AMERICAN ACADEMY OF FAMILY PHYSICIANS

STRONG MEDICINE FOR AMERICA

January 2013

MEDICARE PHYSICIAN PAYMENT REFORM

RECOMMENDATION

AAFP urges Congress to:

- Approve the *Medicare Physician Payment Innovation Act* (HR 5707)
- Repeal the Medicare Sustainable Growth Rate (SGR) and apply unused war fighting (OCO) funds as the offset
- Specify payment rates for a transition period of up to 5 years, with a higher rate for primary care physicians
- Use the transition period to determine effective health delivery alternatives

Specifically, Family Medicine supports the *Medicare Physician Payment Innovation Act* (HR 5707) because it provides a clearly defined path to permanent payment reform. This legislation includes a multi-year transition period with a stipulated annual payment rate increase of 0.5 percent (but 2.5 percent annually for primary care) while CMS tests and evaluates several alternative payment systems. Family Medicine's recommendation is that the current flawed approach does not serve Medicare patients well and must be changed to reflect the value of primary care and family physicians.

Sustainable Growth Rate (SGR)

Unless Congress acts once again to override it, the SGR formula used to calculate annual updates will be reinstituted on January 1, 2013, which will mean a cut of nearly 30 percent in payments for physicians and other Medicare providers. Moreover, the budget agreement that Congress reached in the summer of 2011 requires an additional 2-percent reduction in Medicare payments. Finally, because of the cumulative nature of the formula, additional decreases are projected annually for many years into the future. Yearly or monthly cuts, when coupled with escalating costs associated with operating a medical practice, create an unstable program for everybody – doctors and patients. If the payment system is not stabilized for several years, family physicians will find it increasingly difficult to maintain their practices with Medicare patients.

Positive Payment Differential for Primary Care

Investments in primary care have been shown by many studies to restrain cost growth and improve the outcomes of care in a health system. For example, a recent study states, "If every American made use of primary care, the health care system would see an estimated $67 billion in savings

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annually."[1] People with a usual source of care have better health outcomes and fewer disparities in health outcomes and lower costs.[2] Even the Government Accountability Office (GAO) reports that "Ample research in recent years concludes that the nation's over reliance on specialty care services at the expense of primary care leads to a health care system that is less efficient. At the same time, research shows that preventive care, care coordination for the chronically ill, and continuity of care – all hallmarks of primary care medicine – can achieve improved outcomes and cost savings." [3] But the current payment system does not reflect the value that primary care provides to the health of Medicare beneficiaries. Instead, it rewards procedures, tests, technology and acute care rather than preventive health care, the coordination of care and chronic disease management. The payment system needs to be re-balanced to increase payment for primary care to reduce the disparity in payment compared to specialty care.

Demand for Primary Care Physicians

To achieve the efficiencies that a health care delivery system based on primary care can provide to those in the U.S., an investment in the incremental improvement of payment for primary care services compared to payment for specialty care is essential. Between 1995 and 2004 primary care salaries increased by 21 percent; however, in the same period, specialists' salaries increased by 38 percent. The already large and growing gap between payments for specialist and primary care physicians reduces the likelihood that a medical student would pursue primary care. To encourage more students to be able to choose family medicine, among other steps, it is essential to ensure that payment for primary care services reflects its relative value to the health care system and the population.

Primary Care Incentive Payment

The *Affordable Care Act* includes an important provision that directs CMS to pay primary care physicians (defined as those with a specialty designation of family medicine, internal medicine, geriatric medicine or pediatric medicine) an additional 10 percent for primary care services, defined essentially as office visits, home visits and nursing home visits. This incentive payment program exists from January 1, 2011 to December 31, 2015. The goal of this incentive payment is to recognize to some degree the value of primary care and to improve compensation for these services. Family Medicine appreciates the underlying message of the provision, but is asking Congress to increase the payment and make it permanent. Otherwise, the incentive is too limited to achieve its important goals.

Medicaid Payment Parity for Primary Care

Similarly, the final version of the *Affordable Care Act* includes a provision to require state Medicaid programs to pay primary care physicians at least as much as the Medicare program does for primary care and specific preventive health services. The difference in payment for these services varies from state to state, but it can be quite significant. This equalization in payment is only for 2 years (2013 and 2014). The federal government picks up the cost of this equalization program. Again, the AAFP is asking Congress to make this permanent if the equalized payment is going to help family physicians afford to treat Medicaid patients.

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[1] Access Granted: The Primary Care Payoff, August 2007, National Association of Community Health Centers, The Robert Graham Center, Capitol Link (pgs 1-2)

[2] Healthy People 2020, Access to Health Services (healthypeople.gov/2020)

[3] Testimony before the Committee on Health, Education, Labor, and Pensions, U.S. Senate. Primary Care Professionals: Recent Supply Trends, Projections and Valuation of Services. Statement of A. Bruce Steinwald, Director Health Care, United States Accountability Office. February 12, 2008 GAO-08-472T