ryan
U.S. House of Representatives
1233 Longworth House Office Building
Washington, D.C. 20515

The Honorable Jeff Sessions
United States Senate
326 Russell Senate Office Building
Washington, DC 20510

The Honorable Chris Van Hollen
U.S. House of Representatives
1707 Longworth House Office Building
Washington, D.C. 20515

Dear Budget Conference Committee Leaders:

On behalf of the American College of Physicians (ACP), I am writing to provide input into your conference committee discussions, specifically with regard to issues that are of the upmost importance to our members and their patients: repealing the Sustainable Growth Rate (SGR) formula and replacing it with a fair and stable system of physician payment in the Medicare program and replacing sequestration cuts to essential health programs with a more thoughtful approach to reducing inappropriate spending in the health care system.

ACP is the largest medical specialty organization and second-largest physician group in the United States, representing 137,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum, from health to complex illness.

Our members are fully committed to doing their part to improve outcomes and reduce costs. We are committed to:

- Developing and encouraging use of evidence-based clinical guidelines to reduce over-use of ineffective, wasteful, and even harmful care; and engaging our patients in shared decision-making based on such guidelines. ACP's own High Value Care Initiative offers recommendations relating to dozens of clinical scenarios where a particular test or procedure may not be medically indicated, such as routine use of advanced imaging for patients with low back pain.
- Transitioning away from systems that pay physicians mostly based on how many procedures or visits we perform (traditional Fee-For-Service), to models that align payments with the value of the care we provide to our patients.
- Creating and participating in new delivery models, such as Patient-Centered Medical Homes and Accountable Care Organizations, which organize care around the needs of patients, incorporating best practices to achieve the best measureable outcomes, both effectively and efficiently. Patient-Centered Medical Homes—high performing primary care practices—in particular have been shown to improve outcomes and lower costs in the many medical home programs that are available across the country to tens of millions of patients.

- Measuring our results, through clinical performance measures that have been developed by physicians based on science, and validated by consumers, physicians, and other stakeholders through a transparent process.
- Creating more transparency and accuracy in the pricing of medical procedures, including redistributing payments for over-priced services to undervalued ones.
- Proposing responsible ways to achieve hundreds of billions of dollars in federal spending on health care, replacing across-the-board "sequestration" cuts that are harming medical research and other critical health programs.

Congress must also do its part by enacting comprehensive Medicare physician payment reform legislation to repeal the Sustainable Growth Rate (SGR) formula. This formula has resulted in scheduled across-the-board Medicare cuts to physicians in every single year since 2001. In most years, Congress has passed a short-term "patch" that prevents the next round of cuts, but does not change the underlying SGR formula that caused the problem in the first place. Year after year, the scheduled cut has gotten bigger, with physicians and their patients now facing a more than 24% cut on January 1, 2014. The uncertainty and lack of payment stability created by the SGR is the single biggest obstacle to physicians making the transition to better payment and delivery models aligned with value to patients. The SGR needs to go, and it needs to go now.

ACP's specific proposals to reform Medicare physician payments and replace sequestration with responsible approaches to reduce the federal budget deficit are described below.

Repeal of the Sustainable Growth Rate (SGR) system

The SGR formula creates significant uncertainty in the Medicare program for both physicians and beneficiaries—an issue that has been acknowledged and actively approached in a bi-partisan way by the House Energy & Commerce Committee, the House Ways & Means Committee, and the Senate Finance Committee. All of these Committees have been seeking input from multiple stakeholders over the past year on how to repeal and move beyond the SGR, with the House Energy & Commerce Committee most recently approving legislation to this effect. The Medicare Patient Access and Quality Improvement Act of 2013, H.R. 2810, was unanimously passed by the Committee on July 31, 2013. ACP has provided a significant amount of input into these proposals and discussions and would like to summarize some of the key aspects of our recommendations.

As was stated in our letter to the House Energy & Commerce Committee on July 9, 2013 and in subsequent communications, the College strongly believes that any legislation to repeal the SGR should advance the following policy objectives:

1. **Create a clear transition timetable for physicians to participate in new payment and delivery models, with a graduated and positive quality incentive program during this transition, including higher transitional payments for physician practices organized as Patient-Centered Medical Homes (PCMHs) and Patient-Centered Medical Home Specialty Practices/ Neighbors (PCMH-N).**
2. **Create a process for the Department of Health & Human Services (HHS) to "deem" alternative payment models and quality improvement programs that meet criteria to ensure that the programs have the key elements associated with better outcomes and more effective care.**
3. **Direct Medicare to pay for complex chronic care management.**
4. **Accelerate adoption of new payment and delivery models that evidence shows are effective in improving outcomes and effectiveness of care, including but not limited to PCMHs and PCMH-Neighbors.**

The final, bi-partisan bill that was passed by the House Energy & Commerce Committee is consistent with these policy objectives: providing positive and stable baseline updates for physicians during a transition phase of five years, authorizing payment for complex chronic care management codes starting in 2015, establishing a fee-for-service quality incentive update program starting in 2019, and creating a pathway for physicians to participate alternative payment models (APMs) within the first year following the bill's enactment. Our understanding is that the Ways and Means Committee will soon be working to develop a similar framework.

We are also pleased that the Senate Finance Committee has reached out to ACP and other physician membership organizations, on a bipartisan basis, to seek our ideas on developing an alternative to the SGR that would also create a framework for value-based payment policies. In a May 11 letter[1] to the committee, ACP offered dozens of specific suggestions on how to improve the Medicare physician fee schedule and fee for service, focusing on approaches that would reduce inappropriate utilization and bring greater value to the program. Chairman Max Baucus highlighted ACP's proposals in a June 10, 2013 statement for the record:

"I want to highlight the letter from the American College of Physicians. They gave us concrete examples, down to how Medicare could incentivize physicians to use guidelines that help them decide when to order tests and perform procedures. This would encourage doctors to provide the care seniors need, and avoid unnecessary care that might cause harm. I'm not saying we will accept all of their suggestions, but their comments help us see different angles of potential policies."

Our recommendations to the Senate Finance Committee include:

- Fund and certify shared decision support tools. Authorize payment to physicians who use such tools to engage their patients in shared decision-making, focused on the top twenty most expensive and/or most frequently performed procedures, particularly those that are considered preference-sensitive or are elective. In January 2013, Lee and Emanuel[2] investigated the potential of shared decision making approaches, such as the use of patient-decision aids, on improving care and reducing cost. They found substantial evidence of savings including, but not limited to, the following: that patients who participate in shared decision making choose less invasive surgical options and more conservative treatment than do patients who do not use decision aids; and that implementing shared decision making for just 11 procedures would yield more than $9 billion in savings nationally over 10 years.
- Direct HHS to explore alternatives to prior authorization, including creating incentives for use of appropriate use criteria, and exempting practices from prior authorization that are participating in value-based payment programs.
- Authorize HHS to conduct a pilot-test of utilization benchmarking tools to enable physicians to compare their utilization patterns with their peers and make voluntary improvements as appropriate based on such data.
- Direct HHS to explore ways to provide physicians with accurate data on the quality and total cost of care provided by other clinicians and hospitals within their geographic communities to enable them to make informed referral decisions.
    - Continue to support and fund research on comparative effectiveness through the Patient-Centered Outcomes Research Institute (PCORI). The Commonwealth Fund estimates that the effective dissemination of comparative effectiveness information and its use in the

[1] ACP Letter to the Senate Finance Committee, May 11, 2013 (www.acponline.org/acp_policy/letters/acp_response_to_sfc_2013.pdf)

[2] Lee and Emanuel (2013). "Shared Decision Making to Improve Care and Reduce Costs"NEJM. Accessed at: http://www.nejm.org/doi/full/10.1056/NEJMp1209500 .

development of insurance benefit designs would save an estimated $174 billion over 10 years for the federal government.[3]

- While ACP supports continuation of the in-office ancillary services exemption under the Stark self-referral laws in order to provide patients with convenient, one-stop access to testing, especially in models like the PCMH, the College is aware of concerns and data that physician ownership of diagnostic facilities may be associated with higher utilization, and therefore the College would support a program to monitor such utilization that is targeted at identifying practices that are outliers. Specifically, we recommend that Congress direct the Secretary to monitor utilization of high cost/high frequency testing in practices where physicians own their own facilities, to provide education feedback to outliers, and to encourage more extensive use of specialty-developed appropriate use criteria, particularly targeted at practices that are outliers in terms of their utilization of high frequency testing compared to practices that do not have an ownership interest in such facilities.
- Authorize the Secretary to provide adequate Medicare payment for the extended and complex counseling required for physicians to develop end of life care plans with their patients
    - A 2012 study conducted by researchers for the Commonwealth Fund[4] found that programs focused on end-of-life care have provided physicians with techniques for delivering bad news, managing transitions to palliative care, and handling requests for therapies that are likely to be futile. The researchers also found that these programs helped to elicit patient preferences, leading to lower utilization in some locations.
    - Other researchers,[5] using a predictive model, concluded that telephonic end-of-life counseling provided as an ancillary Medicare service, guided by a predictive model, can reach a majority of individuals needing support and can reduce costs by facilitating voluntary election of less intensive care. Average Medicare costs were $1913 lower for intervention group decedents compared with control group decedents in the last 6 months of life for a total savings of $5.95 million.
- Eliminate provider-based billing delivered in an outpatient, hospital-system owned practice when the care being provided is not dependent on the hospital facility and its associated technologies. However, elimination of provider-based billing in such circumstances should only be carried out in conjunction with other new and innovative approaches, building on payment and delivery system reform efforts, in order to ensure adequate support of safety-net facilities.

It is essential the Congress complete the work on enacting comprehensive Medicare physician payment reform legislation, based on the significant bi-partisan progress that has already been made. Such an effort, when seen through to completion, will result in significant and long term savings to the health care system overall. **Therefore ACP strongly recommends that the Budget Conference Committee include, in your budget framework to be reported to Congress by December 13, enactment of legislation to repeal the SGR and replace it with a value-based payment framework. We also strongly urge the Budget Conference Committee to recommend that enactment of such Medicare physician payment reform legislation occur prior to the end of this calendar year.**

---

[3] Davis, Guterman, et. al., "Starting on the Path to a High Performance Health System: Analysis of Health System Reform Provisions of Reform Bills in the House of Representatives and Senate" Accessed on 10/23/2013 at: http://www.commonwealthfund.org/Publications/Fund-Reports/2009/Nov/Starting-on-the-Path-to-a-High-Performance-Health-System.aspx?page=all

[4] Commonwealth Fund, June/July 2012 - http://www.commonwealthfund.org/Newsletters/Quality-Matters/2012/June-July/In-Focus.aspx .

[5] Hamlet et al., Am J Manag Care (2010) "Impact of predictive model-directed end-of-life counseling for Medicare beneficiaries." Accessed at: http://www.ncbi.nlm.nih.gov/pubmed/20469958 .

Additional information on ACP's proposals to reform physician payments and repeal the SGR can be found in:

- ACP Statement for the Record: Energy & Commerce Health Subcommittee Hearing on SGR: Data, Measures and Models; Building a Future Medicare Physician Payment System (February 14, 2013) (http://www.acponline.org/acp_policy/letters/health_hearing_sgr_feb_14_2013.pdf)
- ACP's response to the GOP SGR framework proposal as released on February 7, 2013 by the Ways & Means and Energy & Commerce Committees (February 25, 2013) (http://www.acponline.org/acp_policy/letters/gop_sgr_framework_proposal_as_released_by_the_ways_means_energy_commerce_committees_2013.pdf)
- ACP response to the House Ways & Means and Energy & Commerce majority April 3, 2013 second-iteration proposal on eliminating the SGR (April 17, 2013) (http://www.acponline.org/acp_policy/letters/majority_2nd_iteration_proposal_on_eliminating_sgr_2013.pdf)
- Statement for the Record on Developing a Viable Medicare Physician Payment Policy - Hearing before the House Ways and Means Health Subcommittee (May 7, 2013) (http://www.acponline.org/acp_policy/testimony/ways_and_means_medicare_physician_payment_testimony_2013.pdf)
- ACP response to the Senate Finance Committee: How to improve the Medicare physician fee schedule and fee for service (May 31, 2013) (http://www.acponline.org/acp_policy/letters/acp_response_to_sfc_2013.pdf)
- ACP response to May 28, 2013 Energy & Commerce legislative proposal to repeal the Sustainable Growth Rate (June 10, 2013) (http://www.acponline.org/acp_policy/letters/energy_and_commerce_legislative_proposal_repeal_sgr_2013.pdf)
- ACP response letter to Energy & Commerce Committee June 28, 2013 SGR Legislative Draft Proposal (July 9, 2013) (http://www.acponline.org/acp_policy/letters/acp_response_e_and_c_june_28_leg_language_sgr_2013.pdf)
- ACP letter to House Energy & Commerce Committee regarding their July 18, 2013 legislative proposal to repeal the SGR (July 19, 2013) (http://www.acponline.org/acp_policy/letters/acp_letter_e_and_c_sgr_2013_leg_proposal_2013.pdf)
- A Crosswalk of Energy & Commerce July 18, 2013 Legislative Proposal with ACP's Policy on Physician Payment Reform and SGR (July 22, 2013) (http://www.acponline.org/acp_policy/policies/e_and_c_july_18_side_by_side_analysis_2013.pdf)

Replace Sequestration with Policies to Reduce Unnecessary Spending in the Health Care System

Budget sequestration already is having a devastating impact on medical research and public health. Continuation of the discretionary spending caps included in the Budget Control Act of 2013 would set back progress in medical research, potentially for generations. The National Institutes of Health reports[6] that sequestration will result in:

- "Approximately 700 fewer competitive research project grants issued
- Approximately 750 fewer new patients admitted to the NIH Clinical Center
- No increase in stipends for National Research Service Award recipients in FY2013"

The agency further reports that the sequestration cuts will have the following impact:

- "Delay in medical progress:

[6] The National Institutes of Health report on the impact of sequestration. June 3, 2013. Accessed at: http://www.nih.gov/news/health/jun2013/nih-03.htm

    - Medical breakthroughs do not happen overnight. In almost all instances, breakthrough discoveries result from years of incremental research to understand how disease starts and progresses.
    - Even after the cause and potential drug target of a disease is discovered, it takes on average 13 years and $1 billion to develop a treatment for that target.
    - Therefore, cuts to research are delaying progress in medical breakthroughs, including:
        - development of better cancer drugs that zero in on a tumor with fewer side effects
        - research on a universal flu vaccine that could fight every strain of influenza without needing a yearly shot.
        - prevention of debilitating chronic conditions that are costly to society and delay development of more effective treatments for common and rare diseases affecting millions of Americans.
- Risk to scientific workforce:
    - NIH drives job creation and economic growth. NIH research funding directly supports hundreds of thousands of American jobs and serves as a foundation for the medical innovation sector, which employs 1 million U.S. citizens. Cuts to NIH funding will have an economic impact in communities throughout the U.S. For every six applications submitted to the NIH, only one will be funded. Sequestration is reducing the overall funding available for grants. See the history of NIH funding success rates."

The Coalition for Health Funding, of which ACP is a member, reports that sequestration will have the following health impacts:[7]

- 659,476 fewer people would be tested for HIV
- 48,845 fewer women would be screened for cancer
- 211,958 fewer children would be vaccinated
- 6,240 fewer children receiving dental screenings and preventive services
- 1,788 fewer seniors receiving primary care, dental care, and psychiatric care
- 4,500 fewer underserved and uninsured seniors receiving care in acute, ambulatory, or long-term care settings
- 3,579 fewer individuals receiving clinical psychology services
- 22,592 fewer health care providers receiving continuing education on cultural competence, women's health, diabetes, hypertension, obesity, health disparities, and related topics
- CDC would not be able to support 2,500 specialized disease detectives in state and local health departments; outbreaks of foodborne disease, meningitis, pneumonia, and other conditions would be investigated and stopped more slowly or not at all. An estimated 150 fewer foodborne outbreaks would be identified and stopped promptly. A single outbreak can cost millions of dollars and health care and productivity losses, send hundreds of people to hospitals, and kill children and adults.
- Life-saving immunizations would be denied to children and adults. Approximately 840,000 fewer vaccines would be made available to protect local communities, increasing the risk of preventable outbreaks.
- Public health programs that protect entire communities by reducing vaccination disparities would be cut.
- Between 210,000 and 840,000 children and adults would be denied life-saving vaccines that prevent hepatitis B, influenza, measles, and pertussis outbreaks.

[7] Coalition for Health Funding report on the Impact of Sequestration. Accessed at: http://publichealthfunding.org/uploads/Sequestration_Impacts.pdf

- The time to identify and appropriately treat victims of a chemical attack would double from five days to up to two weeks, increasing suffering and death, as support is eliminated for laboratories which can diagnose and help doctors treat patients. The uncertainty resulting from this delay would have significant consequences in national security and economic stability.
- Approximately 800 additional individuals would contract HIV due to reduction in the availability of HIV tests and prevention. This would cost the United States $250 million, since every HIV infection costs more than $300,000 in health care costs.
- 50,000 fewer women would be screened for breast and cervical cancer, resulting in 800 fewer cancers detected early.
- CDC's highly effective program to prevent diabetes would have to be scaled back, meaning that tens of thousands more Americans would develop diabetes over the coming years. Each person with diabetes costs $6,600 more in health care spending every year.

The College believes that it is essential that such devastating sequestration cuts be replaced with a more responsible approach to reducing the federal budget deficit. To this end, the College has provided Congress with specific options to achieve hundreds of billions of dollars in potential savings, targeting the true drivers of higher health care spending. These options were outlined in depth in a letter to the joint select committee on deficit reduction on September 12, 2011.[8] Many of these ideas are incorporated into the recommendations outlined above; however, we would like to reiterate several additional options presented at that time that are still relevant for your committee's consideration.

- Preserving and broadening the base on GME funding by requiring all payers to participate and allocate GME funding more strategically based on an assessment of workforce needs and skills required. There are no current budget estimates available for this approach, but legislation introduced 10 years ago to require an all-payer system was estimated to result in $4.0 billion in federal revenue through a 1 percent premium tax on private payers and $1.5 billion in *annua*l savings to the federal government through reduced Medicare IME payments.

- Reduce the costs of defensive medicine by enacting the following policies, which the CBO estimated could save $62 billion.[9] The Commission on Fiscal Responsibility and Reform[10] recommended the following be considered: (1) Modifying the "collateral source" rule to allow outside sources of income collected as a result of an injury (for example workers' compensation benefits or insurance benefits) to be considered in deciding awards; (2) Imposing a statute of limitations – perhaps one to three years – on medical malpractice lawsuits; (3) Replacing joint-and-several liability with a fair-share rule, under which a defendant in a lawsuit would be liable only for the percentage of the final award that was equal to his or her share of responsibility for the injury; (4) Creating specialized "health courts" for medical malpractice lawsuits; and (5) Allowing "safe haven" rules for providers who follow best practices of care. The estimated savings from this approach is $17 billion. In addition, ACP believes that safe harbors from medical liability lawsuits should be provided to physicians who are following evidence-based guidelines of care, such as those from ACP's High Value Care initiative. We would be pleased to share our specific ideas on how to structure a safe harbor policy.

---

[8] ACP Letter to the joint select committee on deficit reduction on September 12, 2011: Reduce Federal Healthcare Spending in a Socially and Fiscally Responsible Manner (http://www.acponline.org/acp_policy/letters/reduce_federal_spending_2011.pdf).

[9] Congressional Budget Office, Reducing the Deficit, Spending and Revenue Options, March, 2011, accessed 6 September 2011 at www.cbo.gov/ftpdocs/120xx/doc12085/03-10-ReducingTheDeficit.pdf.

[10] The National Commission on Fiscal Responsibility and Reform, The Moment of Truth, accessed 6 September 2011 at www.fiscalcommission.gov/sites/fiscalcommission.gov/files/documents/TheMomentofTruth12_1_2010.pdf.

- Require manufacturers to pay a minimum rebate on drugs covered under Medicare part D for low-income beneficiaries. The CBO estimated the savings for the rebate only would be $110 billion.[11]
- Give the federal government broad authority to negotiate prices of drugs paid by Medicare, which could save as much as $300 billion, according to the Center for Economic and Policy Research.[12]
- Place dual eligibles in Medicaid managed care: Approximately nine million low-income seniors and disabled individuals are covered by both Medicaid and Medicare. The divided coverage for dual eligibles results in poor coordination of care for this vulnerable population and higher costs to both federal and state governments. The Bipartisan Commission on Fiscal Responsibility and Reform[13] recommends giving Medicaid full responsibility for providing health coverage to dual eligibles and requiring that they be enrolled in Medicaid managed care programs, which could save $12 billion. Medicare would continue to pay its share of the costs, reimbursing Medicaid. Medicaid has a larger system of managed care than does Medicare, and this would result in better care coordination and administrative simplicity. ACP generally supports this concept, but recommends that any managed care arrangements, in which dual-eligible persons would be enrolled, need to be carefully designed to protect a very vulnerable population.
- Accelerate the excise tax on high cost health plans or replace it with an overall cap on the tax exclusion for employer-sponsored health insurance. According to the CBO, this could save $309 billion over 10 years if the excise tax is accelerated and modified.[14] The Bipartisan Policy Center estimates that it would save $113 billion if the tax exclusion is capped and then gradually phased out.[15]
- Replace Medicare's current mix of cost-sharing requirements with a single, combined annual deductible. The CBO estimates that establishing a $550 deductible covering all Part A and Part B services, a uniform coinsurance rate of 20 percent for amounts above that deductible (including inpatient expenses), and an annual cap of $5,500 on each enrollee's total cost-sharing liabilities would save $32 billion over 10 years.[16] ACP supports the concept of combining A and B into a single cost-sharing structure, provided that preventive services are not subject to the deductible (current law), the deductible is set an actuarially appropriate level, and a lower cost sharing level is set for lower-income beneficiaries, so as not to discourage beneficiaries from receiving recommended care.

ACP recognizes that many of the policy options presented above are controversial. Yet these recommendations show that it is possible to achieve savings of hundreds of billions of dollars in a way that would allow the sequestration caps to be replaced, ensure continued funding of critical health care, and permanently repeal the Medicare SGR formula.

---

[11] Congressional Budget Office, Reducing the Deficit, Spending and Revenue Options, March, 2011.
[12] Center for Economic and Policy Research, Negotiating Prices with Drug Companies Could Save Medicare $30 Billion, March 7, 2007, accessed 6 September 2011 at www.cepr.net/index.php/press-releases/press-releases/negotiating-prices-with-drug-companies-could-save-medicare-30-billion/.
[13] The National Commission on Fiscal Responsibility and Reform, The Moment of Truth.
[14] Congressional Budget Office, Reducing the Deficit, Spending and Revenue Options, March, 2011.
[15] Domenici and Rivlin, Restoring America's Future, Debt Reduction Task Force, Bipartisan Policy Center , November 10, 2010, accessed 6 September at http://www.bipartisanpolicy.org/sites/default/files/BPC%20FINAL%20REPORT%20FOR%20PRINTER%2002%2028%2011.pdf.
[16] Congressional Budget Office, Reducing the Deficit, Spending and Revenue Options, March, 2011.

Conclusion

The College recognizes the difficulties involved in achieving a bipartisan policy consensus on the federal budget. Yet we know that is possible for Republicans and Democrats alike to find common ground, as evidenced by the bipartisan progress that has been made to date on legislation to repeal the Medicare SGR formula and transition to a value-based payment system. ACP is committed to doing all that it can to help Congress find consensus on policies to reform Medicare physician payments; reduce misuse and over-use of marginal, ineffective and even harmful medical interventions; and replace sequestration with more responsible and effective approaches to reduce health care spending and the federal budget deficit.

Sincerely,

Molly Cooke, MD, FACP
President

CC: Budget Conference Committee Members