



## **Medicare Physician Payment Reform**

The Medicare physician payment formula, based on the sustainable growth rate (SGR), is fundamentally flawed and produces steep annual cuts in Medicare physician payments that had to be averted by Congress since 2002. The Medicare Improvement Patient and Protection Act of 2007 (MIPPA) averted a 10.6% cut in July 2008 and implemented 18 months of positive physician payment updates. During this period of reprieve, the physician community is working to develop alternative Medicare physician payment reform proposals to address both the 21% cut physicians face on January 1, 2010, and the 40% in cuts that are projected over the coming decade.

Because the federal government is the nation's largest health insurer, Medicare and other federal programs are frequently viewed as a potential vehicle for promoting new health care quality improvement initiatives and other health system reforms. The instability of the Medicare physician payment system, however, has an impact on the feasibility and public acceptance of such proposals.

### **Replacing the SGR**

There is bi-partisan support in both Houses of Congress to replace the current SGR to prevent disastrous consequences for the Medicare program. The primary barrier to replacing the SGR with payment updates based on the Medicare Economic Index (MEI) is the \$439 billion price tag.

- A key method for reducing the cost of replacing the SGR is removing drugs from the SGR formula.
  - For the past several years, the AMA and key Members of Congress have presented legal analysis demonstrating that CMS has the authority to adjust the SGR formula by removing Part B drugs from physician services.
  - Drugs have consumed an ever-increasing share of SGR dollars, increasing from 3.7% of the total in 1996 to 9.7% in 2007. This means that drug costs are lowering the allowable growth target for actual physician services each year as drug costs consume an increasing share of total allowed spending under the SGR.
  - If the Administration were to retroactively remove physician administered drugs from the spending calculations under the SGR back to the base year, it would reduce the 10-year cost for replacing the SGR with updates based on the MEI by about \$150 billion, according to AMA estimates.
  - We urge the new Administration to remove drugs from the SGR spending calculation, and ask Congress to urge the new Administration to do so, as well.

### **Transitional Medicare Physician Payment System**

- The SGR may be retained in some form while transitioning to a new payment system. Congressional leaders are considering a multiple spending target system based on service category sub-sets (such as primary care and preventive services; imaging services; surgical services, and others). This proposal has some support within the Federation, but

permutations of the fundamentally flawed SGR are unlikely to solve the problem of inequitable physician payment updates. It also will be difficult for the Centers for Medicare and Medicaid Services (CMS) to accurately manage micro-targets, and high year-to-year utilization variation could produce broad payment swings.

- If transitional targets are implemented, Congress should eliminate the cumulative aspect of the SGR to eliminate the compounding effect that triggers steeper cuts over the years and makes replacing the SGR increasingly expensive.

### **Additional Medicare Physician Payment Reforms**

- Other reform proposals that are being considered include:
  - **The medical home** model, which is supported by the AMA, is based on care coordination that results in less resource use and better health outcomes, with bonus payments for achieving these efficiencies.
  - **Quality incentives** include initiatives like the Physician Quality Reporting Initiative (PQRI). As directed by Congress, CMS is currently developing a plan to transition to physician value-based purchasing. In addition, the AMA has made a number of concrete recommendations to CMS for reforming the PQRI program.
  - **Bundling episodes of care** encompasses many different possibilities, including the current bundling of physician surgical services and the much broader concept of coupling multiple physicians or physician and hospital services into a single payment.
  - **Gainsharing** provides incentives to physicians and hospitals to work together to improve performance and quality outcomes and reduce costs.
  - **Accountable care organizations** encourage coordination of care across payment silos, and reward efficiency for meeting resource use and quality targets.
- These reform proposals can have significant advantages as well as disadvantages, with varying impact on physicians depending on many factors, such as medical specialty or size of practice. Each has complexities that must be addressed, including the need for a well-developed risk adjustment methodology, to avoid unintended adverse consequences for patients. We urge Congress to direct CMS to work with federal policymakers, physician specialties and private entities to improve current risk adjustment techniques.
- The AMA does not support implementation of reforms in a budget-neutral fashion whereby payments for an initiative would necessitate across-the-board payment cuts for other physician services. Medicare payments for all physicians' services have failed to keep pace with increased practice costs, and reductions would further threaten the stability of the program. We urge Congress to consider alternatives that rely on savings from across the Medicare program to increased payment for reform proposals. Avoiding a narrow application of budget neutrality within the Medicare physician fee schedule will enable physicians to focus on working with Congress to develop and implement truly meaningful health system changes that hold promise for improving the health status and quality of care delivered to our patients and for strengthening our nation's troubled economy.