REPORT 4 OF THE REPORT OF THE COUNCIL ON MEDICAL SERVICE (I-08)
Emerging Medicare Physician Payment Methodologies
(Reference Committee J)

EXECUTIVE SUMMARY

In 2008, for the seventh year in a row, physicians were threatened with Medicare payment cuts as a result of the flawed Sustainable Growth Rate (SGR) formula used to determine annual physician payment updates. Due to strong advocacy by the American Medical Association (AMA) and the Federation, the 10.6% cut scheduled for July 1, 2008 was averted when Congress acted to replace 18 months of projected cuts with a 1.1% payment update for 2009. Unfortunately, the potential negative implications of the SGR continue.

Policymakers have become increasingly critical of the overall design of Medicare's physician payment system, and are expressing concern that its incentives are a major factor in rising costs. Many recent discussions of Medicare payment highlight the need to increase "value" for the money spent.

The Council on Medical Service believes that the ongoing pressure of projected physician payment cuts, combined with growing momentum to modify the Medicare physician payment system, necessitate the AMA assuming a leadership role in shaping Medicare payment reforms. To help position the AMA to effectively shape and respond to proposals for Medicare payment reform, and to strengthen its efforts to avert further physician payment cuts, the Council on Medical Service is developing recommendations to the House of Delegates regarding how alternative Medicare payment methodologies should be structured in order to best serve patients and physicians. The Council believes that the House of Delegates needs to carefully consider the alternatives that are receiving the most attention from policymakers—bundled payments, gainsharing, the medical home concept, and pay for performance—and adopt policy that will allow the AMA to communicate effectively and forcefully in discussions about Medicare physician payment reform.

Some of the issues raised by these payment policy alternatives are complex, and it may be challenging to develop new policy that adequately addresses the concerns of all physicians. This report has been prepared to give members of the House of Delegates and the Federation the opportunity to discuss and express their views on these alternatives before the Council formally brings recommendations to the House of Delegates. The Council will present a report at the 2009 Annual Meeting that contains a series of recommendations regarding potential Medicare physician payment reforms, based on input received.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 4 - I-08

Subject: Emerging Medicare Physician Payment Methodologies

Presented by: David O. Barbe, MD, Chair

Referred to: Reference Committee J
(Jack J. Beller, MD, Chair)

In 2008, for the seventh year in a row, physicians were threatened with Medicare payment cuts as a result of the flawed Sustainable Growth Rate (SGR) formula used to determine annual physician payment updates. Due to strong advocacy by the American Medical Association and the Federation, the 10.6% cut scheduled for July 1, 2008 was averted when Congress acted to replace 18 months of projected cuts with a 1.1% payment update for 2009. Unfortunately, the potential negative implications of the SGR continue. Despite the fact that over the past several years physicians have successfully averted cumulative cuts of 24%, physician payment rates remain at 2001 levels, and payment updates have fallen 16% below increases in the government's conservative measure of practice cost inflation. Without further Congressional action, physicians are expected to face a 20% payment cut in January 2010.

Policymakers have become increasingly critical of the overall design of Medicare's physician payment system, and are expressing concern that its incentives are a major factor in rising costs. Many recent discussions of Medicare payment highlight the need to increase "value" for the money spent.

The Council on Medical Service believes that the ongoing pressure of projected physician payment cuts, combined with growing momentum to modify the Medicare physician payment system, necessitate the AMA assuming a leadership role in shaping Medicare payment reforms. In order to respond to these challenges, the AMA contracted with Health Policy Alternatives (HPA), Inc. to prepare an analysis of the current Medicare physician payment system and options for its modification, including the pros and cons of the alternative approaches. The Council met with principals of HPA in March 2008, and gratefully acknowledges their work, much of which has been included in this report.

To help position the AMA to effectively shape and respond to proposals for Medicare payment reform, and to strengthen its efforts to avert further physician pay cuts, the Council on Medical Service is developing recommendations to the House of Delegates as to how alternative Medicare payment methodologies should be structured in order to best serve patients and physicians. The Council believes that the House of Delegates needs to carefully consider the alternatives that are receiving the most attention from policymakers, and adopt policy that will allow the AMA to communicate effectively and forcefully in discussions about Medicare physician payment reform. Some of the issues raised by these payment policy alternatives are complex, and it may be challenging to develop new policy that adequately addresses the concerns of all physicians. For that reason, the Council believes that members of the House of Delegates and the Federation should have the opportunity to discuss and express their views on these alternatives before the

Council brings formal recommendations to the House of Delegates. The Council is addressing the issue of potential Medicare physician payment reforms in two steps, as follows:

1. This report identifies concerns and criticisms that are being attributed to the current Medicare physician payment system, and describes some possible alternatives that are being discussed by relevant stakeholders. Information on these alternatives is presented for discussion and comment before the Reference Committee at the 2008 Interim Meeting. The Council asks that members of the House, as well as state medical associations and national medical specialty societies, convey any additional views and comments on these options to the Council by January 9, 2009.

2. The Council will present a report at the 2009 Annual Meeting that contains a series of recommendations regarding potential Medicare physician payment reforms, based on input received.

The Council has previously used a two-report approach with other significant reports with potentially controversial recommendations. For example, the Council used this strategy when it developed policy recommendations for the current AMA proposal to expand coverage and choice (Council on Medical Service Reports 5-I-97 and 9-A-98), as well as policy on medical care for patients with low incomes (Council on Medical Service Reports 8-A-03 and 1-I-03).

ACTIONS AT THE 2008 ANNUAL MEETING

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." In addition, the House adopted Resolution 121 (A-08), which asked that the AMA conduct a study and prepare a report on gainsharing arrangements between physicians and hospitals.

Because the Council was anticipating preparation of this report, the House was made aware via a notation on Resolutions 110 and 121 (A-08) that the issues raised in these resolutions were currently under study by the Council. The timeliness of these resolutions is perhaps further evidence that payment reform proposals are gaining momentum. The issues addressed in Resolutions 110 and 121 (A-08) will be discussed in this report, and a final action on Referred Resolution 110 (A-08) will be recommended in the Council's report for the 2009 Annual Meeting.

THE URGENT NEED FOR POLICY DEVELOPMENT

The spending projections for Medicare under current law manifest mounting pressure on the federal budget, exhaustion of the trust fund that permits full payment of currently scheduled benefits, and growth in costs that is unsustainable in the long-term. Long-standing AMA Policy H-330.898 (AMA Policy Database) 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 purchase of coverage. In addition, several AMA policies and directives call for a repeal of the SGR (e.g., H-390.855, H-390.852, D-390.969).

Policymakers have concerns about the appropriateness of Medicare's fee-for-service physician payment policies. The opinion that fee-for-service payments fail to provide incentives to improve efficiency or quality of care, and may encourage over-utilization of services, is gaining momentum. As discussed later in this report, pressure is growing for more bundling of services commonly performed together, to provide appropriate incentives for the adoption of performance improvements, and to minimize incentives that may facilitate inappropriate utilization patterns. The Council believes that the AMA has the opportunity to take a leadership role in developing a framework that will help further address concerns related to efficiency and volume growth.

CONCERNS ABOUT THE CURRENT MEDICARE PAYMENT SYSTEM

Current debate over broader Medicare physician payment policies reflects concern with controlling volume growth, aligning incentives to reward appropriate, high-quality delivery of care, and discouraging the inefficient use of resources. Citing the *Dartmouth Atlas* and other sources that document apparent 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.

Medicare's fee-for-service payment policies have drawn concern from policymakers since Medicare's inception. Initially physicians were paid based on the "customary and prevailing rate (CPR)" system, which based payment on a physician's actual charge for a given service. In the mid-1970s Congress established a mechanism to cap annual fee increases under CPR, but concerns about the rate of growth in physician expenditures and perceived inequities in Medicare payment across specialties persisted. Policymakers considered physician payment reforms that would move away from a fee-for-service system, including the use of a capitated system, or one that would base payment on diagnosis related groups (DRGs) or a similar bundled payment approach. The Resource Based Relative Value Scale (RBRVS) that has provided the underlying basis for the Medicare physician payment system for the past 17 years provided an opportunity to maintain a fee-for-service payment system, while addressing concerns about payment inequities. The simultaneous application of an adjustment factor (initially the Medicare Volume Performance Standard [MVPS], to be replaced by the SGR) addressed concerns about controlling volume growth. The intent of the MVPS / SGR formula was to control expenditure growth by adjusting for the difference between actual Medicare expenditure growth and the "allowed" or "targeted" growth rate. Under SGR, the targeted rate is based on changes in: the per capita gross domestic product; fees; enrollment; and law and regulation. Each year's payment update calculation begins with the Medicare Economic Index (MEI), which is a government index of practice cost inflation. The update is then adjusted up or down from MEI based on how spending compares to the SGR targets. The design and use of the MEI is the subject of Council on Medical Service Report 6-I-08, also before the House at this meeting.

Actual medical spending growth continues to far exceed target rates, which are based on gross domestic product growth calculations that have been significantly below health care inflation for several years. In addition, the SGR target calculation does not adequately recognize changes in medical technology or shifts in site of service that have resulted in reductions in hospital expenditures and corresponding increases in physician expenditures. Under SGR, physicians face

pay cuts of 40% in the coming decade, and the already exorbitant price tag to produce a long-term fix continues to grow at an exponential rate.

A NOTE ABOUT COMPARATIVE EFFECTIVENESS

The AMA recognizes the need for increased research to help improve medicine's understanding about best practices and optimizing the balance between medical outcomes and treatment costs. Policy H-155.940 advocates that sources of medical research funding give priority to studies that collect both clinical and cost data; use evaluation criteria that take into account cost impacts as well as clinical outcomes; translate research findings into useable information on the relative cost-effectiveness of alternative diagnostic services and treatments; and widely disseminate cost-effectiveness information to physicians and other health care decision-makers.

Efforts to quantify the optimal relationship between clinical outcomes and treatment costs are gaining popularity in the form of comparative effectiveness research (CER). Council on Medical Service Report 5 (I-08), also before the House at this meeting, discusses CER in more detail, with an emphasis on potential options for promoting CER, and disseminating and eliciting behavior change based on research findings.

ALTERNATIVE MEDICARE PHYSICIAN PAYMENT OPTIONS

The Appendix to this report provides a concise analysis of four key payment methodologies that are currently receiving the most attention from policymakers and key organizations such as the Centers for Medicare and Medicaid Services (CMS) and the Medicare Payment Advisory Commission (MedPAC). Payment methodologies that emphasize bundled payments, gainsharing, the use of the medical home to coordinate care, and pay-for-performance arrangements are being targeted as possible solutions to the perceived problem of inefficient delivery of Medicare physician services. The Council believes that one or more – or a combination – of these alternative methodologies may be incorporated into future Medicare payment policy.

As noted above, the intent of this report is to inform and solicit feedback from the House of Delegates about these payment methodologies, which the Council believes are likely to be discussed and promoted with increasing intensity. The options are not presented in any particular order, and the House should keep in mind that most of the options have multiple variations, and one or more of these options could be combined to create a hybrid policy.

Bundled Payments

Under a bundled payment approach, a single payment is made for an array of health care services. The services could relate to the activities of a single physician (or other provider), or to services provided by multiple physicians and providers. The bundle could, for example, include services provided by a hospital during a Medicare beneficiary's inpatient stay, and the services of the operating surgeon, the anesthesiologist, and even consulting physicians. The bundle could include all services provided 30, 60 or 90 days following discharge. Alternatively, the bundle could relate solely to services provided by a physician, or physicians, on an ambulatory basis. The bundle could be defined on a monthly or other time-related basis, or it could be defined on an episode of care basis.

Medicare already makes use of bundled payments under its hospital inpatient and outpatient prospective payment systems, under the payment systems that apply to other providers, such as skilled nursing facilities, dialysis facilities and home health agencies, and also to certain types of physician services, such as global surgical services, some diagnostic imaging procedures, and the monthly payments provided to physicians treating patients with end-stage renal disease. Although bundling is currently much more modest for outpatient care than it is for inpatient care, CMS has recently announced plans to review non-surgical procedures to identify more opportunities to bundle services together.

MedPAC also has recently given considerable attention to the issue of bundled payment. In its June 2008 report to Congress, MedPAC recommended that:

- CMS confidentially report to hospitals and physicians readmission rates and resource use around hospitalization episodes. Beginning in the third year, providers' relative resource use should be publicly disclosed.

- To encourage providers to collaborate and better coordinate care, CMS reduce payments to hospitals with relatively high readmission rates for select conditions and also allow shared accountability between physicians and hospitals. The Congress should also direct the Secretary to report within two years on the feasibility of broader approaches, such as virtual bundling, for encouraging efficiency around hospitalization episodes.

- CMS create a voluntary pilot program to test the feasibility of actual bundled payment for services around hospitalization episodes for select conditions. The pilot must have clear and explicit thresholds for determining whether it can be expanded into the full Medicare program or should be discontinued.

In May 2008, CMS announced a Medicare Acute Care Episode (ACE) Demonstration, under which a single global payment would be made for inpatient facility and professional services, from the date of admission to the date of discharge (including pre-admission testing and any global surgical fee). All physicians practicing at demonstration hospitals would be subject to the payment provisions of the demonstration if they provide services to beneficiaries whose admissions are covered by it.

Among the possible models for organizing a bundled payment are episode groupers, virtual bundling, and accountable care organizations (ACOs).

Episode Groupers: Episode groupers are algorithms and related software used to group claims into episodes of care and to adjust for differences in patient severity by using such variables as age and gender. Payments to a physician (or multiple physicians) would be based on care delivered during an episode of care, using defined start and finish dates that encompass the episode. Several proprietary software programs already exist, including Episode Treatment Groups, developed by Symmetry Health Data Systems, and Medstat Episode Groups, developed by Thomson Medstat. In addition, PROMETHEUS Payment Inc. has developed a system of evidence-informed case rates (ECRs) to help categorize and price episodes of care. ECRs are based on clinical practice guidelines that are used to determine the services that would be required in treating a patient with the condition covered by a particular set of guidelines. The Robert Wood Johnson Foundation has recently awarded $6.4 million in grants to PROMETHEUS Payment to enable it to further develop and test its payment model.

Virtual Bundling: Medicare payments to physicians and hospitals would continue to be made on a fee-for-service basis, but special software would be used to group Medicare claims into episodes of care, thereby permitting resource comparisons to be made at a local, state, regional or national level. These comparative data could initially be provided to providers on a confidential basis and later shared with the public. Physicians that meet certain standards would be eligible for a bonus payment. Eventually, hospitals and physicians with relatively "low" resource utilization could qualify for financial rewards and those with "high" utilization could incur financial penalties. Medicare beneficiaries might even be given financial incentives to seek care from providers demonstrating "low" resource utilization.

Accountable Care Organizations (ACOs): Under the ACO approach, groups of physicians are assigned to "accountable care organizations," which are responsible for quality of care and overall Medicare spending for their patients. Individual ACOs could be subject to expenditure and/or resource targets, and bonuses or penalties would be assigned to the ACO based on overall performance relative to the targets. Physicians could be paid on a fee-for-service basis, less a withhold, to be paid out at the end of the year pending ACO performance.

From a performance measurement perspective, the ACO option has the potential advantages of a large sample size, the relevance of a broader scope of performance measures, and the feasibility of including all physicians who contribute to the care of a population. ACOs are also not necessarily dependent on hospital participation, and therefore may be appropriate for physicians with limited hospital involvement. ACOs also offer an opportunity for solo practitioners or smaller physician groups to pool resources to invest in systems that could help control costs and improve quality, such as health information technology.

MedPAC considered the ACO concept during its April 2008 meeting, and discussed several issues, including whether an ACO should include a hospital (as well as the physician group); whether participation should be voluntary or mandatory; how to set expenditure targets; and how payment determinations should be made. At the time this report was prepared, MedPAC had not made any specific recommendations with respect to the use of ACOs.

Issues and Concerns with Bundled Payment

Bundled payment raises a number of issues and concerns. In terms of design, the following issues must be addressed:

- How the "package" subject to bundled payment should be defined (e.g., physician-only services; all services related to a single care episode);
- Whether there should be a single payment or separate payments for different components of the package;
- Which entity or entities should receive the bundled payments and how much flexibility they should have in allocating them among different stakeholders (specifically, how to ensure physicians retain control over their portion of bundled payment);
- How to determine the appropriate payment amount for the package and/or its components;
- Whether and how to risk-adjust payment for such things as severity of illness and differences in patients' socioeconomic status;

- How to pay for an episode of care, if the most resource-intensive tests and procedures occur early in an episode (for example, should payment be front-loaded or paid in equal installments);
- Whether to provide additional payments for teaching hospitals and hospitals caring for the uninsured, as well as for outlier cases;
- How to ensure that physicians and/or hospitals do not avoid treating difficult patients; and
- How to ensure that quality of care does not suffer.

Bundled payment covering both hospital and physicians' services is likely to require modifications to a number of federal laws precluding physician self-referral, kickbacks, and hospital payments to physicians for reducing or limiting patient services, and even amendments to federal antitrust laws and laws applying to tax-exempt hospitals. For example, IRS tax-exempt laws, which prohibit private benefit or inurement by tax-exempt hospitals to physicians, could be implicated in a bundled payment system. It also is likely that the Civil Monetary Penalty Law, originally enacted "in response to reports that hospitals were giving incentives to physicians to discharge patients 'sicker and quicker' under the Medicare inpatient prospective payment system" (MedPAC, 2005) would need to be amended. In addition, policy makers would probably need to pre-empt state laws, such as state self-referral statutes, that might otherwise impede the use of bundled payment arrangements.

Gainsharing

Gainsharing (also referred to as "shared savings" or "shared accountability") is an approach under which hospitals share with physicians the savings produced as a result of changes in care processes. Gainsharing is seen as having the potential to align hospital and physician incentives to provide more cost-effective care, for example, by encouraging more appropriate use of imaging and testing services; more careful choice among available generic and brand name drugs; reductions in medication errors; use of outpatient rather than inpatient services; use of disease management services to preclude the need for hospital admission; and reduction of avoidable readmissions. Gainsharing is often a component of the bundled payment approach.

MedPAC has voiced support for the gainsharing concept. As part of a March 2005 special report on physician-owned specialty hospitals, the Commission made the following recommendation:

> Congress should grant the authority to allow gainsharing arrangements between physicians and hospitals and to regulate those arrangements to protect the quality of care and minimize financial incentives that could affect physician referrals.

In the same report, MedPAC also stated that "the Secretary could require that gainsharing arrangements:

- Identify specific actions that would produce savings, such as limiting the inappropriate use of supplies;
- Are transparent and disclosed to patients;
- Include periodic reviews of quality of care by an independent organization;
- Limit the amount of time during which physicians can share cost savings, to prevent hospitals from using these agreements as a mechanism to induce physician referrals;

- Avoid rewarding physicians for increasing referrals to the hospital, such as capping potential savings based on the number of prior year admissions; and
- Monitor changes in the severity, age, and insurance coverage of patients affected by the arrangement" (MedPAC, 2005).

In its June 2008 report to Congress, MedPAC asserted that, "ideally, the legal framework within which [gainsharing] arrangements would operate could allow joint negotiating with manufacturers to obtain greater discounts on supplies and devices, more efficient scheduling of operating rooms, mutual compliance with clinical protocols for improving efficiency and quality, and sharing bonuses earned for quality achievements."

CMS is actively engaged in efforts to facilitate the implementation of gainsharing arrangements. In the July 7, 2008, proposed rule, CMS invited comments on a proposed new, targeted exception to the physician self-referral statute, intended to offer flexibility for innovative and effective programs, while at the same time protecting the Medicare program and beneficiaries from abuse. CMS explicitly sought input on opportunities, limitations and risks associated with the proposed exception.

Two gainsharing demonstrations have been authorized, but to date neither has been implemented. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) included a provision mandating a five-year Physician Hospital Collaboration Demonstration program, intended to examine the effects of gainsharing approaches that involve long-term follow-up of patients. More recently, the Deficit Reduction Act of 2005 included a provision mandating a three-year Medicare Hospital Gainsharing Demonstration, which will involve a total of six hospitals, two of them rural, and require continuous monitoring of quality and efficiency. CMS intends to approve projects that propose multiple approaches to achieving savings, with the focus being on short-term improvements in quality and efficiency during the in-patient stay and immediately following discharge.

The 2008 edition of the *Dartmouth Atlas* offers a gainsharing vision under which savings would be pooled into a national fund to be shared by all providers who participate in pay-for-performance programs. Under this approach, CMS would offer shared savings partnerships to providers who agree to coordinate care among the various sectors of care—inpatient, ambulatory, home health care, chronic institutional care, and hospice—and to implement long-term budgets aimed at achieving the resource input and utilization benchmarks similar to those of a relatively efficient provider. The Dartmouth researchers believe that the cost-sharing provision would create revenue for the provider partners to compensate for the financial consequences of any required downsizing in acute care components, including the amortization of debts to bond holders and employee buy-outs. The researchers also believe that shared savings could be used to help pay for the infrastructure required to coordinate care, such as health information technology (HIT) systems, and for services not funded under traditional Medicare Parts A and B, such as nurse coaches.

Issues and Concerns with Gainsharing

Gainsharing could provide a means for physicians to receive some of the payments that would otherwise go to hospitals (that is, Medicare Part A payments) in addition to Medicare Part B payments; of course, they would only receive such payments in return for helping hospitals reduce their costs. Gainsharing could be perceived favorably as a means for increasing Medicare physician payments while satisfying budget neutrality constraints.

However, there is relatively little experience with gainsharing, and gainsharing authority could be abused by some hospitals or physicians. As with bundled payments, it would be important to ensure that physicians retain control over their payments, rather than allowing hospitals or other entities to determine payment allocations. Over time, any reductions in hospital costs brought about by gainsharing would almost certainly be taken into account in setting future hospital payment rates, and thus it might become increasingly difficult to produce ongoing, shareable savings. In addition many physicians today spend relatively little or no time in the hospital setting and thus many physicians could probably expect little or no gain from gainsharing arrangements. Furthermore, consumers may be concerned about the impact on quality of care or access to the most appropriate technology. The impact on physician liability exposure is uncertain.

As in the case of bundling arrangements discussed previously, there are several legal and regulatory barriers associated with the implementation of gainsharing arrangements. Although the Office of the Inspector General (OIG) of the Department of Health and Human Services has recently taken a more flexible view of gainsharing arrangements on a case-by-case basis, the OIG remains concerned that gainsharing could result in such behaviors as "(i) stinting on patient care; (ii) 'cherry picking' healthy patients and steering sicker (and more costly) patients to hospitals that do not offer such arrangements; (iii) payments in exchange for patient referrals; and (iv) unfair competition (a 'race to the bottom') among hospitals offering cost savings programs to foster physician loyalty and attract more referrals" (OIG, 2007).

A federal law authorizing broader use of gainsharing would most likely need to incorporate specific safeguards to address the issues raised by the OIG, and there is the risk that these safeguards could become unduly burdensome or even effectively preclude the use of gainsharing arrangements.

AMA comments on the July 7, 2008, proposed rule urged CMS to proceed with caution as it evaluates whether and how to encourage gainsharing in Medicare. The AMA emphasized the importance of ensuring that physicians retain control over their payments under a gainsharing arrangement, and encouraged CMS to ensure that the exception not create incentives to cut back on patient care, limit the therapeutic choices available to doctors and their patients, create disincentives to treat patients with disabilities and chronic health conditions, or slow the development and diffusion of medical innovation.

Medical Home

Concerns about inadequate coordination of patient care have led to calls for a new organizational and payment model known as the medical home. The term "medical home" was first coined by the American Academy of Pediatrics (AAP) in 1967 and initially referred to a central place for archiving a child's medical record. The concept has been further developed since that time. Four organizations, the American Academy of Family Physicians (AAFP), the AAP, the American College of Physicians (ACP) and the American Osteopathic Association (AOA), have published "Joint Principles of the Patient-Centered Medical Home." Under these principles, the medical home takes responsibility for arranging care, makes effective use of HIT to monitor, coordinate, and manage patient care, provides enhanced access to care through open scheduling, expanded hours and new communication options, and undergoes a voluntary recognition process by some non-governmental entity. The National Committee on Quality Assurance has worked with primary care physician organizations to develop such a recognition process.

Implementation of a CMS medical home demonstration has been delayed until 2010. However, following a recommendation from MedPAC, Congress adopted legislation expanding the demonstration to a pilot program, which could ultimately be implemented nationwide without additional legislation. The CMS pilot will use three tiers of medical home, each of which will need to meet increasingly stringent qualifying criteria. The AMA/Specialty Society RVS Update Committee (RUC) recently submitted detailed recommendations to CMS regarding the nomenclature for each of the three tiers and for the relative values that should be assigned to each tier (on a per patient per month basis, assuming a typical panel of 250 Medicare patients per physician). The RUC also recommended that CMS collect "clinical as well as fiscal endpoints to measure the success" of the medical home demonstration project. The RUC received letters from AAFP, ACP and CMS commending the RUC on its work on the medical home.

In MedPAC's recommendation to Congress regarding the development of a medical home pilot project, MedPAC recommended that medical homes include at least the following capabilities:

- Furnish primary care (including coordinating appropriate preventive, maintenance, and acute health services);
- Conduct care management;
- Use health information technology for active clinical decision support;
- Have a formal quality improvement program;
- Maintain 24-hour patient communication and rapid access;
- Keep up-to-date records of beneficiaries' advance directives; and
- Maintain a written understanding with each beneficiary designating the provider as a medical home.

MedPAC further recommended that Medicare provide medical homes with timely data on patient utilization, and that the pilot require a physician pay-for-performance program.

The AMA has policy supporting the general concept of the medical home, although it does not define or endorse any specific criteria. Policy D-200.986 (4) "supports the concept of partnerships between primary care physicians and patients to coordinate access to all needed medical services and consultations (a "medical home") for all patients."

<u>Issues and Concerns with the Medical Home Concept</u>

The medical home concept is being championed because it is expected to improve patient care at little extra cost, and has the potential to produce savings (for example, through reduced hospital admissions and emergency department visits, and the avoidance of duplicative testing). It also increases payment to primary care and other "medical home" practices without necessarily requiring increased face-to-face patient contacts.

However, the medical home concept continues to evolve and questions remain about the best structure for a medical home or specifically what it must do in order to receive extra payments. A fundamental challenge to the care coordination goal of the medical home is the fact that most proponents of the concept emphasize that the medical home would not have a gatekeeper function and that Medicare beneficiaries would retain the option of seeking care from specialists or other sources without a referral from the medical home. MedPAC gave considerable attention to how to ensure the medical home could coordinate care without becoming a gatekeeper during its April 2008 meeting. Among the options discussed were the following:

- Requiring Medicare beneficiaries to notify their medical home if they obtain treatment from providers not designated by that home;
- Requiring CMS or its contractors to make monthly reports to each medical home detailing the health care services their Medicare beneficiaries have received (ideally, similar communications would come from Medicaid programs—for the dually eligible—and even from Medicare Part D prescription drug plans);
- Requiring health professionals consulted by Medicare beneficiaries with a designated medical home to communicate with the medical home (this might be facilitated by having some kind of notation on the beneficiary's identification card); and
- Conducting a public education campaign to inform beneficiaries about the benefits of primary care and a medical home and encourage them to seek care first from their medical home.

Others have suggested that if mandating that Medicare beneficiaries designate primary care physicians as gatekeepers is not politically viable, perhaps financial incentives in the form of reduced cost-sharing or lower Medicare Part B premiums could be offered to beneficiaries who voluntarily agree to have services coordinated by a primary care physician or medical home.

In addition, there is some concern that it may be difficult for many primary care practices, especially small practices or those located in rural areas, to meet the criteria for participating as a medical home or be able to discharge the obligations expected of a medical home. There is also debate about whether the medical home concept should be limited to primary care physicians, or if the concept could also be applicable to specialists who, while treating a chronic medical condition, might also manage all aspects of a patient's care.

There is also some uncertainty about whether the best payment model for a medical home would be a monthly management or care coordination fee for each Medicare beneficiary, plus fee-for-service payments for everything else, or a combined monthly payment covering all the services provided by the medical home. The latter approach, essentially primary care capitation, could be problematic if it resulted in reduced access and quality. One option might be to use a monthly, per-capita management fee and fee-for-service payment for other services in the case of solo and small-group practices and expanded capitation for larger groups, especially large multispecialty group practices.

Pay-for-Performance

The final payment option that has been gaining support among policymakers is pay-for-performance (P4P). The P4P concept continues to attract attention as a means to establish incentives for meeting quality and/or efficiency benchmarks, including patient satisfaction measures, or for other actions or behaviors, such as the adoption and effective use of HIT. The concept has received strong support from policy makers, including the Institute of Medicine (IOM) and the MedPAC, and considerable resources have been devoted to developing, reviewing and endorsing performance measures. To date, the AMA convened Physician Consortium for Performance Improvement has developed approximately 215 performance measures that are available for implementation, and it continues to enhance quality of care and patient safety by taking the lead in the development, testing, and maintenance of evidence-based clinical performance measures and measurement resources for physicians.

As the House is aware, the AMA has been actively engaged in P4P debates and discussions for several years, and the Board of Trustees has prepared several detailed reports on this issue (e.g., Board of Trustees Report 5-A-05, and Board of Trustees Report 18-A-07). AMA advocacy with regard to proposed P4P initiatives is guided by a comprehensive set of principles and guidelines related to P4P initiatives adopted by the House of Delegates (Policy H-450.947), which emphasize quality of care; the patient/physician relationship; voluntary physician participation; the use of accurate data and fair reporting; and the use of fair and equitable program incentives that provide new funds for positive incentives.

DISCUSSION

The purpose of this report has been to analyze criticisms that are being leveled against the current Medicare payment system, and to examine in detail the four broad categories of payment reform proposals that currently appear to have the most viability from the perspective of key policymakers. The Council is aware that, in addition to the specific pilot projects mentioned in this report, several other demonstrations using a variety of these payment methodologies have taken place. It should also be noted that, although the Council specifically chose to focus this report on broader payment methodologies, efforts to identify alternatives to the SGR specifically are also ongoing. Among alternatives being discussed are to repeal the SGR entirely, or replace it with multiple targets based on specialty, geography, type of service, or some other unit.

Each of the primary broad payment methodologies being discussed – bundling, gainsharing, promotion of the medical home, and pay-for-performance – have shortcomings from the varied perspectives within organized medicine. However, physicians must be able to respond clearly, and in a unified manner, to proposals that advocate the use of one or more of these payment methodologies.

The grid in the appendix outlines the pros and cons of each of the major options presented in this report. The Council envisions using this framework to develop recommendations that would ensure that alternative payment methodologies are implemented in ways that do not disadvantage or disenfranchise groups of physicians, or our patients. As with the pay-for-performance guidelines developed in 2005, the Council is confident that the AMA can agree upon a set of principles that will demonstrate medicine's willingness to work toward common goals of high quality, efficiently-delivered medical care, while at the same time ensuring that the realities of medical practice are taken into consideration.

For purposes of clarity, and consistent with health policy literature to date, the report highlights discrete proposals to modify the Medicare payment system. However, as noted, the next chapter in Medicare physician payment is likely to be a hybrid approach that combines features from various proposals, potentially even allowing physicians the opportunity to choose the system that works best for them. Although blended approaches could be complex to administer, future reforms that preserve flexibility for different types of practices may be more feasible than attempts to impose a single, uniform system.

The Council is seeking the advice and suggestions of members of the House of Delegates, state medical associations, and national medical specialty societies in developing these principles. The Council is interested in knowing if there are benefits or risks to these four payment methodologies that have been overlooked, or whether there are elements that are included but should be deleted. At the same time, the Council is interested in knowing if there are alternative ways to demonstrate

organized medicine's commitment to responding to concerns about escalating volume growth and costs within the Medicare program. At this time it is critical that the AMA continue to build its reputation as a partner, rather than an adversary, of creating a more robust and secure Medicare program.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted and the remainder of the report be filed:

1. That our American Medical Association forward the testimony and comments from Reference Committee and House of Delegates discussions regarding the alternative Medicare payment methodologies outlined in this report to the Council on Medical Service for consideration in developing its recommendations for a follow up report at the 2009 Annual Meeting. (Directive to Take Action)

2. That our AMA encourage members of the House of Delegates, state medical associations, and national medical specialty societies to forward any additional comments on the alternative Medicare payment methodologies outlined in this report to the Council on Medical Service by January 9, 2009. (Directive to Take Action)

Fiscal Note: Staff cost estimated to be less than $500 to implement.

References are available from the Division of Socioeconomic Policy Development.

APPENDIX

Major Options for Changing Medicare Physician Payment Policy

Adapted from material prepared for the AMA by Health Policy Alternatives, Inc.

Option	Major Pros	Major Cons
Bundled Payments	• Concept already used by Medicare to pay hospital inpatient services and global surgical services (among others) • Could provide incentives for reducing the costs of patient care • If bundle includes both hospital and physician services, could permit physicians to share in any savings produced by changes in patient management	• Concept not yet well developed where bundle includes services provided by multiple independent providers • Key unanswered questions relate to the contents of the bundle, the appropriate recipient(s) of the bundled payment, how to allocate the bundled payment amounts, and how to risk-adjust these payment amounts • Physicians could have difficulty accessing payments if funds are controlled by hospitals • Option could have limited relevance for physicians whose practices involve little hospital-related care • Could create competitive environment between groups of physicians
Gainsharing	• Would allow physicians to share in savings produced by reducing hospital costs • Would be compatible with existing Medicare payment policies (each provider would be paid as they are today but hospitals could also share savings with the physicians who helped produce them) • Could provide incentives for reducing the costs of patient care and improving patient outcomes • Hospitals appear supportive of the gainsharing option • Ongoing public disclosure of hospital performance data would make it possible to monitor, at least to some extent, the impact of gainsharing	• Physicians could have difficulty accessing payments if funds are controlled by hospitals • Ongoing, sharable savings could be difficult to sustain • Option would have limited relevance for physicians whose practices involve little hospital-related care • Policy makers could end up imposing too many conditions on the use of gainsharing • Could increase professional liability exposure

Option	Major Pros	Major Cons
Medical Home	• Considerable effort has already been devoted to developing the concept • Could increase payments to physician practices serving as medical homes, many or most of which are likely to be primary care practices • Would provide incentives to better coordinate patient care, thereby improving patient outcomes and potentially reducing health care costs (e.g., by reducing emergency department visits and avoidable hospitalizations) • Could make primary care more attractive to medical students and residents • Could provide an incentive for physicians to invest in health information technology • Could stimulate development of interoperable health information technology network	• The medical home concept continues to evolve, and there is not wide-spread agreement on the essential features of a medical home • It may be a challenge for some practices to meet the care management and information technology requirements to qualify as a medical home • Might increase Medicare expenditures, especially if the primary outcome is increased utilization of underused services • If subject to budget neutrality requirements, increased payments to medical homes would require reductions in spending for other Medicare services
Pay-for-Performance	• Multiple physician performance measures have already been developed by the Physician Consortium for Performance Improvement and others, and are being used • Approach could improve physician performance on selected measures • Could be used to increase patient access to shared decision making aids (e.g., with respect to discretionary surgery) or reduce unexplained geographic variation in Medicare per-beneficiary expenditures • Could provide an incentive for physicians to invest in health information technology • Could stimulate development of interoperable health information technology network	• Measures might not focus on what is important or be able to cover the full range of patient care • Might simply improve care documentation • Likely to be difficult to apply at least some measures at the individual physician level (small numbers problem) • Data collection and reporting can be burdensome for physician practices, especially if different payers use different measures • Risk-adjusting performance data will be challenging • Likely to be applied on a budget-neutral basis, meaning that good performers can only receive additional payment if other physicians receive reduced payments. • Could increase Medicare expenditures if principal outcome is increased use of underused services • Might lead physicians to shun vulnerable populations