



Fix Medicare Physician Payment

Background

The Medicare physician fee schedule is updated annually by applying a sustainable growth rate (SGR) target calculation intended to control growth. Since 2002, Medicare physician spending has exceeded the target set by the SGR and triggered a reduction in physician fees. Although Congress has repeatedly intervened to prevent reductions in Medicare physician payments, it has not reformed the SGR formula. The cumulative result of multiple, short-term Congressional interventions has created a deficit of billions of dollars in Medicare's physician payment system and requires larger payment cuts each year. In 2013, the Congressional Budget Office reduced its estimated cost of repealing the SGR from \$244 billion to \$116.5 billion. In the past year Congress has made unprecedented progress with SGR repeal by advancing bi-partisan, bi-cameral legislation, and we urge Congress to resume and complete these efforts. Now is the time to act.

Additionally, cuts to physician payments resulting from sequestration further destabilize the Medicare program and compound the already dire situation for medical group practices caused by the SGR formula. The instability created by the combination of sequestration and the ever-present SGR undermines efforts to achieve broader, long-term reforms to the Medicare program.

MGMA position

In order for Medicare beneficiaries to have access to high-quality physician care, Congress and the administration should:

- Repeal the SGR and sequester cuts, and replace the SGR with a Medicare physician payment system that adequately reimburses physicians for annual increases in the cost of providing patient care.
- Create incentives for providers to coordinate and improve care and achieve cost efficiencies while accommodating different practice models. The Medicare program must be flexible and give physicians credit under Medicare Part B for savings they achieve in Part A.
- Provide a 5 year period of payment stability while Medicare pilot tests new physician payment approaches. Testing new payment models prior to widespread implementation is also critical. 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 their composition, capabilities and community needs.

Reduce Medicare Quality Reporting Burdens

Background

The government has sought to encourage the adoption of health information technology (HIT) and to improve the quality and efficiency of patient care by implementing Medicare quality reporting programs. These programs include Physician Quality Reporting System (PQRS), the Meaningful Use Electronic Health Record (EHR) program and the Value-Based Payment Modifier (VBPM) program. Over time, these programs have become increasingly complicated and duplicative. There has also been a shift from rewarding

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providers for their participation to penalizing providers who do not meet the numerous, often burdensome requirements for each program.

MGMA position

In general, MGMA is supportive of programs that reward quality and HIT adoption but opposes the imposition of penalties on those unable to meet complex program requirements. MGMA supports reasonable and achievable incentive programs, and encourages Congress and administrative agencies to implement policies that achieve the government's objectives without placing an undue administrative burden on physician practices. In an effort to develop and implement policies that improve the quality of care delivered to patients while reducing administrative inefficiencies, Congress and the administration should:

- Harmonize and simplify the data reporting requirements and processes. For instance, the government should deem all eligible professionals (EPs) that meet Meaningful Use requirements (and therefore report clinical quality measures under that program) as also successfully meeting all PQRS and VBPM clinical quality reporting requirements in each corresponding performance year.
- Establish robust and workable group practice reporting options. Clinicians enter into group arrangements to achieve the efficiencies of the group practice model and to allow them to focus on patient care rather than paperwork. Quality reporting programs should permit physician practices to leverage cost-effective group reporting options and support the team approach to care delivery.
- If penalties exist, institute adequate hardship exceptions and appeals processes. There are legitimate situations where physicians and group practices are unable to meet program requirements and exceptions and an appeals process should be available to avoid unfair penalties. Where penalties exist, they should be based on actual performance during the time period to which they are applied and should not be based on performance in a previous year.
- Provide timely and meaningful feedback and assistance with identifying and correcting unsatisfactory reporting throughout the year. Receiving feedback reports nine months after the completion of the reporting year, for example in the case of PQRS, is not timely. Actionable feedback should be provided throughout the year and then again within eight to 12 weeks of completion of the program year.

About MGMA

MGMA is the leading association for medical practice administrators and executives since 1926. MGMA helps members create successful medical group practices that deliver the highest-quality patient care, and MGMA produces some of the most credible and robust medical practice economic data and data solutions in the industry. Through national membership and 50 state affiliates, MGMA represents more than 33,000 medical practice administrators and executives in practices of all sizes, types, structures and specialties in which more than 280,000 physicians practice.

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