NEW DEMOCRAT COALITION PRINCIPLES FOR SUPPORTING INNOVATION IN OUR NATION'S HEALTH CARE SYSTEM

As New Democrats, we are committed to the successful implementation of health care reforms that will expand access to and affordability of coverage, improve quality and delivery of care and slow the rate of growth in health care spending. While much progress has been made in these areas, we believe that numerous opportunities and challenges remain. The following principles will serve as a foundation for a strategic direction for the Coalition on health care policy.

I. Structure the Medicare payment system to reward quality and value while reducing costs for patients and providers.

The Medicare physician payment system, driven by the so-called "sustainable growth rate" (SGR), is undeniably unsustainable. The SGR must be repealed and replaced with a value-driven methodology that accurately reflects the cost and value of delivering care and encourages quality over volume. There should be a number of physician payment models that build on successful demonstrations under the Affordable Care Act (ACA), as well as existing cost-effective, high quality models that are currently in operation around the country. Payment reform should allow for several options that will meet the needs of different providers and patient populations across geographic regions and settings.

- Gradually phase out the sustainable growth rate formula and provide physicians a transition period to fully adapt to new payment models.
- Expand upon the mission of Center for Medicare and Medicaid Innovation to include testing alternative delivery and payment models to ensure that viable alternatives to the fee-for-service model will be available to all providers in the near-term.
- Collaborate with patients, providers, payers and academics to develop intermediate benchmarks in our health reform efforts to ensure that overly stringent standards do not impede the evolution and adoption of new, innovative models.
- More rapidly require the Centers for Medicare and Medicaid Services (CMS) to deploy a robust menu of payment and delivery models, including at least one multi-payor option, from which physicians and other providers may choose, such as:
    - Patient-centered medical homes,
    - Bundled payments,
    - Accountable care organizations,
    - Global payments,
    - Partial, risk-adjusted capitation, and
    - Other care coordination models.
- Consider the impact of Medicare, Medicaid and private insurance reimbursement policies on current and projected workforce shortages in the health professions.
- Support the ongoing education and training of health care professionals to ensure an adequate supply of highly qualified physicians, nurses and allied professionals capable of meeting the diverse health care needs of all Americans that is cost effective and contributes to improved health outcomes.

II. Facilitate cooperation between the public and private sectors to promote successful implementation of health care delivery models that increase efficiency and improve patient care.

Numerous multi-payer and private-payor demonstration projects are underway across the country, ranging from medical homes to models conceptually similar to Accountable Care Organizations (ACOs). Many of these programs have documented success in achieving savings while improving the quality of care through increased care coordination. Given the alignment of these objectives with those of the Medicare program, CMS should build off of the success of these programs. If successfully integrated, private-sector investments can offset the upfront capital costs inherent in the transition to a new delivery model and increase participation.

- Facilitate participation in new Medicare delivery models by allowing more advanced health systems already participating in multi-payer demonstrations that have shown progress to expand these practices to traditional Medicare fee-for-service beneficiaries.
- Encourage providers, particularly those in less advanced systems, to take advantage of the administrative simplification and streamlined data collection methods that may be available by contracting with outside entities.
- Enable private payers to invest in infrastructure development for smaller practices seeking to develop or participate in innovative care delivery models.
- Align quality measures with those that have served as accurate assessment tools in other areas of the Medicare program, multi-payer demonstrations or the private sector. Coordinate with public and private sectors to identify mutually acceptable, consistent standards that may be employed by all to minimize reporting burdens and provide administrative simplification throughout the health care industry.
- Improve consistency in data collection and analysis across Medicare shared savings programs.
- Consolidate elements of various shared savings programs such as quality reporting systems and technical assistance to conserve resources.
- While protecting patient privacy, increase de-identified data sharing across the Medicare program to allow for more accurate comparisons of spending and outcomes.
- Invest in enhanced research, better care coordination and disease management through continued support for providers and third party payers to reduce the burden of conversion from ICD-9 to ICD-10.
- Continue support of the public-private partnership to detect and prevent fraud, waste, and abuse in our health programs.

III. Modernize the FDA approval process to foster innovation, growth through competition and timely patient access to new treatments and technologies.

Our nation's regulatory system must function in a manner that encourages the development of innovative medical technology. The FDA has the challenging task of approving new therapeutics and devices to ensure safety for American consumers. In so doing, the FDA has the responsibility to proceed in a timely and predictable manner to avoid unnecessary delays in the approval process. While safety is paramount, such delays, if unjustifiable, can delay bringing life-saving products to market for American consumers. We must ensure that the FDA is operating at a level of protecting the health and safety of consumers while maximizing our nation's innovative potential. Reauthorization of the Medical Device User Fee Act (MDUFA) and the Prescription Drug User Fee Act (PDUFA) legislation, both of which expire October 1, 2012, should address the following priorities.

- Ensure that the FDA has the funding and Congressional support to carry out its mission in the most effective, consistent and reliable way possible with expert staff.
- Provide the FDA with the resources necessary to keep pace with an industry defined by rapid changes within increasingly complex science. In this challenging fiscal and economic environment, it's also necessary to ensure FDA uses that funding more efficiently to meet its performance targets. We will continue to advocate for a regulatory system that emphasizes safety, but keeps a concentrated, top-to-bottom focus on innovation.
- Engage industry stakeholders to better assess the cost of moving products through the FDA approval process and ensure that user fees are being spent wisely in an effort to efficiently advance safe and effective products to the market.
- Make sure that our FDA approval process operates in a way that keeps our innovative companies in the United States , ensures their products are available in the U.S. marketplace, and maintains our nation's competitiveness in the global economy.
- Build on some of the successful practices demonstrated through FDA's 510(k) approval process, and continue to support new avenues that allow new technology and innovations, when found to be safe and effective, to get to market in the most efficient way possible.
- Address the uncertainties rampant in the FDA approval process by setting forth more explicit and transparent guidelines for drug and device manufacturers. Foster an open dialogue between regulators and the private sector throughout the process to reduce administrative burdens on both sides.

IV. Promote widespread adoption of interoperable health information technology systems across health care settings to reduce healthcare costs and provide savings for patients and businesses.

Health Information Technology is central to the success of implementing integrated delivery models. As a result of investments in HIT in the HITECH Act, nearly 25 percent of office-based physicians already have fully functioning electronic medical records, according to a 2010 Centers for Disease Control and Prevention study. The Congressional Budget Office estimates that 90 percent of physicians will have implemented HIT by 2019. However, many providers, especially those in small practices, continue to struggle with the upfront costs involved in adopting HIT systems. We must build upon existing HIT programs to ensure that small practices have access to the training and technology necessary to meet meaningful use standards established by CMS.

- Foster a Health Information Technology marketplace in which small provider practices, small hospitals and providers in disadvantaged communities can purchase and become meaningful users of comprehensive, affordable HIT systems and reduce financial risks associated with these investments.
- Ensure confidence that available systems will enable providers to become fully compliant with "meaningful use" standards.
- Incentivize Regional Extension to seek out providers most in need of the technical assistance, guidance, and information on best practices to become meaningful users of Electronic Health Records (EHRs).
- Make sure that meaningful use standards are not strictly focused on inputs, but place an appropriate emphasis on outcomes as well.

The New Democrat Coalition Health Care Task Force is led by co-chairs Representative Allyson Y. Schwartz (PA-13) and Representative Kurt Schrader (OR-5).