Subject: Medicare Physician Payment Reform  
(Resolution 110, A-08)

Presented by: David O. Barbe, MD, Chair

Referred to: Reference Committee A  
(Steven E. Larson, MD, Chair)

At the 2008 Interim Meeting the House of Delegates adopted the recommendations in Council on Medical Service (CMS) Report 4, “Emerging Medicare Physician Payment Methodologies” (Policy D-390.964, AMA Policy Database), which called for members of the House and the Federation to provide comments to the Council on bundling, gainsharing, the medical home, and pay-for-performance as strategies for reforming the Medicare physician payment system. The intent of the report was to help the American Medical Association (AMA) effectively shape and respond to proposals for Medicare payment reform by giving members of the House of Delegates and the Federation the opportunity to discuss and express their views on the reform strategies most often proposed by policymakers.

In addition to Council Report 4-I-08, several resolutions recently presented to the House of Delegates addressed payment reforms under consideration by the Centers for Medicare and Medicaid Services and the health policy community. At the 2008 Annual Meeting, the House of Delegates referred Resolution 110 (A-08), introduced by the Infectious Disease Society of America, which asked that the AMA “oppose all public and private efforts to bundle providers’ payments around a hospitalization and follow-up outpatient care…[and] work with appropriate public and private officials and advisory bodies to ensure that bundled payment reforms do not lead to hospital-controlled payments.” Aware that the Council was preparing to study bundling as one of the Medicare physician payment alternatives, the Board of Trustees assigned Resolution 110 (A-08) to the Council so that it could be addressed as part of its report for the 2009 Annual Meeting.

In addition, the House of Delegates adopted Resolution 121 (A-08), which asked that the AMA prepare a report on gainsharing arrangements between physicians and hospitals. Gainsharing was one of the methodologies specifically discussed in Council on Medical Service Report 4 (I-08), and that report outlined issues and concerns typically raised by gainsharing proposals. The Council also received numerous comments on the gainsharing methodology, as part of the feedback received from the Federation regarding Council Report 4-I-08.

Finally, at the 2008 Interim Meeting, in addition to considering CMS Report 4-I-08, the House took action on several resolutions focused specifically on the promotion of care coordination and the medical home (i.e., Resolutions 804, 803, 819 and 820). The medical home concept was one of the methodologies highlighted in Council Report 4-I-08, and generated extensive discussion at the Interim Meeting. CMS Report 8, also before the House at this meeting, focuses on the medical home concept, and responds to action taken by the House at the 2008 Interim Meeting.
Based on the Council’s study and input received from the Federation, this report provides recommendations to help ensure that alternative physician payment methodologies are designed and implemented in ways that do not disadvantage or disenfranchise groups of physicians or patients.

A COLLABORATIVE RESPONSE TO THE URGENT NEED FOR REFORM

The spending projections for Medicare under current law manifest mounting pressure on the federal budget, pending exhaustion of the Part A trust fund, and growth in costs that is unsustainable in the long-term. Long-standing AMA Policy H-330.898 presents both short- and long-term strategies for Medicare reform, and reflects the AMA’s commitment to ultimately transition Medicare to a system of pre-funded financing. More recent policies (e.g., H-330.896 and D-330.928) advocate a series of interim steps to help strengthen the program, including restructuring beneficiary cost sharing, and offering beneficiaries a choice of plans for which the federal government would contribute a standard amount toward the purchase of coverage. In addition, several AMA policies and directives call for a repeal of the Sustainable Growth Rate (SGR) (e.g., H-390.855, H-390.852, D-390.969), and support the right of physicians to be able to balance bill patients the difference between Medicare payment rates and the physician’s normal charge (e.g., H-385.991, D-390.986). Policy D-390.974 supports ensuring that physicians are fully informed regarding their choice of involvement with the Medicare program (i.e., as a participating physician, a non-participating physician who accepts assignment on a case-by-case basis, and the right to opt-out of Medicare).

Unrelenting AMA efforts to secure permanent changes in the SGR formula appear to finally be making an impact. The Administration’s 2010 budget proposal adopted a more realistic forecast of Medicare physician spending than has been used in previous budgets by acknowledging that severe physician payment cuts called for by the flawed SGR formula are not a viable source of budget savings. Significantly, the budget proposal includes $329.6 billion over 10 years “to account for expected Medicare payments to physicians.” The AMA is working with the Federation to urge Congress to follow the Administration’s lead and support adoption of a new Medicare baseline for physician payments.

The AMA is encouraged by the opportunity presented by the Administration’s budget, yet it is clear that Congress expects physicians to demonstrate a real commitment to change. There is widespread agreement that payment reforms are needed to make health care less fragmented, achieve better health outcomes, and reduce the rate of growth in health care costs. In particular, many policymakers are questioning the appropriateness of Medicare’s fee-for-service physician payment policies. Current debate over broader Medicare physician payment policies reflects a desire to control volume growth, align incentives to reward appropriate, high-quality delivery of care, and discourage the inefficient use of resources. Citing the *Dartmouth Atlas* and other sources that attribute geographic variation in health care utilization to inefficiencies in care delivery, policy leaders are advocating the use of payment mechanisms that are intended to realign the incentives inherent in the current fee-for-service system by moving from a volume-based payment system to one based on value and the quality of care delivered.

While the Council does not accept the premise that fee-for-service payment policies, per se, are responsible for excessive cost growth or inefficiencies in health care delivery, the scrutiny of physician incentives and payment policies requires the AMA to take a leadership role in advocating for meaningful Medicare physician payment reform adaptations that preserve the assets of the current delivery system but also enhance the sustainability of the program and facilitate improved access to care and better value.
FEEDBACK RECEIVED ON COUNCIL ON MEDICAL SERVICE REPORT 4-I-08

The Council requested feedback on the issues and options raised in Council Report 4-I-08 from the Federation through various mechanisms, including the recommendations in the report (D-390.964), an announcement in the November 29, 2008 “Advocacy Update,” and two requests sent electronically to the executive directors of the state medical associations and national medical specialty societies on November 17, 2008 and January 19, 2009. In addition, the AMA convened two meetings of Federation staff to discuss Medicare payment methodologies – a fly-in in Chicago on October 29, 2008, and a webinar conducted on February 20, 2009. For the fly-in and webinar, the AMA invited staff from selected national medical specialty societies that comprise the largest portion of Medicare physician payment, selected state medical associations based on Medicare geographic spending variations, the American Osteopathic Association, and the Medical Group Management Association. The Council is grateful for the feedback it received from the participants at these meetings, in testimony provided at the 2008 Interim Meeting, and in comments provided at the “Alternative Medicare Physician Payment Methodologies” educational session, held on November 9 at the 2008 Interim Meeting, and at the 2009 Presidents’ Forum, held on March 9. The Council greatly appreciates the efforts of the individuals and medical societies that provided written comments on these issues.

CMS Report 4-I-08 focused primarily on four Medicare physician payment methodologies: gainsharing, bundling, the medical home, and pay-for-performance. With the exception of the medical home, which is addressed in more detail in CMS Report 8-A-09, there was little consensus on the viability or appeal of any one of these potential payment methodologies. The vast majority of Federation comments indicated the need for additional information on how a new payment policy might be designed and implemented before any “support” could be offered on behalf of physicians. Many commenters indicated that demonstration projects could help identify strengths and weaknesses of various payment designs, and that permanent action should be delayed until meaningful data can be gathered and analyzed.

The need for well-designed and evaluated demonstration projects notwithstanding, several medical societies expressed concern about the implementation details of the proposed methodologies. For example, the potential for conflicts between hospitals and physicians was often cited as an obstacle to successful implementation of bundling or gainsharing arrangements. Federation comments reflected a fear that hospitals would assume too much control over physician payments under either a bundling or a gainsharing structure, unless specific safeguards were put in place to prevent this. Several medical societies also expressed concern that bundling or gainsharing arrangements have the potential to adversely affect patient care. Societies emphasized the need for careful risk-adjustment methodologies and flexible structures that allow physicians to provide appropriate care for individual patients without being penalized.

Federation comments suggested that some physicians have accepted (though not necessarily embraced) the concept of pay-for-performance as a way to link payment and incentives to quality outcomes, although significant concerns remain about its implementation. Consistent themes emerged about the importance of providing high quality and appropriate care to patients, and the sense that better methods of data collection and dissemination could help physicians initiate changes at the local level that could increase efficiencies and provide greater value for their patients. Comments reflected two “gaps” in data collection and dissemination: clinical effectiveness research that could offer physicians baseline information about the best treatments and technologies available for specific conditions or illnesses (i.e., comparative effectiveness research [CER]), and practice-oriented data that could help physicians learn from and measure
themselves against their peers. Consistent with concerns about bundling and gainsharing, comments reflected the fact that improvements in risk adjustment methodologies are necessary to ensure that payment reforms do not result in cost savings only when physicians treat the healthiest patients. Physicians also expressed the need for freedom and flexibility to make innovations in their practices and to pursue collaborative local arrangements that could help them increase efficiencies.

Although several members of the Federation expressed strong support for the medical home model and its potential to enhance care coordination, many medical societies pointed to the need for additional information about this methodology. Specifically, concerns were raised about implementation of the medical home model with regard to funding sources, criteria for medical home eligibility, and the risk of the medical home model being implemented in a way that creates a barrier for patients seeking specialty treatment. These issues are discussed further in CMS Report 8-A-09, but reflect themes common among most of the Federation comments on all of the payment methodologies. Comments generally addressed the need to prevent “budget neutral” financing mechanisms, ensure participation options for a broad range of specialists and practice sizes, and encourage incentive structures that ensure the highest quality patient care.

CONSISTENT THEMES AMONG FEDERATION COMMENTS

Given the complexity of issues associated with pursuing a new physician payment structure, it is not surprising that the comments received from members of the Federation did not yield a clear consensus about a preferred methodology among those currently being discussed. Yet the Council notes that there was a high level of consistency about the general principles that should be considered when developing or evaluating a Medicare physician payment reform strategy, regardless of the methodology. Support for or opposition to a specific payment methodology appears to be based less on the merit of the methodology, per se, than on the likelihood that the payment design will offer maximum benefits with minimal harm.

Many of the areas of opportunity or concern expressed about the individual payment methodologies discussed in the Council Report 4-I-08 were in fact applicable to all of the methodologies, and mirrored those presented in the Appendix of that report. Specifically, the Federation offered consistent support for opportunities to enhance patient care through increased care coordination and adherence to performance standards; allowing physicians to share in savings resulting from increased efficiencies in patient care; and identifying ways to improve patient care and lower costs.

Similarly, most of the concerns that were raised were about issues such as budget neutrality and funding sources; calculation and distribution of payment incentives; the ability of physicians to participate regardless of patient mix, specialty or practice type; and the need to ensure that incentives are adequate to cover administrative requirements.

DISCUSSION

Council Report 4-I-08 highlighted four Medicare physician payment methodologies that seemed to be receiving the most attention from policymakers, while acknowledging the presence of other options and the likelihood that physician payment reforms would likely involve a hybrid approach that combines features of various proposals. Based on the comments received from members of the Federation, the Council determined that the AMA should focus its advocacy more broadly than support for (or opposition to) any specific reform strategy. The Council believes that the House of Delegates needs to establish general policy that allows the AMA to work with Congress and
policymakers to establish support for a framework for reform that allows maximum flexibility for
physicians to experiment with alternative approaches to achieving savings for the Medicare
program while improving care coordination and quality.

A more flexible approach to Medicare reform has been the subject of recent presentations and
articles by members of the health policy community. For example, at the 15th Princeton
Conference on health policy, held in May 2008, Stuart Guterman of the Commonwealth Fund’s
Program on Medicare’s Future, outlined a payment reform proposal that placed medical practices
along a continuum from small, independent practices to large, vertically-integrated multispecialty
practices allied with one or more hospitals. The proposal envisioned adjusting the design and
amount of payment incentives based on where practices fall on the continuum, in order to
accommodate the unique resource needs and availability of different practice sizes and styles.
Similarly, a July 2, 2008 JAMA commentary by Stephen Shortell, MD, and Lawrence Casalino,
MD, described five potential models of accountable care systems, each of which could have
payment rates shaped to a greater or lesser extent by performance measurement and care
coordination results, depending on the capabilities of each system.

Through comments received from members of the Federation, the Council identified a set of
general principles that should guide the development and implementation of any Medicare
physician payment reform proposal. These principles derive from a need to ensure that payment
reforms are designed to support, rather than undermine, physician efforts to provide the best quality
care to their patients in the most efficient and effective manner. It is also critical that future
Medicare physician payment rates adequately reflect the cost of medical practice. Current fee-for-
service levels do not cover the full cost of treating Medicare patients, forcing doctors to cost shift
to private payers, and increasing costs throughout the health care system. The Council believes
that the principles outlined in this report will provide AMA leadership with a strong framework on
which to base their advocacy efforts, while also permitting enough flexibility to ensure that the
AMA is able to be a strong negotiator in policy discussions.

The Council notes several areas where policy changes or additional support will be necessary in
order to facilitate experimentation with innovative and meaningful payment reforms. Support for
investment in comparative effectiveness research, and in better methods of data collection and
dissemination about physician practice patterns will help provide physicians with the data and
information necessary to ensure that they are providing the best care to their patients in the most
effective and efficient manner. Development of more sensitive risk adjusters will ensure that data
can be accurately interpreted and that neither physicians nor patients are harmed by analyses that
do not adequately reflect differences in all the conditions that affect care delivery and outcomes.

The AMA also needs to help ensure that physicians have the freedom and the resources to create
organizational structures that can help maximize physician involvement in reform opportunities.
This is especially important for smaller, independent practices, which might otherwise be forced to
become absorbed by hospitals or multi-specialty practices in order to participate in innovative care
and shared-savings opportunities. Examples of organizational structures that are intended to
encourage and facilitate care innovations are the “bonus-eligible organization” (BEO) described in
a December 2008 Congressional Budget Office “budget options” report on health care, and
“accountable care organizations” (ACOs) such as those described by the Medicare Payment
Advisory Commission and Elliot Fisher of the Center for Health Policy Research at the Dartmouth
Institute for Health Policy and Clinical Practice. Both BEOs and ACOs facilitate “shared savings”
arrangements, where participating physicians agree to work together to manage and coordinate care
for patients, and qualify for bonus payments if the organization as a whole meets certain quality
and spending benchmarks. In general, these organizations must have a formal legal structure to
enable them to receive and distribute bonuses to participating physicians, but the practices themselves remain independent.

Physicians should have the flexibility to participate in alternative physician payment experiments coordinated through other types of entities as well. The Council believes that the strongest and most viable opportunities for physician payment innovation will emerge from experiments developed and implemented by physician-driven groups, such as medical societies, organized medical staffs, independent practice associations or individual physician practices. The AMA has been actively engaged in efforts to secure changes in antitrust and other laws that will be critical to ensuring the flexibility and collaboration necessary to pursue these innovations.

Significant changes must be made to the Medicare program in order to ensure that physicians are able to continue serving Medicare patients. The Council realizes that real Medicare payment reform needs to involve a comprehensive approach to financing as well as physician payment and incentives. AMA policy is strong regarding the importance of pluralism, patient choice and responsibility, and the right of physicians to balance bill in order to obtain payment in full for their services. These long-term and comprehensive reforms should remain a key element of the AMA’s Medicare advocacy efforts.

As noted, the intent of Policy D-390.964 has been accomplished through the extensive feedback the Council received from the Federation on the Medicare physician payment reform issues addressed in CMS Report 4-I-08. Accordingly, the Council recommends that Policy D-390.964 be rescinded.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 110 (A-08), and the remainder of the report be filed:

1. That our American Medical Association (AMA) advocate for the development and adoption of Medicare physician payment reforms that adhere to the following principles:

   a) promote improved patient access to high-quality, cost-effective care;
   b) be designed with input from physician community;
   c) ensure that physicians have an appropriate level of decision-making authority over bonus or shared-savings distributions;
   d) not require budget neutrality within Medicare Part B;
   e) be based on payment rates that are sufficient to cover the full cost of sustainable medical practice;
   f) ensure reasonable implementation timeframes, with adequate support available to assist physicians with the implementation process;
   g) make participation options available for varying practice sizes, patient mixes, specialties, and locales;
   h) use adequate risk adjustment methodologies;
   i) incorporate incentives large enough to merit additional investments by physicians;
   j) provide patients with information and incentives to encourage appropriate utilization of medical care, including the use of preventive services and self-management protocols;
   k) provide a mechanism to ensure that budget baselines are reevaluated at regular intervals and are reflective of trends in service utilization. (New HOD Policy)
2. That our AMA continue to advocate for adequate investment in comparative effectiveness research that is consistent with AMA Policy H-460.909, and in effective methods of translating research findings relating to quality of care into clinical practice. (Directive to Take Action)

3. That our AMA advocate for better methods of data collection, development, reporting and dissemination of practical clinical decision-making tools for patients and physicians, and rapid, confidential feedback about comparative practice patterns to physicians to enable them to make the best use of the information at the local and specialty level. (Directive to Take Action)

4. That our AMA urge physician organizations, including state medical associations and national medical specialty societies, to develop and recruit groups of physicians to experiment with diverse ideas for achieving Medicare savings, including the development of organizational structures that maximize participation opportunities for physician practices. (Directive to Take Action)

5. That our AMA continue to advocate for changes in antitrust and other laws that would facilitate shared-savings arrangements, and enable solo and small group practices to make innovations that could enhance care coordination and increase the value of health care delivery. (Directive to Take Action)

6. That our AMA support local innovation and funding of demonstration projects that allow physicians to benefit from increased efficiencies based on practice changes that best fit local needs. (Directive to Take Action)

7. That our AMA work with appropriate public and private officials and advisory bodies to ensure that bundled payments, if implemented, do not lead to hospital-controlled payments to physicians. (Directive to Take Action)

8. That our AMA reaffirm Policy D-330.924, which calls for a commitment to total reform of the current Medicare system by making it a high priority on the AMA’s legislative agenda, and that the AMA’s reform efforts continue to be centered on our long-standing policies of pluralism (AMA Policy H-165.844), freedom of choice (H-165.920, H-373.998, H-390.854), defined contributions (D-330.937), and balance billing (D-380.996, H-385.991, D-390.969). (Reaffirm HOD Policy)

9. That our AMA rescind Policy D-390.964. (Rescind HOD Policy)

Fiscal Note: Staff cost estimated to be $4,580 to implement.

References are available from the AMA Division of Socioeconomic Policy Development.