TEXAS MEDICAL ASSOCIATION

Physicians Caring for Texans

June 10, 2013

The Honorable David Lee "Dave" Camp
Chairman
Committee on Ways and Means
341 Cannon House Office Building
United States House of Representatives
Washington, DC 20515

The Honorable Stephen "Fred" Upton
Chairman
Energy and Commerce Committee
United States House of Representatives
2183 Rayburn House Office Building
Washington, DC 20515

The Honorable Kevin P. Brady
Chairman
Ways and Means, Subcommittee on Health
301 Cannon House Office Building
United States House of Representatives
Washington, DC 20515

The Honorable Joseph R. "Joe" Pitts
Chairman
Energy and Commerce Subcommittee on Health
United States House of Representatives
420 Cannon House Office Building
Washington, DC 20515

Dear Chairmen:

The Texas Medical Association (TMA) appreciates this opportunity to offer insight on the Medicare Sustainable Growth Rate (SGR) Formula Replacement Proposal that is currently being developed and discussed in the United States House of Representatives Committee on Energy and Commerce.

TMA is a private voluntary, nonprofit association of Texas physicians and medical students. TMA was founded in 1853 to serve the people of Texas in matters of medical care, prevention and cure of disease, and improvement of public health. Today, its mission is to "Improve the health of all Texans." Its more than 47,000 members practice in all fields of medical specialization. It is located in Austin and has 120 component county medical societies around the state.

TMA generally supports current efforts to reform the SGR and stop the cycle of year-end or partial-year and sometimes-retroactive patches to the physician fee schedule that perpetuate financial uncertainty for Medicare providers at a time when stability is most needed. The Association offers the following specific insights on the formula replacement proposal.

Phase I

The proposal calls for the repeal of the SGR and creating a period of stable payments. It is important that payments during this period be adequate to cover physician practice operating cost and that payments be updated annually using a method that is adequate to cover increases in practice operating costs.

The adequacy of the current fee schedule has been eroding for more than a decade. Since 2000, the fee schedule updates have not covered provider cost increases as measured by the federal Medicare Economic Index (MEI). Additionally, Medicare legislation and regulation have added reporting requirements and other new administrative burdens that increase physician practice cost in ways that are not measured by the MEI. Cost increases that exceed revenue increases threaten the economic viability of physician businesses and are hurting access to care for Medicare beneficiaries. In Texas, 41 percent of Texas physicians now report that they do not accept all new Medicare patients in their practices.

We urge that the proposed period of stable payments include annual updates at least equal to the annual MEI increase.

Payment Localities

In association with the implementation of the current proposal, we have heard renewed requests for revisions to Medicare's payment locality definitions. An update of the payment localities is long overdue, and should be required for all multi-locality states, not for a select few. The locality boundaries should be updated as soon as practical, as urban growth and changing demographics have caused serious payment distortions. The Centers for Medicare & Medicaid Services (CMS) should be required to reevaluate locality definitions periodically and revise them when needed, just as they are required to update the components of the geographic practice cost index (GPCI) and other payment factors.

Phase II

The proposal to design new methods for assessing and rewarding quality is much needed. Although the proposal does not mention the Medicare value-based payment modifier required by current law starting in 2015, we certainly hope that the proposal is to replace the current provision, not to add another "quality" program to the current one, which has serious flaws and may result in financial penalties for physicians who treat disadvantaged patients.

We agree that quality measures must be created by physicians. Physicians have the clinical knowledge necessary to develop these measures in a patient-centric manner that improves – and does not merely ration -- care. Physicians are better able to understand that rigid adherence to protocols can be dangerous for patients who do not match statistical norms. Furthermore, since physicians are intrinsically motivated to provide good care to their patients, the most important part of any quality measurement program may be the provision, directly to physicians, of accurate, meaningful, and timely information about the selected measures. Physicians can help to define the information that they would find to be meaningful and actionable. Furthermore, any new payment methods, incentives, or efficiency or quality measures must first be evaluated in actual medical practices before being widely implemented. Changes of this importance must not be based on conceptual policy designs without evaluation and feedback in a full range of actual patient care settings.

We support the proposals to allow physicians to choose whether to be assessed individually or as a group and also to select comparison groups, baselines, and methods. It is extremely important that any program be designed to accommodate small physician practices and to minimize reporting requirements and other administrative burdens that divert time and resources from patient care. To avoid major disruptions in the provision of patient care, payment for services rendered (fee for service) must be a major payment option and the basis of any reforms. Any departures from this payment methodology should be voluntary, undertaken in small increments, and well-tested to ensure there are no adverse consequences for patient access to care.

Furthermore, if incentives depend on risk-adjustment to be meaningful, new risk adjustment measures must be developed. CMS currently does not track all of the information necessary for proper risk-adjustment. The factors that affect many of the measures that are currently in use include patient poverty, educational attainment, and other social and cultural variables (such as perspectives on care at the end of life). Before any new performance based payment system is implemented, all relevant factors for risk adjustment must be collected and assessed.

Next, TMA strongly urges that the proposal expressly prohibit performance measurement methods that are dependent on patient compliance. Any measure that is affected by patient decision-making should be designed in a way that permits physicians to exclude patients who decline recommended care or who fail to follow up on recommended tests and procedures. Physicians are willing to be accountable for those activities within their control. However, as the physician must respect a patient's autonomy, the patient's decision to forego recommended treatment or diagnostic procedures must *not* be held against the physician. Should those

working on the proposal desire to encourage certain patient decision-making, then the proposal should include a reward system applicable to the patient. Patient responsibility must be respected and encouraged so that all of the responsibility for a person's health, morbidity, and compliance to medical orders does not rest solely with the physician. Neither patients nor physicians should face financial penalties for undesired patient behavior; those penalties could cause adverse impacts on patients who are unwilling or unable to comply with recommended care, either because they are unable to find physicians who will care for them or because they simply avoid interaction with the health care system.

TMA also is very concerned that the measurement systems and payment methodologies will result in a bureaucratic morass from which payment for services will never be forthcoming or will come with a crushing administrative burden that will outweigh the benefit of participating in the program. Continuing to add new reporting requirements increases the administrative cost burden that Medicare imposes on medical practices. The additional administrative costs must be factored into any new system. These additional costs will increase the total cost of medical care and thus the proposal must *mandate* CMS to undertake a return-on-investment analysis prior to implementing any measure or performance based payment system. Quite simply, new administrative requirements should not be imposed unless they will produce quantifiable returns.

Phase III

This phase proposes FFS payment system to also account for the efficiency of care provided. TMA is not convinced that efficiency measures can be developed that do not create incentives to withhold treatment and testing for Medicare patients. As with quality measures, efficiency incentives should be implemented only if they have been developed by physicians, tested in a wide variety of patient care settings, and proven to produce no adverse consequences on patient care. Implementation of an efficiency measure should be undertaken only after testing and extremely careful public review.

There is also an unstated, yet very alarming, premise when discussing *efficiency*. To be efficient, one must produce or be capable of producing an intended result within a *defined set of resources.* TMA is concerned about *who* decides the appropriate resources (and number or amount of resources) that should be brought to any particular patient. The decision on the care that is to be brought to a patient for cure or alleviation of discomfort, pain, or suffering is traditionally left to the patient and physician. Deciding upon whether any particular course of treatment is worth the resources to be expended is extremely value-laden. TMA suggests the government should avoid intervening in these decisions.

We are grateful that the SGR problem and the design of physician incentive programs is receiving your thorough, careful and thoughtful consideration. We would be happy to provide any support you need in this urgent and critical matter.

Sincerely,

Stephen L. Brotherton, MD
President

cc: The Honorable Joe Barton
The Honorable Michael Burgess
The Honorable Lloyd Doggett
The Honorable Gene Green
The Honorable Ralph Hall
The Honorable Sam Johnson
The Honorable Kenny Marchant