

May 2010

MEDICARE PHYSICIAN PAYMENT REFORM

RECOMMENDATION

Family Medicine urges Congress to:

Replace the formula known as the **Sustainable Growth Rate (SGR)** that determines the annual Medicare physician payments.

- Recognize the **value of primary care** by improving the bonus payment for those services.
- Expand access to the federal demonstrations of the **patient-centered medical home** by eliminating the requirements for Medicare or Medicaid patients to be “high need” beneficiaries.
- Support CMS changes to the final fee schedule rule modestly increasing Medicare reimbursement for evaluation and management services.

Sustainable Growth Rate (SGR)

Unless Congress overrides it, the SGR formula used to calculate annual updates will be reinstated on June 1, 2010, which means a 21.2-percent cut in payment rates for physicians. Moreover, because of the cumulative nature of the formula, additional decreases in the 5-percent range are projected annually for many years into the future. Such unrelenting decreases in payment demonstrate the dysfunctional nature of the formula and, when coupled with the escalating costs associated with operating a medical practice, will make it impossible for a growing number of family physicians to accept new Medicare patients. Family medicine supports the recommendation of the Medicare Payment Advisory Commission (MedPAC) to repeal the SGR formula and base the conversion factor on a stable, predictable index commensurate with the cost of delivering health care services. The family medicine organizations also prefer provisions that have been offered in the House that would create separate higher expenditure targets for primary care than for subspecialty care.

Recognizing the Value of Primary Care

Substantial evidence indicates that primary care-based health care adds overall value through increased efficiency and better health outcomes. However, our nation’s system fosters fragmentation, rewards volume and undervalues primary care. Consistently over two decades, health industry literature has described a growing disparity that has resulted in a near 100-percent compensation difference between primary care and subspecialty medicine and suggests this is a predominant reason that fewer medical students are choosing primary care. The family medicine organizations appreciate that Congress has taken the first step of recognizing the value of primary care by increasing payment for those services in some cases.

However, because under the *Patient Protection and Affordable Care Act*, only physicians who provide 60 percent or more of their services as primary care are eligible for this bonus, few rural physicians will realize this added Medicare reimbursement. A more appropriate eligibility threshold would be 50 percent. An administratively easier approach might be to allow all primary care physicians who practice in a primary care Health Professions Shortage Area to be deemed eligible.

This bonus should be considered a necessary down payment on the goal of health coverage for all, because a reformed health system must be predicated on an adequate and high-functioning primary care workforce. The return-on-investment for Medicare would be considerably better than the investment in primary care would cost, as demonstrated by reports by the Commonwealth Fund.¹

Family medicine recommends that the eligibility threshold be lowered from 60 percent of the primary care physicians' allowed charges for primary care services to 50 percent. There are additional payment codes for primary care services that were not included in the list included in the health reform law that should be added. Finally, Congress should apply the bonus to all Medicare billings and make the bonus permanent.

Care Management in a Patient-Centered Medical Home

Medicare does not compensate physicians for the considerable time and effort of organizing and coordinating a patient's care. Family medicine organizations, along with the American Academy of Pediatrics, the American College of Physicians and the American Osteopathic Association describe a patient-centered medical home, in which the team of health care providers is led by a physician and offers coordinated, comprehensive primary care, as an effective way of managing health care. Such integration of care would contribute to better patient health and would avoid some costly hospitalizations, duplicative testing and unnecessary procedures.

A promising option is to use a blended model of payment that combines a fee-for-service system with a monthly stipend for care management. This care-management fee would be paid directly to the practice that the patient chooses as the patient's medical home and which is recognized by an independent third party organization as a qualified patient-centered medical home.

Regulatory Adjustments

The Centers for Medicare and Medicaid Services (CMS) enacted needed changes in the implementation of the final rule for Medicare payments to physicians in 2010. By eliminating consultation codes and updating practice expense data, CMS was able to modestly increase the value of 'evaluation and management' codes which are among the codes most used by family physicians. Family medicine urges Congress to allow these changes to stand and not overrule the CMS regulation.

1. In "[Fundamental Reform of Payment for Adult Primary Care: Comprehensive Payment for Comprehensive Care](#)" (*Journal of General Internal Medicine*, Mar. 2007), Goroll, Schoenbaum, et. al., The Commonwealth Fund, 2007.