Outline for 2007 Medicare SGR Legislation

Recommendation 1: The SGR should be repealed and replaced with an update system that reflects increases in physicians' and other health professionals' practice costs.

Provision 101: Enact legislation that permanently repeals the SGR formula and utilizes the same approach for Medicare payment updates for physician and health professional services as is currently used for hospitals, nursing homes and other providers. Updates would be determined through a two-step process involving the Medicare Payment Advisory Commission (MedPAC) making a recommendation to Congress using its payment update framework and Congress reviewing and acting on the MedPAC recommendation. The starting point in the MedPAC process is the forecast increase in medical practice costs.

Recommendation 2: Congress should support initiatives by organizations representing physicians and other health care professionals to bridge gaps in care and assure the appropriateness of services provided to Medicare beneficiaries.

Provision 201: Establish programs involving CMS working with national organizations representing physicians and other health professionals to develop databases and methodologies to analyze various diagnostic and treatment patterns. Such methodologies should include systems that would provide physicians/health professionals with data enabling them to compare their practice patterns to practice patterns of other physicians/health professionals with a similar patient mix. Utilize positive financial incentives—such as lump-sum payments to physicians/health professionals, higher payment updates, and shared savings—to encourage voluntary practitioner participation in the data collection process and adoption of more appropriate patterns of care.

Provision 202: Establish collaborative programs with state and county medical societies and health professional organizations, as well as physician group practices, to develop local utilization management and education programs in order to address geographic variations in care. Utilize positive financial incentives such as lump-sum payments to physicians/health professionals, higher payment updates, and shared savings to encourage voluntary practitioner participation in the utilization management activities.

Provision 203: Provide positive incentives for physicians and other health care professionals to acquire and use health information technologies that allow practices to improve efficiencies, participate in quality reporting initiatives, share information and reduce duplicative services.

Provision 204: Provide opportunities for physicians and other health professionals to participate in care coordination programs and quality improvement programs in which rates of surgical interventions, hospital admissions, readmissions, complications and lengths-of-stay would be measured and practitioners would receive a share of any associated savings to the Medicare program.

Provision 205: Provide increased funding for the Agency for Healthcare Research and Quality to conduct the program of research on outcomes of health care items and services established by Sec. 1013 of the Medicare Modernization Act and to disseminate the results to organizations representing physicians and other health professionals in order to improve the effectiveness of clinical decisionmaking.

Recommendation 3: If immediate repeal of the SGR is not possible, Congress must: establish by law a transition, pathway and “date certain” to complete elimination of the SGR; provide positive physician/health care professional updates set by statute for each year until repeal takes effect; stabilize payments for a minimum of two years by providing positive baseline updates to all physicians/health care professionals; spend down the costs of repealing the SGR by fully funding the positive updates; and urge the Administration to exercise its authority to remove physician-administered drugs from the SGR and make other refinements in the formula to help reduce the cost of Congressional action.

Provision 301:

Step 1 Provide payment updates for 2008 and 2009 equal to the projected rate of increase in the Medicare Economic Index (MEI). MedPAC has recommended a 2008 update of 1.7% based on its estimate of the increase in practice costs offset by a productivity adjustment. Fully fund these positive updates so that they do not lead to additional years of future pay cuts or deeper cuts in years after 2009. Direct that these payment updates will not be included in calculations of the National Per Capita Medicare Advantage Growth Percentage for 2008, 2009 and future years. Take steps such as reducing growth in other factors that contribute to Part B premium increases or adjusting beneficiary premium requirements to protect beneficiaries from unpredictable, steep premium increases.

Step 2: Establish statutory annual updates at the projected rate of growth in MEI for each year from 2010 through 2015.

Step 3: Repeal the SGR effective in 2016. Provide for payment updates in 2016 and future years utilizing the same approach that is currently used for hospitals, nursing homes and other providers. Updates would be determined through a two-step process involving MedPAC making a recommendation to Congress using its payment update framework and Congress reviewing and acting on the MedPAC recommendation. Adjust this proposal as needed to address congressional budget rules and to allow out-year savings from reducing any annual updates currently projected by CBO at above the MEI to be used to help offset forecast pay cuts.

Provision 302: Model the way in which new Medicare benefits are accounted for in the physician payment system after the pass-through payments for new technologies in the outpatient prospective payment system. For example, modify the SGR “law and regulation” factor to exclude from both actual and target spending all costs associated with new legislated benefits and national coverage determinations adopted following the date of enactment for a period of two years from their implementation date. Base cost estimates following the two-year pass-through period on actual data.

Provision 303: Urge the Administration to: use the $1.35 billion Physician Assistance and Quality Initiative Fund to help offset the negative 2008 payment update; reduce the productivity adjustment to the MEI; and remove spending on Part B drugs from calculations of actual and allowed spending under the SGR from the SGR base year forward.

Recommendation 4: The transitional 2007 Medicare Physicians Quality Reporting Initiative should be re-examined before being expanded into future years.

Provision 401: Provide all physicians and health professionals with payment updates that cover increases in their practice costs. Create a separate, non-punitive financing mechanism that is not subject to budget neutrality and that provides positive incentives for participation in voluntary initiatives to improve health care quality. Eligible initiatives would include but not be limited to: pay-for-reporting and pay-for-performance programs, adoption of electronic medical records, programs to facilitate coordination of care, and the use of clinical appropriateness criteria developed by organizations representing physicians and other health care professionals. Initiatives could also include grants for developing and pilot testing data registry systems and for participation in these registries.

Provision 402: Congress should require CMS to solicit input from organizations representing physicians and other health professionals and to conduct ongoing evaluations of the PQRI. Findings from these evaluations should be used to refine the measures, reporting methodologies and timetable, as appropriate, for a voluntary quality reporting program. This quality reporting program should provide positive financial incentives to physicians and other health professionals for using clinical performance and structural measures to manage quality and utilization of care for patients with high-impact chronic conditions and other significant gaps in care in order to reduce hospital admissions, readmissions, complications, lengths-of-stay and to improve care outcomes.

Provision 403: Measures should be developed through a transparent consensus process, such as the Physician Consortium for Performance Improvement, that involves representatives of national physician and other health professionalspecialty organizations whose members treat the condition for which measures are being developed. Measures should also be endorsed by a multi-stakeholder organization.

American Academy of Audiology
American Academy of Dermatology Association
American Academy of Facial Plastic and Reconstructive Surgery
American Academy of Family Physicians
American Academy of Hospice and Palliative Medicine
American Academy of Neurology
American Academy of Ophthalmology
American Academy of Otolaryngology-Head and Neck Surgery
American Academy of Physical Medicine and Rehabilitation
American Academy of Physician Assistants
American Association for the Study of Liver Diseases

American Association of Clinical Endocrinologists
American Association of Clinical Urologists
American Association of Neurological Surgeons
American Association of Orthopaedic Surgeons
American Association of Nurse Anesthetists
American Chiropractic Association
American College of Cardiology
American College of Chest Physicians
American College of Emergency Physicians
American College of Gastroenterology
American College of Nurse-Midwives
American College of Obstetricians and Gynecologists
American College of Osteopathic Family Physicians
American College of Osteopathic Internists
American College of Osteopathic Surgeons
American College of Physicians
American College of Preventive Medicine
American College of Radiology
American College of Rheumatology
American College of Surgeons
American Gastroenterological Association
American Geriatrics Society
American Medical Association
American Medical Directors Association
American Medical Group Association
American Occupational Therapy Association
American Optometric Association
American Osteopathic Academy of Orthopedics
American Osteopathic Association
American Physical Therapy Association
American Podiatric Medical Association
American Psychiatric Association
American Psychological Association
American Rhinologic Society
American Society for Clinical Pathology
American Society for Gastrointestinal Endoscopy
American Society for Reproductive Medicine
American Society for Therapeutic Radiology and Oncology
American Society of Anesthesiologists
American Society of Breast Surgeons
American Society of Cataract and Refractive Surgery
American Society of Clinical Oncology
American Society of Echocardiography
American Society of General Surgeons
American Society of Hematology
American Society of Nephrology

American Society of Nuclear Cardiology
American Society of Plastic Surgeons
American Society of Transplant Surgeons
American Speech-Language-Hearing Association
American Thoracic Society
American Urogynecologic Society
American Urological Association
Association of American Medical Colleges
Association of Women's Health, Obstetric and Neonatal Nurses
College of American Pathologists
Child Neurology Society
Congress of Neurological Surgeons
Heart Rhythm Society
Infectious Diseases Society of America
Joint Council of Allergy, Asthma and Immunology
Medical Group Management Association
National Association of Clinical Nurse Specialists
National Association of Social Workers
National Association of Spine Specialists
National Medical Association
National Rural Health Association
Renal Physicians Association
Society for Cardiovascular Angiography and Interventions
Society for Vascular Surgery
Society of Gynecologic Oncologists
Society of Hospital Medicine
Society of Interventional Radiology
Society of Nuclear Medicine
Society of Thoracic Surgeons
The Endocrine Society