

September 17, 2013

The Honorable Dave Camp, Chairman  
Ways and Means Committee  
U.S. House of Representatives  
Washington, DC 20515

The Honorable Sander Levin, Ranking Member  
Ways and Means Committee  
U.S. House of Representatives  
Washington, DC 20515

The Honorable Kevin Brady, Chairman  
Subcommittee on Health  
Ways and Means Committee  
U.S. House of Representatives  
Washington, DC 20515

The Honorable Jim McDermott, MD, Ranking Member  
Subcommittee on Health  
Ways and Means Committee  
U.S. House of Representatives  
Washington, DC 20515

**Subject:** Medicare Sustainable Growth Rate Reform

Dear Representatives Camp, Levin, Brady and McDermott:

On behalf of the undersigned state medical and national specialty societies, we are writing to thank you for your ongoing efforts to develop legislation to repeal and replace Medicare's sustainable growth rate (SGR) formula. Eliminating the SGR and replacing it with a stable Medicare physician payment system, which provides security for patients and the physicians who care for them, is critical to ensuring the viability of the program well into the future.

As you move forward, our organizations firmly believe that the following three driving principles are essential elements of any SGR replacement legislation:

- ***Patient-Shared Billing.*** Access to quality healthcare can only be ensured by fundamentally reforming our broken medical payment system. The right to privately contract for services is a touchstone of American freedom and liberty. Patients and physicians must be allowed to freely exercise this right without third party interference or penalty.
- ***Determination of Quality Medical Care.*** The determination of the quality of medical care must be made by the profession of medicine, not by the government or other third party payers.
- ***Medical Liability Reform.*** Medical liability reform is essential to ensure access to quality, affordable healthcare for all patients.

We therefore urge you to incorporate these provisions into the Medicare physician payment reform legislation under consideration by the House Ways and Means Committee.

### ***Patient-Shared Billing***

We all know that Medicare is very important to seniors, and we know that seniors are worried about its future and financial security. Seniors have paid into the system for many years and they certainly deserve to get what they were promised — a Medicare benefit that allows them access to the physician of their choice, even if he or she is no longer accepting Medicare.

Unfortunately, under current law, they cannot. Baby boomers are now entering the Medicare program, there is a shrinking pool of primary care and specialty physicians, and it is increasingly difficult for seniors and individuals with disabilities to find physicians who accept new Medicare patients as the gap between government-controlled payment rates and the cost of running a practice grows wider. Physicians are also reconsidering their participation in Medicare as they face an increasing number of regulations and penalties for failing to comply with meaningful use, quality reporting and documentation requirements; thus further exacerbating the number of physicians available to treat the elderly.

Clearly, the key to preserving our Medicare patients' access to quality medical care is to overhaul the flawed Medicare payment system, and an essential element of payment reform includes allowing patients and physicians to voluntarily enter into arrangements known as private contracts.

Patient-shared billing is the only way to ensure that our patients can maintain control over their own medical decisions. Contrary to current law, physicians should be free to opt in or out of Medicare on a per-patient basis, while patients could pay for their care as they see fit and be reimbursed for an amount equal to that paid to "participating" Medicare physicians. A patient who chooses to see a physician outside the Medicare system should not be treated as if he or she does not have insurance, and Medicare should pay its fair share of the charge and allow the patient to pay the balance. While the government may have the right to determine what it will pay toward medical care, it does not have the right to determine the value of that medical care. This value determination should ultimately be made by the individual patient, and by allowing patients to contract with the physicians of their choice for any amount not covered by Medicare, patients will have the power to exercise this value judgment.

Rep. Tom Price's bill, H.R. 1310, the Medicare Patient Empowerment Act, reflects these important principles, and we therefore encourage you to incorporate this into the final SGR reform legislation.

### ***Quality Improvement***

In an effort to rein in spending and improve patient outcomes, over the last decade the Federal Government and private sector have adopted a number of policies that aim to hold healthcare professionals increasingly accountable for the cost and quality of care they provide. By changing the healthcare system from one that rewards quantity, to one that rewards better value through the use of performance measurement, it is believed that quality will be enhanced and overall healthcare costs will be reduced. This was a central theme of the Affordable Care Act, and current efforts to reform Medicare's physician payment system appear to be accelerating this pay-for-performance trend.

As a general matter, physicians are very accustomed to having their quality evaluated throughout their careers as caregivers. This first starts with medical school and residency training programs, which assess basic clinical knowledge and competence. Physician skills are further evaluated by the national board certifying organizations — both initially and at regular intervals through maintenance of certification requirements. Additionally, credentials are periodically verified by the states and hospitals within which physicians are licensed to practice. Finally, the medical profession is also

taking steps to improve the value of care through the development of clinical practice guidelines/ practice parameters, appropriate use criteria and clinical data registries.

When it comes to developing mandatory quality reporting requirements in Medicare, however, we are highly skeptical that CMS can measure and evaluate quality in a way that will improve care for the patients we treat. It is simply impractical and unnecessary for a federal insurance plan to also become an arbiter of physician quality. Rather, the determination of quality medical care must be made by the profession and the patients we serve. Efforts by the Federal Government to develop pay-for-performance programs — including the Physician Quality Reporting System (PQRS) and the Electronic Health Record (EHR) Program — have dramatically increased the cost of providing care, are distracting physicians from tending to their patients' real needs, have increased the administrative hassles of practicing medicine, and have, for the most part, failed to significantly improve clinical outcomes.

Our organizations strongly believe that replacing the SGR with a new system that pays physicians based on their compliance with quality measures — even if these quality improvement metrics are developed by physicians — will further expand Medicare's bureaucracy, and ultimately the government, not the profession, will dictate the practice of medicine. Such a system certainly contradicts the original intent of Congress when it passed the Medicare statute.<sup>1</sup> And while this principle has clearly eroded over the past few decades, Congress should refrain from further expanding the role of government into the practice of medicine. Furthermore, it is simply impossible to develop quality parameters that are (1) easily applicable to all populations, in (2) every type of practice setting, that can also be (3) reliably collected and (4) reported by treating physicians, and (5) fairly assessed by reviewers so as to (6) retain real clinical relevance and improve the care physicians give to their patients. It is therefore essential that physicians direct the development of quality assessment metrics and tools.

### ***Medical Liability Reform***

Finally, we urge you to incorporate medical liability protections in your SGR reform plan, since Medicare now essentially mandates that physicians follow quality-related guidelines. If physicians are now required to follow government or other mandated treatment protocols, quality metrics and/or guidelines, then they should expect to be protected from litigation if they follow such guidelines, but are nevertheless sued. Physicians should not be required to choose between payment penalties for non-compliance with government quality standards on the one hand, and litigation from a patient for following such guidelines on the other.

Without a doubt, federal legislation modeled after the laws in California or Texas, which both include reasonable limits on non-economic damages, is the gold standard. However, other options should be considered as well. One idea put forward by Reps. Tom Price and Charles Boustany last year would

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<sup>1</sup> 42 U.S.C §1395 states: "Nothing in this title shall be construed to authorize any federal officers or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person."

disallow noneconomic or punitive damages in cases where the physician rendered medical treatment that is consistent with best practice guidelines developed by physician specialty organizations. Importantly, under this proposal, these guidelines may not be introduced as evidence of negligence or deviation in the standard of care in a healthcare lawsuit unless they have previously been introduced by the defendant. Furthermore, there is no presumption of negligence if a physician provides treatment in a manner inconsistent with such guidelines.

Another idea was included in H.R. 2810, the “Medicare Patient Access and Quality Improvement Act,” the SGR replacement legislation that unanimously passed out of the House Energy and Commerce Committee on July 31, 2013. This provision makes it clear that the development, recognition, or implementation of any guideline or other standard under any Federal healthcare provision shall not be construed to establish the standard of care or duty of care owed by a healthcare provider to a patient in any medical malpractice or medical product liability action or claim.

Both of these complementary medical liability provisions should be included in the final SGR replacement legislation.

### ***Conclusion***

We can all agree that Medicare beneficiaries should receive the best possible care available, and the medical profession is unquestionably committed to delivering high quality healthcare. Furthermore, Medicare’s physician payment formula is fatally flawed and is in dire need of repeal. As you continue to consider options for replacing the SGR, however, we caution against trading one unworkable payment system for another. The unintended consequences of a new quality-based payment system could lead to adverse risk selection thereby limiting, not expanding, patient access to care. Ultimately, patients, not the government, should be empowered to determine the value of their care, and Congress should adopt legislation that will achieve this goal.

Once again, thank you for your commitment to repealing and replacing the SGR. We hope you will give our comments and suggestions every consideration. In the meantime, if you have any questions or need further information, please feel free to contact Katie O. Orrico with the neurosurgeons at 202-446-2024 or [korrico@neurosurgery.org](mailto:korrico@neurosurgery.org).

Sincerely,

Medical Association of the State of Alabama  
Connecticut State Medical Society  
Medical Society of Delaware  
Medical Society of the District of Columbia  
Florida Medical Association  
Medical Association of Georgia  
Kansas Medical Society  
Louisiana State Medical Association  
Mississippi State Medical Association  
Medical Society of New Jersey

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Medical Society of the State of New York  
North Carolina Medical Society  
Oklahoma State Medical Society  
South Carolina Medical Association  
Tennessee Medical Association  
American Academy of Facial Plastic and Reconstructive Surgery  
American Association of Clinical Urologists  
American Association of Neurological Surgeons  
American Society of Cataract and Refractive Surgery  
American Society of General Surgeons  
American Society of Plastic Surgeons  
Congress of Neurological Surgeons  
National Association of Spine Specialists

cc: Members, Ways and Means Committee