Position Statement

Principles for Physician Payment Reform

This Position Statement was developed as an educational tool based on the opinion of the authors. It is not a product of a systematic review. Readers are encouraged to consider the information presented and reach their own conclusions.

Background

The AAOS has previously developed and published two statements on Medicare Reform Principles¹ and on Principles of Health Care Reform and Specialty Care.² These position statements address Medicare reform and health care reform on a broad level including payment reform, solvency of Medicare, and beneficiary access to Health Savings Accounts (HSAs) among many items. This statement addresses physician payment reform specifically and is intended as a guide for policy makers and others in developing and advancing new payment models as well as key criteria for evaluating the success of these models.

Request for Action

1. Replace the flawed Sustained Growth Rate (SGR) formula with a more fair and flexible payment formula for physician services paid under Medicare Part B. The annual saga over SGR focuses on the short-term goal of avoiding a catastrophic and punitive reduction in physician payment rates. Precious time and energy is diverted away from designing a payment system that is sustainable in the long-term and allows physician payment rates to keep up with long-term changes in economic costs. The present payment system serves neither physicians, nor patients, nor policy-makers. Congress must immediately begin designing a new model based on the more rationale prospective payment systems used for Part A Medicare services that include annual market basket updates to payment rates.

2. Eliminate the Independent Payment Advisory Board (IPAB) and create a mechanism for review of Medicare payment rules and regulations that will focus on all aspects of health care payment, not just on physician payment rates as IMAC is currently intended to do. Any such review body must be accountable to Congress and should not be an independent body with statutory powers. The majority of members of this Advisory Council must be physicians and medical providers. Medical providers are the best judges of the potential impacts of any physician payment models on the quality of care delivered to patients.

After accomplishing these two immediate and essential steps, we then urge Congress to consider the following principles when assessing physician payment reform.
Reforming Health Care Delivery: Principles for Physician Payment Reform

Quality of Care must be the primary focus of all payment reform

Our current payment system offers few financial incentives to providers to offer higher quality care to patients. It instead pays the same amount for a given treatment intervention regardless of the quality of care delivered and the outcome of the intervention. This does not serve our patients or our healthcare system well and is contrary to a market-driven approach to payment. A market-driven approach would provide incentives for higher quality (rather than quantity) care, and would thus encourage providers to improve the quality and value of the care they provide. The AAOS believes payment reform must provide financial incentives that reward higher quality care based on appropriately risk-adjusted, patient-centric measures of health outcome. This system must be careful to account for the co-morbidities that are beyond a provider's control such as medical co-morbidities (i.e. obesity), patient mobility, noncompliance with treatment recommendations, and other factors. We believe this tiered payment system can be accomplished and can be built upon Evidence-Based Guidelines, Appropriate Use Criteria, risk-adjusted Performance measures, and participation in national registries which have been created and disseminated by specialty societies in the last ten years. We now have a foundation of quality measures and evolving evidences in virtually every area of medical practice. These are the best sources for a quality focused payment system.

We also have a sufficient foundation of outcomes research to begin to determine what constitutes a high quality outcome compared to a low quality outcome. These types of quality measures should be the foundation of a new physician payment model that does not rely on the current fee-for-service payment mechanisms.

Ensure Fiscal Solvency of Federal Programs

The current approach to physician payment is the worst of all worlds. It stifles payment, discourages innovation, and still manages to threaten the fiscal solvency of the U.S. Federal Government. Any physician payment reform needs to balance equitable payment with a commitment to the long-term solvency of Federal Health Care programs.

Overutilization of unnecessary care needs to addressed and reduced

The current combination of increased risk of malpractice litigation and a fee-for-service system with no mechanism for annual updates has led to the problem of overutilization of medically unnecessary services. Overutilization not only drives up costs but exposes patients to unneeded tests and procedures that may negatively affect their health. Payment reform must curb this growth, not by cutting reimbursement of so-called over utilized procedures, but by paying for quality outcomes and by reducing or offsetting the risk of medical malpractice lawsuits. Reducing payment rates for discrete services will do nothing to curb the utilization problems.

Cap Medical Malpractice Liability or offer higher payments to compensate for increasing Medical Liability Insurance

Congress must choose one of two options: either pass federal legislation capping medical liability suits, or offer payments that offset the unmanageable medical liability insurance costs faced by all providers but most acutely by providers of high-risk medical care such as orthopaedic surgery. Even if these options are not immediate possibilities, Congress could create a Medical Review court which can review Medical Malpractice cases and dismiss cases deemed frivolous. Without reforming our current medical malpractice system, there is little chance of achieving meaningful reductions in total Federal spending on physician services.
Eliminate real Medicare fraud

It is impossible to accurately account for the percentage of total Federal spending on physician services paid for fraudulent services, but it is reasonable to assume it is a significant and unnecessary waste of revenue. Any efforts to eliminate Medicare fraud must focus on true Medicare fraud and not become a mechanism for bogus charges against honest providers of services. Congress should encourage the Centers for Medicare and Medicaid Services to work closely with specialty societies to identify Medicare utilization patterns that run counter to specialty society guidelines on best coding and billing practices. This collaborative effort could generate millions of dollars of savings without punishing honest physicians who constitute the vast majority of physicians in the United States.

Encourage medical innovation, do not stifle it

Payment systems should reward physicians for developing medically innovative treatments that are better for our patients and reduce health care costs by keeping patients healthier and out of hospitals. Orthopaedics has long been a driver of medical innovation such as arthroscopic treatments for conditions which formerly required open surgery. These types of innovative technological advances have saved employers, patients, Medicare, and other payers billions of dollars a year in reduced costs. Yet, our current system, with its perverse incentives, financially punishes arthroscopic surgeons because these procedures require less time and fewer hospital visits than the previous methods and our current payment model pays more for procedures with longer procedure times and more hospital patient visits. This is economically irrational and must be corrected in future payment reform. By tying payment to quality and to savings generated by medical innovation, Medicare can reduce overall costs and drive innovation.

Adopt multiple approaches to payment reform that do not treat all physician services as one size fits all

Our current healthcare system is diverse, with organizational models ranging from solo practitioners to comprehensive, fully-integrated systems of care. What works well in one type of practice may not work for all. Yet our current payment system operates on the assumption that all practices are the same. More flexibility will reduce inefficiency and properly price physician services provided in the multiple settings that exist today. Payment reform must acknowledge this diversity and the need for flexibility.

Adopt and facilitate physician feedback

Our current system makes meaningful interaction between physicians and policy makers difficult and rare. This is a disservice to our patients and to taxpayers. Feedback mechanisms must be developed that will accurately assess how physicians are responding to new models and incentives. Local and federal "innovation zones" are one strategy to speed learning and dissemination of "what works best" in varied circumstances.

Encourage public and private sector collaboration

New payment models can and should be able to be integrated into private sector models. Any new payment models need to align with private sector approaches. The public and private sectors should be brought together to collaborate and share approaches that reward outcomes and value and reduce administrative demands.

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Position Statement 1180

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