



July 31, 2013

The Honorable Fred Upton
Chairman
Committee on Energy & Commerce
U.S. House of Representatives
Washington, DC 20515

The Honorable Henry Waxman
Ranking Member
Committee on Energy & Commerce
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Upton and Ranking Member Waxman:

On behalf of AARP's 37 million members and the millions of Americans with Medicare, thank you for your bipartisan work to reform Medicare provider reimbursement and the sustainable growth rate (SGR). The bill currently before the Committee is a significant step in the right direction. It repeals the SGR in Medicare fee-for-service and replaces it with payment updates tied to quality and resource use. The bill also proposes a pathway for new alternative payment models to be developed, tested, and implemented. However, we believe improvements can be made to strengthen and improve some of the concepts in the bill, taking advantage of progress already underway and hastening overall improvement in our health care system.

First, while fee-for-service (FFS) may always be the best option for some providers, Congress should do more to make alternative payment models attractive to most practices. This includes dis-incentivizing fee-for-service and providing the technical support small practices, in particular, will need to transform their service delivery. Further, as currently written, there will be an annual 0.5 percent increase in FFS base payment rates in perpetuity. Constant, open-ended payment increases weakens the incentive to adopt alternative models. We agree there should be a period of payment stability to allow time for the development of new models and measures. Providers also need time to adopt new systems, to collect and report performance information, and to use this information to improve care. Yet without stronger incentives for providers to adopt alternative payment models, perpetual positive FFS payment updates may delay the changes we urgently need.

Second, we have concerns about using "peer cohorts" to make quality comparisons of like providers. Any provider who is qualified to perform a particular service should be compared with all others performing the same service, not like providers. For example, if a nurse practitioner and a physician are both qualified to perform the same service, they should be compared together, not nurse to nurse and doctor to doctor. This is a much more patient-centric way of looking at assessment, and prevents cohorts from becoming silos.

Third, the bill calls for two new "contracting entities"- one to review and recommend proposals for alternative payment models, and one to manage demonstration projects for

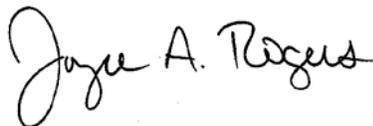
models approved by the Secretary. The Centers for Medicare and Medicaid Services (CMS), particularly the Center for Medicare and Medicaid Innovation (CMMI), already have the expertise and infrastructure in place to develop new payment models. Establishing new entities to perform these crucial responsibilities creates a bureaucratic redundancy and is an unnecessary use of resources. CMS and CMMI should be empowered to expand upon the work they are already doing.

Fourth, the section of the bill on “Sources of Quality Measures and Clinical Practice Improvement Activities” states a measure “shall not be required to be consensus-based”. We believe all quality measures, regardless of their origin, should be endorsed by a consensus-based organization. Having agreement among the consumer, clinical, hospital, purchaser communities, and others, ensures the results are credible, consistent, and meaningful to end users, including clinicians and patients. We welcome proposed quality measures coming from a variety of sources, such as certified registries, maintenance of certification, etc. However, all measures approved for use should be endorsed by a consensus-based organization (e.g., the National Quality Forum) in order to facilitate standardization, benchmarking, and public reporting.

Finally, we are concerned advanced practice registered nurses (APRNs) and other providers who routinely coordinate care will not be eligible for payment under the proposed complex chronic conditions management codes. The legislation restricts payment for care coordination services to physicians who are certified as medical homes. AARP believes this should be expanded to APRNs and other qualified clinicians who not only conduct care coordination activities, but are also recognized medical homes, such as Life Long Care, a New Hampshire-based APRN-led medical home which achieved NCQA designation in 2010.

Again, thank you for your continued bipartisan work to address this long-standing Medicare reimbursement issue. Reforming the flawed SGR system and ending the yearly uncertainty of provider payment cuts will bring peace of mind to Medicare beneficiaries, and help ensure they continue to have access to their providers. As Congress looks for ways to offset the cost of a permanent SGR fix, we ask you keep in mind that the typical Medicare beneficiary lives on an income of \$22,500 and already spends 17 percent of their income on health care. Any pay-for should not add a financial burden to beneficiaries, either through increased out-of-pocket costs or reduced benefits. We look forward to working with you in building a payment system which improves outcomes, provides better care, and reduces costs. If you have any questions, please feel free to call me, or have your staff contact Ariel Gonzalez of our Government Affairs staff at agonzalez@aarp.org or 202-434-3770.

Sincerely,

A handwritten signature in cursive script that reads "Joyce A. Rogers". The signature is written in black ink and is positioned above the typed name and title.

Joyce A. Rogers
Senior Vice President
Government Affairs