

April 28, 2011

Honorable Fred Upton  
Chairman, Energy and Commerce Committee  
U.S. House of Representatives  
Washington, D.C. 20515

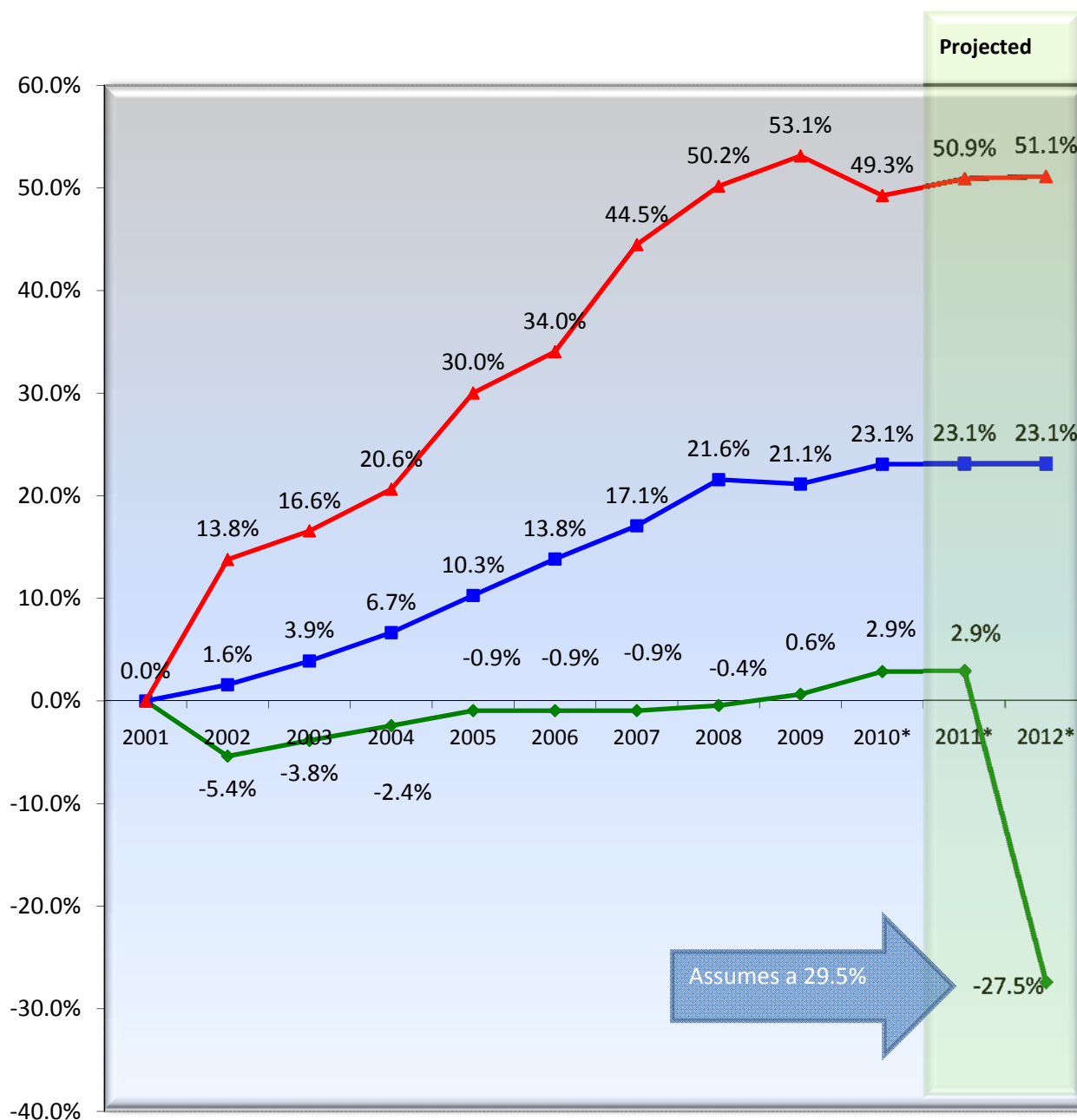
Dear Chairman Upton:

The Medical Group Management Association (MGMA) is pleased to respond to your request for input on the kind of payment system that should replace the Medicare physician fee schedule. As the nation's principal voice for medical group practices with 22,500 members who lead 13,600 organizations in which some 280,000 physicians provide more than 40 percent of the nation's health care services our members understand the challenges created by the current payment system. As you are painfully aware, under current law, Medicare physician payment will be reduced significantly in 2012 and further reductions are likely for several years. There is widespread agreement among experts and stakeholders that the existing physician payment system under the Medicare program is inadequate. Although Congress has repeatedly intervened to prevent rate cuts, it has never completed the task of finalizing change to the formula that dictates these cuts.

### **Medicare Physician Payment System Implications**

It is clear that the sustainable growth rate (SGR) formula is flawed and does not adequately address growth in spending, as MGMA data shows below. For more than 50 years, MGMA has conducted annual surveys that focus on revenues, expenses, provider compensation and production, management compensation and group performance for medical and academic practices. The chart shows that the total operating cost per full time equivalent (FTE) physician has increased by 51 percent since 2001, while Medicare physician payments have remained relatively stagnant during that same time period with a sharp decrease forecasted for 2012. This widening gap will be insurmountable for many physician practices as it destabilizes business operations and decreases access to care for Medicare beneficiaries. In 2010, MGMA conducted a member survey that focused on the potential effect future reductions in Medicare physician payment would have on practices and the patients they serve. The study found that many medical practices were likely to limit the number of new Medicare patients they accept unless Congress takes action to halt pending Medicare reimbursement cuts. In addition to reducing the number of Medicare patients they see, practices stated they would take other steps to address decreased reimbursement, such as delaying the purchase of electronic health records.

### Cumulative Percent Change Since 2001 for the Medicare Physician Payments, Not Hospital/IDS-Owned Multispecialty Group Operating Cost, and the Consumer Price Index



\* 2010, 2011, and 2012 median operating cost values are three year moving average projections of previous years' data.

\* 2010, 2011, and 2012 CPI figures are the July 2010 semiannual figure.

\* Assumed reduction figure based upon CMS analysis (3/15/11 released).



Many stakeholders agree that the ultimate solution is to permanently replace the Sustainable Growth Rate (SGR) formula with a system that actually keeps pace with the cost of caring for our nation's seniors. Continuing the practice of enacting temporary patches serves no one. Medical practices are committed to taking the leadership role in developing Medicare payment reforms to replace the SGR once and for all, and we are counting on Congress to make permanent reform a reality.

## **Reports to Congress**

We believe reevaluating past proposals to reform the SGR formula and incorporating some of these ideas into new initiatives will pave the way to an improved and equitable payment model.

In a 2005 report, the Government Accountability Office (GAO) categorized options for alternatives around two themes: (1) proposals that end the use of spending targets and separate fee updates from explicit efforts to moderate spending growth; and (2) proposals that retain spending targets but modify the current SGR system to address perceived shortcomings. The first approach emphasizes stable fee updates, while the second automatically adjusts fee updates if spending growth deviates from a predetermined target. GAO stated that "the choice between the two approaches may hinge on whether primary consideration should be given to stable fee increases or to the need for fiscal discipline within the Medicare program."<sup>i</sup> The second approach would end targets as an explicit measure for moderating spending growth. Updates would be based on cost increases with the possibility of specifically addressing high volume service categories such as medical imaging.

In its March 2007 report, the Medicare Payment Advisory Commission (MedPAC) described two possible paths: one path would eliminate the SGR and emphasize the development and adoption of approaches for improving incentives for physicians and other providers to furnish lower cost and higher quality care. The second path would add a new system of expenditure targets in addition to these approaches. However, MedPAC did not make any recommendations in favor of any single alternative to the SGR. MedPAC's report did stress that "a major investment should be made in Medicare's capability to develop, implement, and refine payment systems to reward quality and efficient use of resources while improving payment equity." Examples cited by MedPAC include pay-for-performance programs for quality, improving payment accuracy, and bundling payments to reduce overutilization.<sup>ii</sup>

Most recently, on April 15, MedPAC staff offered a brief assessment of the SGR and its current problems. The commission highlighted the system's failure to differentiate by provider and its strictly budgetary format. These problems do not encourage improving quality or efficiency, and temporary fixes to the payment system provide uncertainty in the Medicare program and reduce access for beneficiaries. The commissioners all favored repealing the SGR. A number of commissioners suggested that Congress should "write-off" the SGR fix; likewise, other commissioners proposed that money for the fix could come from reducing spending in other programs, though noted that spending outside of Medicare is beyond the scope of the commission. Regardless of the ultimate fix, commissioners were in agreement that any future temporary SGR fixes need to last for at least a year to provide stability to the program.

## **Recommendations and Transition to New Payment Models**

In agreement with both reports, MGMA also urges Congress to repeal SGR and replace it with an update system that reflects increases in physicians' practice costs. We call on Congress to incorporate a five-year period of statutory updates based on the Medicare economic index (MEI) as part of a transition to a new Medicare physician payment system. The transition period would allow a phase out of the SGR formula over several years while instituting major payment reforms that move away from fee-for-service.

We advocate for Congress to establish such a transition pathway in order to provide stability to the Medicare system with positive funded updates over the next five years until a replacement takes effect. Uncertainty for

practices that continue to receive last minute Congressional patchwork fixes fails to foster either provider or patient confidence.

There are numerous proposals for payment changes that would promote integrated care delivery and encourage cost-effective medical treatment. Options include but are not limited to bundled payment, partial capitation, development of accountable care organizations, and breaking down the silos between separate payment systems for different sectors of Medicare (Part A and B).

These innovative financing and delivery systems need to be developed further. This transition pathway is necessary to ensure that new payment models appropriately incorporate quality care parameters and information technology implementation into the payment calculation and that innovative payment methodologies are tested and evaluated in a variety of practice settings. An ongoing evaluation process should be created to determine if a system is ready for wider implementation, requires further testing or proves ineffective.

Given the diversity of medical practices, a single, one-size-fits-all approach must be avoided and physicians should have flexibility to adopt different approaches based on the composition and capabilities of their practice. These new models require data infrastructure and skilled staff to analyze data, as well as the ability to share information and coordinate care. Medicare should offer timely data sharing and positive financial incentives to assist medical practices that wish to experiment with alternative approaches to achieving savings as part of this transitional pathway.

## Conclusion

In conclusion, it is clear that long-range savings and continued increased quality and accountable care will require other reforms to the current payment system. We urge Congress to base any new payment system on flexibility to accommodate different practice types. Innovative payment and delivery system models should not be incorporated into the Medicare system until they are properly tested.

We thank you for the opportunity to share our views on this vital topic. We are committed to working with you to repeal the SGR formula and replace it with a more equitable system. Should you have any questions regarding these comments, please contact Miranda Franco, MGMA Government Affairs Associate, at 202.293.3450 or [mfranco@mgma.org](mailto:mfranco@mgma.org).

Sincerely,



William F. Jessee, MD, FACMPE  
President and Chief Executive Officer

cc:

The Honorable Henry Waxman  
The Honorable Joe Barton  
The Honorable John Dingell  
The Honorable Joe Pitts  
The Honorable Frank Pallone  
The Honorable Michael Burgess, MD

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<sup>i</sup> U.S. Government Accountability Office, Medicare Physician Payments: Concerns about Spending Target System Prompt Interest in Considering Reforms, GAO-05-85, October 8, 2004.

<sup>ii</sup> Medicare Payment Advisory Commission, Assessing Alternatives to the Sustainable Growth Rate System, March 07