“Medicare Physician Payments: 2007 and Beyond”

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SUSTAINABLE GROWTH RATE (SGR)

Physician Fees Cuts for 2007 and Beyond

The underlying cause of the problem of physician fee cuts is the Sustainable Growth Rate (SGR) methodology, the basis used to determine physician fee schedule adjustments. While intercessions by Congress have ameliorated payments for doctors in the short term, they exacerbate the problem in the long term. Since the SGR target level is set to recapture cumulative overspending, excess spending is carried forward to be recovered in future years.

Medicare Sustainable Growth Rate

The Balanced Budget Act of 1997 (BBA) established the SGR methodology that sets yearly spending targets for physicians' services under Medicare. These SGR targets are intended to control the growth in aggregate Medicare expenditures for physicians' services. The fee schedule update is raised or lowered to echo the comparison of actual expenditures to target expenditures. If expenditures exceed the target, the update is reduced and conversely is raised if expenditures are less than the target.

Target expenditures for each year are equal to target expenditures from the previous year increased by the SGR, a percentage computed by combining estimates of the changes in each of four factors:

1. The estimated percentage change in fees for physicians' services
2. The estimated change in the average number of Medicare fee-for-service beneficiaries
3. The estimated 10-year average annual growth in real gross domestic product (GDP) per capita
4. The estimated change in expenditures due to changes in law or regulations

Make the Methodology Better

AMGA has long called for changes in the physician payment update system, including, among others, a call for eliminating SGR from the update calculation. Each one of the four data estimates used in the formula has been criticized for having insufficient, inaccurate, or irrelevant elements. The GDP imposes the volume and intensity spending target on the SGR, but the GDP has no relationship to physician services. A cost-based approach would be a more realistic and equitable basis to use.

The matter of volume control will still need to be addressed in an alternative to the SGR methodology. Criticisms of nationally applied volume controls such as the SGR method, fault the fact that it is too broadly based, an umbrella approach that is too unrefined for

the purpose intended. It applies the same "fix" of payment reductions to all, irrespective of and causal linkage to the problems being addressed, significant medical services volume growth. One approach that has been suggested is the creation of geographically based volume control groupings as a means to address regional variations in medical service volumes. It has been postulated and to some extent demonstrated that there is no correlation between the increase in services and improved quality of care.

The Medicare Payment Advisory Commission (MedPAC), an independent body charged with making recommendations to Congress about Medicare, in its March 2006 Report, suggested implementing multiple SGR target pools, instead of the current, single national pool. While the AMGA does not favor continuation of the SGR, it could support the creation of methods that are not nationally applied to all, one that groups volume control methods in a more even handed and equitable way. In particular, we favor a multiplicity of groupings, one of which takes into account the effectiveness and efficiencies of highly organized and integrated delivery systems, a grouping that is based on membership in organized physician group practices or networks.

Medical Group Practice Volume Proposal

If Congress eliminates the SGR, but still requires a type of volume control mechanism for physician services, AMGA supports the idea of a separate volume control method using

an aggregation for medical group practices. Some of the key concepts for such a pooling include:

- Being based on multi-specialty medical groups because of their systematic approach to integrating quality and technological improvements, their evaluation of patient outcomes, and their application of HIT.
- Criteria for participation would include:
    - Proof of a group's accountability, organization, and commitment to evidence-based medicine and quality measurement/improvement, demonstration of an appropriate HIT infrastructure;
    - Participating groups would have their services aggregated into a collective group practice pool;
    - Continued participation would be dependent upon meeting performance standards; such as,
        - Broad application of health information technology (HIT);
        - Demonstration of a systematic approach to quality improvement
        - Development of coordinated care for beneficiaries with multiple chronic conditions;
- Appropriate risk adjustment factors for the patient population served should be developed and used to assure fairness and equity in computation of the pool.
- Design features need to assure correct matching, i.e. assignment of patients to the respective group practices;

- The pool would be designed to encompass participation beyond already existing medical groups, with incentives to encourage physicians to develop alliances with health plans, hospital medical staffs, and specialty group practices to meet the participation criteria;
- Savings realized in actual expenditures that fall below the target levels, should be shared with groups to provide incentives and reward success (this dovetails with emerging pay for performance focuses and might prove an effective alternative or supplementary approach for multi-specialty medical group practices).

Group Practices and System Redesign

The seminal Institute of Medicine (IOM) report issued in 2001, *Crossing the Quality Chasm: A New Health System for the 21st Century*, broadly address medical care quality issues and provides strategic direction for improved, redesigned health care delivery in the U.S.

The IOM report enumerates six key challenges for the redesign of health care organizations. They are "redesigning care processes; making effective use of information technologies; managing clinical knowledge and skill; developing effective teams; coordinating care across patient conditions, services, and setting over time, and incorporating performance and outcome measurements for improvement and accountability[1].

[1] Institute of Medicine, *op. cit.*, page 117.

These systems attributes and characteristics are largely present in today's AMGA members. There is a growing body of emerging evidence that suggests that medical practices embodying these systems produce a delivery system that is better able than small physician practices to make effective use of health information technology (including electronic medical records, patient registries, e-prescribing, etc.); is more likely to utilize evidence-based patient care processes; have physicians organized to practice in teams, collaborating with each other and non-physician health care givers; and use performance and outcome data with metrics for quality improvement; and for coordinating care among providers and settings[2].

This body of evidence will likely be expanded as findings from several on-going Medicare demonstration projects on group practice and care coordination become known as the projects conclude. While yet in their early days, pay for performance systems may, as they evolve over time, also play evidentiary roles for systems redesign.

FOSTERING THE GROWTH, DEVELOPMENT AND CREATION OF MULTI-SPECIALTY MEDICAL GROUP PRACTICES

AMGA believes that integrated delivery systems of health care are the most effective and efficient vehicle to provide the highest quality of medical services to Americans. The strongest underpinning of truly integrated delivery systems is the multi-specialty medical group practice model. The group practice model should be a significant national health

[2] Crosson, Francis J. "The Delivery System Matters." *Health Affairs* 24:6 (Nov/Dec 2005): 1543-1548.

care policy to stimulate formation, foster growth, and support development of multi-specialty group medical practices.

Multi-specialty medical group practices are often already the foundation of integrated delivery systems and when not, serve as the best underpinning for integrated health care delivery system formation. Doctors are the only professionals qualified to provide diagnosis and treatment of patients. As such they are the fundamental element, the core of medical care delivery. The most efficient mode of organization for their practices is the multi-specialty group medical practice and it should be the lynchpin of health care delivery in the United States.

Care Coordination

In an effort to address the issues of cost and quality in the Medicare program, Congress has appropriately focused on transforming Medicare into a value-based purchaser of care. CMS announced the implementation of its Physician Voluntary Reporting Program and healthcare leaders in Congress have introduced a similar approach in "pay for performance" (P4P) legislation. These P4P efforts generally rely on provider adherence to clinical practice guidelines that apply to single diseases or health conditions.

While adherence to disease specific guidelines will decrease treatment variation for a particular disease and increase quality of care for some patients, this strategy fails to

address the needs of a majority of Medicare patients, those with multiple chronic conditions. In 1999, almost half (48%) of Medicare patients aged 65 or older had at least 3 chronic conditions; more than twenty percent (21%) had 5 chronic conditions. Costs for treating these high service volume patients accounted for 89% of Medicare's annual budget. As the population ages, the number of chronically ill patients is expected to grow dramatically, with serious financial implications to the Medicare program.

Patients with chronic illnesses typically see multiple physicians and are prescribed multiple medications. Due largely to the complexity of treating these patients, health care for patients with chronic illnesses is often fragmented and poorly coordinated across providers and practice settings.

This lack of coordinated care has negative ramifications. According to a recent study, patients who reported seeing four or more physicians were three times as likely to report at least one type of adverse event (e.g., medicine, medication, or lab). Additionally, only 41 percent of U.S. patients who were taking more than 4 medications had a physician review their medication use during the past year, putting them at risk for adverse reactions. Not surprisingly, these complications increase the likelihood of hospital re-admissions, and additional office visits and procedures. Further, lack of coordination among providers can lead to costly inefficiencies such as duplicative testing, and unnecessary or inappropriate treatment.

In order to address the unique needs of patients with multiple chronic conditions, AMGA recommends that Congress broaden its approach beyond the current focus on single medical specialty/disease specific guidelines and measures to strategies that encourage the provision of coordinated care that emphasizes the necessary interdependency of primary care and specialty care.

In a *Veterans' Health Administration* clinical demonstration project that targeted high cost/use veterans and utilized care coordinators and home monitoring devices, ER visits were reduced by 40%, hospital admissions were reduced by 63%, and hospital bed days of care (BDOC) were reduced by 60%. Nursing home admissions were reduced by 64% and nursing home BDOC were reduced by 88%. Most importantly, quality of life indicators, as measured by patient survey responses, were significantly improved for participating veterans[3].

AMGA has developed a Chronic Care Model that encourages care coordination across practice settings and disease conditions. AMGA's Model focuses on patient-centered care that includes: proactive daily monitoring of health status; reinforcement of self-care behaviors; early detection of problems and early intervention; and coordination of and collaboration among health care disciplines. Treating the "whole" patient is most successful when supported by innovative technologies including centralized electronic medical records, patient registries, and patient monitoring devices that allow the sharing

[3] Meyer, Kobb, Ryan, "Virtually Healthy: Chronic Disease Management in the Home", *Disease Management* 5:2 (2002).

of patient specific information when and where it is needed. Specifically, AMGA recommends incentives for providers that meet these performance measures:

- Structural Measures: EMR systems, patient registries, patient monitoring devices, professional care coordinator(s), integrated teams of primary and specialty care.
- Process Measures: Daily monitoring, case management, medication management, written (electronic or paper) feedback between primary and specialty physicians regarding treatment changes and referrals, multi-specialty treatment plans, patient self-management training.
- Outcomes Measures: Reduced hospitalizations, re-admissions, and BDOC, reduced nursing home admissions, re-admissions and BDOC, reduction in ER visits, patient satisfaction surveys, savings compared to Medicare FFS baseline.

This approach to caring for the chronically ill is fundamentally different than the traditional episodic care geared toward "fixing" patients when they develop a problem. Therefore chronic care requires a different definition of "quality" and a different approach to measurement. It calls for indicators of care coordination or "system-ness" that go beyond process measures for specific disease conditions.

AMGA believes the Model will provide patients with the best care, at the right time in the most appropriate setting. Moreover, the Model will produce significant cost savings due to decreased utilization and duplication of services.

AMGA recommends that Congress and CMS provide incentives to encourage coordinated care in the Medicare program.

Physician Voluntary Reporting Program

PVRP represents CMS' interest in gathering clinical information that can be measured by evidence-based quality indicators. Collection and reporting of these measures will likely serve as part of the foundation of a new Medicare value-based purchasing system. Currently, participation by physicians is elective and involves the use of HCPCS G-codes, or as an alternative, submission of already existing data via the Doctor's Office Quality - Information Technology (DOQ-IT) program.

However, there are barriers inherent in both of these approaches that pose significant obstacles to participation for medical groups. Retooling sophisticated and often unique electronic capabilities to accommodate the keying of G-codes on each generated bill is prohibitively expensive and administratively burdensome. Furthermore, some systems are not currently capable of accommodating G-codes because their software vendor's systems do not handle "zero charges". Also, other medical groups have had difficulty sharing medical records with non-affiliated institutions. Additionally, the DOQ-IT vehicle has too many limitations to make it a broadly available alternative. While technical capabilities may indeed exist, structural limitations caused by funding restrictions, make this approach "hit or miss"—depending on local QIO capacity.

Large multi-specialty group practices are quite different from other types of physician practices. They are, by and large, organized care delivery systems, and as such have built into their fabric an advanced model for performance measurement, quality control and continuous quality improvement. Some medical groups are fully integrated delivery systems and already participate in the Hospital Compare reporting program. Medical groups also participate in CMS demonstrations, as well as other projects focusing on quality and efficient care.

Medical groups provide integrated care, furnished by a team rather than by an individual physician. Within this kind of delivery system, multiple physicians, and other health care professionals, provide care that crosses traditional specialty lines and settings.

Medical groups often have in place internal systemic quality controls, based on continuous peer review and EMRs and other infrastructural support systems. Such medical groups perform as a single entity and therefore should be measured as a single entity. They are large enough for sampling to provide sufficiently robust data to measure quality. They also have a proven track record as efficient providers of care and have existing mechanisms to distribute data and rewards.

Given these differences, AMGA proposes that CMS permit medical groups to collect and submit quality data in the form of periodic, aggregate reporting, rather than through individual billings. This allows medical groups to provide complete data, dramatically reduce physician administrative work and reduce information technology expenses.

The proposal builds upon the strengths of the medical group model and also fulfills CMS' goals for PVRP:

- capturing and reporting on quality data;
- increasing physician participation in PVRP;
- encourage the use of health information technology (HIT), particularly, electronic medical record systems (EMR).

Promoting Effective Use of Health Information Technology (HIT)

Increased adoption and implementation of HIT, which can range from electronic patient registries to sophisticated electronic medical record systems (EMRs), has the potential to increase quality and decrease costs.

Because HIT has the potential to dramatically improve the quality and safety of patient care, some hospitals and medical groups with sophisticated HIT systems are ready to begin exchanging clinical data with community physicians. While many hospitals and medical groups already have web portals that allow physicians access to patient data, there is little two-way exchange of data. Therefore, these providers would like to assist physicians to take the next step and adopt EMRs.

Increased physician adoption of HIT begins to create a culture of use and reliance on sophisticated HIT systems, easing the transition to a wholly electronic system in the future. Of course, not all hospitals and medical groups are in a position to help physicians adopt EMRs, but those that would like to cannot, due to, in large part, to the Stark and AKB laws.

These arrangements implicate the Stark and AKB laws and, because of the draconian sanctions associated with these laws, providers have been reluctant to enter into these arrangements. Notably, in an August 13, 2004 report on barriers to HIT, the General Accountability Office (GAO) stated that Stark and AKB "present barriers by impeding the establishment of arrangements between providers-such as the provision of IT resources-that otherwise promote the adoption of IT." Additionally, the Office of the National Coordinator for Health Information Technology (ONCHIT) stated that these fraud and abuse statutes pose barriers to greater HIT adoption.

AMGA members have pioneered the use and application of HIT in their practices and have, by and large, made significant investments in this important infrastructural element both as a practical matter and for philosophical reasons. Appropriate incentives will have to be forthcoming to advance broad adoption and implementation of HIT to realize its potential for reducing medical errors, improving patient safety, enhancing care coordination, etc. However, any financial support, direct or indirect, that may evolve over time, must take into consideration the investments and leadership demonstrated by

those entities, including many AMGA members, by recognizing and repaying them for having had the vision to install and apply HIT.

Conclusion

The SGR "fix" is a critical focus for the short term to avert the dire consequences of the impending 5.1% physician fee schedule negative update and for the longer term to address the projected cuts for the next years. If left unchecked, there is a high likelihood that access to care for Medicare patients may become increasingly difficult. This fatally flawed methodology must be abolished.

In addition much broader health delivery system redesign is necessary, particularly in the realignment of incentives to assure progress in the attainment of national health care policy objectives such as, delivery of efficient, high quality health care, and coordination of care, particularly for those with chronic diseases. The specifics enumerated in this testimony are all steps in the right direction.

The body of evidence is growing that multi-specialty group medical practices are a delivery mode that offers many advantages and benefits. Many of the national policy goals are already being undertaken and realized by AMGA's members. It is time for Congress to recognize the value and importance of this delivery model and to take legislative action to foster creation, development and growth of multi-specialty medical group practices.

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