

**Joint Recommendations on Eliminating the SGR
and
Supporting Efforts to Promote Health Care Quality and Appropriateness**

Repeal the Sustainable Growth Rate (SGR) update system: The SGR should be repealed this year and replaced with an update system that reflects increases in physicians' and other health professionals' practice costs. A realistic budget baseline for future Medicare payment updates, which accurately reflects the anticipated costs of providing physicians with positive updates under a new update system in lieu of SGR-related cuts, should be incorporated into the federal budget.

- If Congress and the Administration decide to adopt a transitional approach, it should:
 - Establish by law a transition pathway to complete replacement of the SGR by 2015.
 - Provide stability and predictability with positive, funded updates from 2010-2015 set by statute and linked to the Medicare Economic Index (MEI) for each year until a replacement takes effect.
 - Establish a realistic baseline for Medicare spending on physician services that eliminates the assumption that SGR-driven cuts will be implemented, thereby greatly reducing the score assigned to legislation to repeal the SGR.
 - Use regulatory authority to remove physician-administered drugs from the SGR from 1996 on to help reduce the cost of repeal.
 - Use regulatory authority to adjust the Medicare Economic Index to include all the costs of a current medical practice and use realistic productivity assumptions.

Transition to new payment models: Innovative payment system reforms that support physicians in the provision of high-quality care in a cost-effective manner need to be further developed and tested.

- Innovative financing and delivery systems, such as shared savings/gainsharing, bundled payments, and accountable care organizations/bonus eligible organizations, should be further developed. Multiple models of these concepts should be pilot tested and evaluated in a variety of practice settings (including large and small practices), geographic locales (including urban and rural), and among different specialties and patient populations. Demonstrations must ensure that physicians have an appropriate level of decision-making authority over bonus and shared-savings distribution.
- Findings from these new types of systems should be collected and widely disseminated throughout the life of the pilot in order to facilitate mid-course corrections, determine when expansions are warranted, and encourage and guide the formation of new projects.
- An ongoing process should be created to provide for rigorous evaluation, with input from physicians and other stakeholders, of which innovations are ready for wider implementation; which require more evaluation, refinement and testing;

and which have been found not to be effective. Given the diversity of medical practice, a single one-size-fits-all approach must be avoided and physicians should have flexibility to adopt different approaches depending on their practices' composition and capabilities. No system should be implemented that requires physician participation on a mandatory basis without specific Congressional authorization following a thorough evaluation.

- Benchmarks for such evaluations should be established and could include such things as their impact on the quality and efficiency of care rendered, patient impact and satisfaction and considerations of practicality including feasibility for smaller practices and ability to recruit needed personnel.
- Medicare should offer timely data sharing and positive financial incentives, including funds for planning and start-up costs, to assist medical practices, organized medical staffs, and specialty and state medical societies that wish to experiment with alternative approaches to achieving savings for the program and/or improving care coordination and quality. Pilot projects should not be subject to annual budget neutrality constraints and should exercise caution in placing physicians at risk. Experience with these reform options should be documented and disseminated to provide information on best practices and build a solid evidence base for additional reforms in the future.
- New payment methodologies or service bundles must be developed through transparent processes that include appropriate representation by physicians and other health professionals. Such bundles should have appropriate risk-adjustment to reflect the characteristics of the patient population being treated. Medicare should continue to pursue testing and implementation of the medical home model, payment for care coordination services that fall outside a face-to-face encounter and other strategies to eliminate gaps in care and improve chronic disease management.
- Medicare should invest in improvements to our nation's primary care workforce. These investments should be funded by system-wide savings stemming from more appropriate utilization of various services throughout Medicare and without regard to current program silos. Payment increases for primary care services should be considered a change in law that would not require a budget neutrality offset in the Medicare physician payment schedule.
- Current regulatory barriers to medical training outside a hospital setting should be eliminated.
- Loan forgiveness and other debt relief strategies should be employed to encourage practice in specialties and geographic areas with critical shortages.

Promote Healthy Lifestyles and Appropriate Use of Medical Services: Americans of all ages should be encouraged to adopt healthier lifestyles, choose cost-effective care, and play an active role in their medical care.

- Public programs to reduce smoking, obesity and alcohol and drug abuse, and to encourage immunizations and healthy lifestyle choices, should be designed and implemented.
- Medicare preventive care coverage should be expanded to include additional services such as wellness exams and counseling to facilitate joint physician-

patient decision-making to help reduce the incidence and progression of chronic disease.

- Value-based benefits that reduce cost-sharing requirements to help beneficiaries take advantage of specific types of care that are widely recognized as beneficial for their particular condition should be tested on a voluntary basis.
- Medicare should place a high priority on facilitating beneficiaries' adoption of advance directives, consistent with state laws, to improve the appropriateness of end-of-life care.
- Programs that provide physicians with feedback on patient compliance with prescribed tests and therapies, including post-hospital care instructions, should be tested as a potential vehicle to improve care coordination, enhance physician-patient communication and improve quality.

Improve quality reporting and incentives: Improvements are needed in Medicare's physician quality reporting program.

- The Medicare Physician Quality Reporting Initiative (PQRI) must be reexamined and refined and CMS should be supported as it works with the medical community to refine the program and remove obstacles that have hindered physician participation in the program.
- The PQRI's focus should move to demonstrated quality improvements in patient care rather than conditioning positive updates for all physicians and practitioners on "reporting for the sake of reporting."
- Resources to educate physicians on modifications in the PQRI program and processes for obtaining PQRI reports by participating physicians must be improved; interim feedback must be provided on a timely basis and must be subject to appeal and verification to enable more physicians to participate successfully.
- Any physician-level clinical measures used in quality improvement programs must be developed through a multi-specialty consensus process organized by medicine, such as the Physicians' Consortium for Performance Improvement (PCPI). The work of the PCPI should be encouraged and facilitated as the foundation for federal and private quality and efficiency initiatives involving physicians.
- The PQRI must recognize a range of quality improvement activities, including physicians who prospectively report to a clinical registry and who use the collected data to reflect on their care, identify specific patient characteristics and processes that lead to improved outcomes and make meaningful conclusions about the quality and cost of their care.
- Barriers to small physician groups' participation in quality improvement initiatives should be removed through antitrust reforms that allow physicians who collaborate around health information technology and quality improvement initiatives to jointly contract with payers.
- Any performance-based payment structure or public reporting of provider-specific participation results should be contingent on the development of more meaningful measures, proper case mix and risk adjustment algorithms, and

improved program operations. Physician ratings should not be based on factors that they cannot control.

Promote appropriate and effective care: Congress should support initiatives by organizations representing physicians and other health care professionals to bridge gaps in care, assure the appropriateness of services provided to Medicare beneficiaries and reduce inappropriate variation in health care utilization. Such support could include:

- Instructing HHS to work with organizations of physicians and other professionals to develop and refine methodologies to provide timely, accurate, confidential and comparative information to individual practitioners on how their quality and utilization compares to their peers as tools for self-improvement.
- Encouraging efforts by organizations representing physicians and other health professionals to obtain and analyze data on the growth in the utilization of services and quality of services by condition, type of service, episodes of illness, region and specialty.
- Promoting efforts by organizations representing physicians and other practitioners to develop voluntary guidelines/protocols/parameters on the appropriate utilization of services to be used as an alternative to more intrusive and burdensome approaches such as preauthorization by benefits management firms.
- Investing in clinical comparative effectiveness research to help determine which treatments and diagnostic tools are most effective for particular patients and widely disseminating the results. Such research should be conducted with oversight and participation of practicing physicians and sufficient information on limitations and exceptions should be made available so that practicing physicians can determine which patients the findings apply to and exercise discretion in the treatment of individual patients. This information will help national medical specialty societies and practicing physicians translate the findings from research into practice.
- Testing programs that provide liability protection to physicians who participate in Medicare quality incentive programs, and have followed evidence-based clinical guidelines or documented a rationale for departing from the guidelines. Innovative approaches to reducing the cost of defensive medicine should also be explored, such as health courts, cooling off periods, early disclosure and compensation programs, administrative determination of compensation, and standards for expert witness qualifications.
- Providing financial support and positive incentives to help develop and encourage acquisition of tools and information technology to provide consistent high quality care, including decision support, shared decision-making tools, and communication strategies to help physicians translate comparative effectiveness research findings into clinical practice and reduce patient demand for and utilization of marginally effective services.
- Supporting efforts by the profession, the RUC, and CMS to improve the accuracy of Medicare's resource-based relative value scale.

Strengthening Medicare Resources: To completely redesign and redirect financing and delivery system will require program officials to oversee a wide spectrum of tests and evaluations, develop tools to ensure that new systems are both fair and feasible, and prepare physicians and patients for the substantial changes that are envisioned. To ensure a successful transition to a new system, Congress should:

- Ensure that the Centers for Medicare and Medicaid Services (CMS) has adequate staff and funding to improve the operation of the PQRI program, conduct adequate education and outreach with the physician community, and oversee and evaluate a series of robust demonstrations and pilots to test new financing and delivery systems prior to implementation.
- Provide adequate lead time prior to nationwide implementation of any new systems and stagger timelines for new programs so that CMS and the provider community are better able to absorb and manage changes.
- Fund the development of improved risk adjustment methodologies that incorporate additional patient and population characteristics such as obesity and smoking rates.
- Update and upgrade CMS software and hardware systems to facilitate delivery of timely and accurate data on quality and utilization.

Supporting Organizations as of 5/20/09

American Academy of Dermatology Association
American Academy of Facial Plastic and Reconstructive Surgery
American Academy of Family Physicians
American Academy of Home Care Physicians
American Academy of Hospice and Palliative Medicine
American Academy of Neurology Professional Association
American Academy of Ophthalmology
American Academy of Otolaryngology-Head and Neck Surgery
American Academy of Physical Medicine and Rehabilitation
American Association of Clinical Endocrinologists
American Association of Clinical Urologists
American Association of Neurological Surgeons
American Association of Orthopedic Surgeons
American College of Cardiology
American College of Chest Physicians
American College of Emergency Physicians
American College of Nuclear Physicians
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 Radiation Oncology
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 Osteopathic Academy of Orthopedics
American Osteopathic Association
American Rhinologic Society
American Society for Gastrointestinal Endoscopy
American Society for Radiation Oncology
American Society for Reproductive Medicine
American Society of Addiction Medicine
American Society of Anesthesiologists
American Society of Cataract and Refractive Surgery
American Society of Hematology
American Society of Nephrology
American Society of Pediatric Nephrology
American Society of Plastic 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 America
Medical Group Management Association
Renal Physicians Association
Society for Cardiovascular Angiography and Interventions
Society for Vascular Surgery
Society of Gynecologic Oncologists
Society of Hospital Medicine
Society of Nuclear Medicine
The Endocrine Society
The Society of Thoracic Surgeons