

**American Medical Association
Interim Meeting**

OSMAP

Hilton New Orleans Riverside
New Orleans, Louisiana
Friday, November 11, 2011
2:00 P.M.

**CRYSTAL BALL GAZING RE PHYSICIAN PAYMENT IN GOVERNMENT
PROGRAMS:**

TALES OF SGR, MedPAC, SUPERCOMMITTEE, & OTHER MACHINATIONS

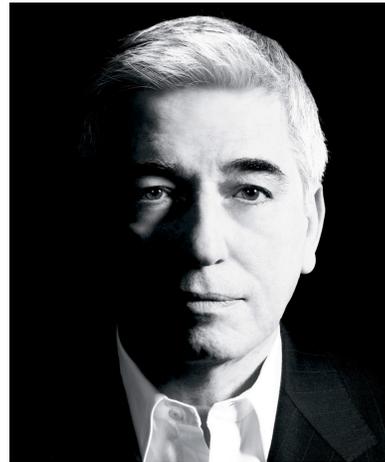
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Former president LSMS (1984-85)

Author of ON LEADERSHIP,
now in 2nd edition



The information in this document is background for my presentation.

The reason for this handout is not to burden you with the need to copy links as I speak.

The goal of the talk is to cut through government jargon concerning the approaches to deal with the debt crisis of the USA and give a prediction what will happen with physician fees in Medicare with the current administration and congress.

SGR or Sustainable Growth Rate is the price-fixing scheme used now by government for payment of physicians for services given to Medicare patient.

Details of the birth of SGR are below.

FACT: SGR not working. Loss of more access to care for seniors is on horizon if the previously delayed cuts, now calculated to be 27.4% (previously stated to be 29.5%), are implemented on January 1, 2012

Excerpt quote below is from: <http://physiciansmoneydigest.com/your-practice/Change-in-Medicare-Cut-Not-Enough>

"This is the eleventh time the Sustainable Growth Rate has resulted in a payment cut. Every year after the first cut in 2002, Congress has postponed the expected cut, which is why the one scheduled to take place on Jan. 1 is so steep. Of course, if the upcoming cut is also postponed, it will simply result in an even steeper one for 2013."

And a word about MedPAC, advisor to Congress on Medicare issues

<http://www.medpac.gov/>

EXCERPT

ABOUT MEDPAC

The Medicare Payment Advisory Commission (MedPAC) is an independent Congressional agency established by the Balanced Budget Act of 1997 (P.L. 105-33) to advise the U.S. Congress on issues affecting the Medicare program. The Commission's statutory mandate is quite broad: In addition to advising the Congress on payments to private health plans participating in Medicare and providers in Medicare's traditional fee-for-service program, MedPAC is also tasked with analyzing access to care, quality of care, and other issues affecting Medicare.

SEE MARCH 11, 2011 REPORT regarding physician payment.
Go to <http://www.medpac.gov/>

and search Medicare Payment Policy March 11, 2011 to get 384 page pdf document.

Plus see the further statements, summarized below in an article at:

<http://www.medpagetoday.com/PublicHealthPolicy/Medicare/28550>

(NOTE THE LAST PARAGRAPH for the revision including cuts to specialists.)

Specialists should bear the brunt of cuts in Medicare payments to physicians, according to the latest Sustainable Growth Rate (SGR) fix floated by Medicare Payment Advisory Commission (MedPAC) staff.

In a [presentation](#) made during the first day of a two-day MedPAC meeting, the MedPAC staff members... (That presentation was on September 15, 2011 and the pdf can be accessed from the MedPageToday article via a hot link.)

The SGR system links physician reimbursement rates to increases in the gross domestic product (GDP). Because spending on physician services has outpaced increases in the GDP, the formula has called for cuts in reimbursements each year over most of the past decade -- and Congress has always voted to push those cuts down the road.

But eventually, it will be time to pay the piper and, right now, that payment is scheduled to be a 30% cut in physician reimbursement, a price that many think is too high to sustain physician participation in Medicare.

Moreover, the pressure to cut Medicare spending comes at the same time that patients are having difficulty finding primary care providers under Medicare.

So the staff members recommended making the necessary cuts only among specialty providers, and freezing reimbursement rates for primary care physicians. Specifically, the plan calls for reducing specialty reimbursement by 5.9% per year for three years, and then freezing it for the next seven years, while primary care's rates would be frozen for 10 years, with no cuts.

Options to prevent disaster in access to care.

1- CONGRESS

Congress could fix problem with legislation but few republicans or democrats have introduced bills and gathered enough votes to allow liberty to be restored with private contracting or balance-billing regardless of what Medicare pays. This would be akin to the Australian model for Medicare.

2- "SUPERCOMMITTEE" The Joint Select Committee on Deficit Reduction

Committee came into existence as a result of the **Budget Control Act of 2011 (BCA)** signed into law on Aug. 2 by President Obama.

3- H.R. 1700: Gives right to balance-bill regardless of what Medicare pays. More discussion further down in this paper.

4- PERHAPS there is a way to balance-bill now without penalty. ASK AMA and your STATE and SPECIALTY SOCIETIES TO INVESTIGATE AND REPORT BACK TO YOU as to validity of this approach! If this is allowed and most don't realize it, spread the word. The loss of access to care could be prevented.

Here is a quick summary of this approach:

a- As a physician, do not participate in Medicare.

b- Render care to Medicare patients who agree to pay you directly with full disclosure to patient and sign appropriate forms.

c- Help the patient fill out form from CMS: [CMS 1490S-ENGLISH](https://www.cms.gov/cmsforms/downloads/cms1490s-english.pdf)
<https://www.cms.gov/cmsforms/downloads/cms1490s-english.pdf>

ANOTHER ALERT as you ponder the above 4 items: Remember that the **Independent Payment Advisory Board (IPAB) is part of PPACA** and this 15-person committee has great power to cut Medicare funds and there is no administrative or judicial appeal. See DJP Update 10-17-2011 and DJP Update 10-24-2011 at:

http://intrepidresources.com/djp_update/?p=767

and

http://intrepidresources.com/djp_update/?p=776

BUT also keep in mind that it is my opinion that the individual mandate of PPACA will be declared unconstitutional by the Supreme Court of the United States no later than the beginning of July 2012 by a 5-4 vote as I have explained in a previous DJP Update. **Also, there is a greater than 50% chance the entire law will be declared unconstitutional because of the lack of a severability clause** in the hastily rushed through legislation. We will know this month if the Supreme Court will take the case for review. That will change the landscape of "health system reform".

NOW BACK TO BCA AND SUPERCOMMITTEE

The BCA has 2 ways to reduce deficit.

a- Caps on discretionary spending

b- Supercommittee

The supercommittee has 12 members, half from Senate and half from House, 6 Democrats and 6 Republicans.

The members of the supercommittee are:

- **House**
 - Rep. Dave Camp (R-MI)
 - Rep. Jeb Hensarling (R-TX)
 - Rep. Fred Upton (R-MI)
 - Rep. Xavier Becerra (D-CA)
 - Rep. Jim Clyburn (D-SC)
 - Rep. Chris Van Hollen (D-MD)
- **Senate**
 - Sen. Max Baucus (D-MT)
 - Sen. John Kerry (D-MA)
 - Sen. Patty Murray (D-WA)
 - Sen. Jon Kyl (R-AZ)
 - Sen. Rob Portman (R-OH)
 - Sen. Pat Toomey (R-PA)

Charge of Committee

Develop a plan to reduce the deficit by 1.5 trillion over the next 10 years.

Key Deadlines

November 23, 2011: Joint Committee Vote

December 23, 2011: House and Senate Vote

(If a majority of the committee agrees on a plan, it will be sent to Congress for a yes or no vote)

January 15, 2012: Enactment or Sequestration (-2%)

January 2013: Sequestration Cuts Enacted

The Supercommittee can cut spending (including Social Security and Medicare), raise revenue, or propose a combination of both. If the committee cannot agree on a plan, or Congress fails to approve it, automatic cuts of \$1.2 trillion will be triggered, again through sequestration.

If a plan by the committee does not become law, \$2 trillion in spending cuts will be made, with some programs like **Social Security and Medicaid completely protected**.

A More Detailed Timeline for supercommittee

<http://www.nationaljournal.com/congress/-super-committee-timeline-to-reduce-the-budget-deficit-20110903>

Sept. 8: The committee holds its first organizational meeting; on the agenda will be setting the rules.

Sept. 13: First public hearing, which will include testimony on "The History and Drivers of Our Nation's Debt and Its Threats" from Congressional Budget Office Director Douglas Elmendorf.

Sept. 22: Deadline for Congress to consider a resolution of disapproval for first \$900 billion tranche of debt limit increase.

Oct. 1-Dec. 31: Timeframe in which both houses of Congress must vote on a Balanced Budget Amendment.

Oct. 14: House and Senate committees must submit recommendations to the committee by this date.

Nov. 23: Deadline for the committee to vote on a plan with \$1.5 trillion in deficit reduction.

Dec. 2: Deadline for the committee to submit report and legislative language to the president and Congress.

Dec. 23: Deadline for both houses to vote on the committee bill.

Jan. 15, 2012: Date that the "trigger" leading to \$1.2 trillion of future spending cuts goes into effect, if the committee's legislation has not been enacted.

February 2012: Approximate time when the first \$900 billion of debt ceiling increase runs out.

February/March 2012: During this period, 15 days after the president uses his authority in the bill to increase the debt ceiling a second time, is the deadline for Congress to consider a resolution of disapproval for the second tranche (\$1.2-\$1.5 trillion) of debt limit increase.

Fall/Winter 2012: The additional \$2.1-\$2.4 trillion of borrowing authority from this law runs out.

Jan. 2, 2013: OMB orders sequestrations for defense and non-defense categories of spending necessary to meet spending cuts required by the "trigger."

Sources: *National Journal* [reporting](#) and [Rasky Baerlein](#), a Washington communications firm.

Sequestration is a mechanism through which automatic, across-the-board spending cuts are made.

Sequestration: *"The action of taking legal possession of assets until a debt has been paid or other claims have been met."*

"The action of taking forcible possession of something; confiscation."

(Definition from online dictionaries)

IMPORTANT To REMEMBER

"The supercommittee can consider any budget changes when creating its proposal, including cutting Social Security, Medicare, and Medicaid."

“Both Social Security and Medicaid are entirely protected if the Super Committee fails, while Medicare fees to providers can be cut by up to two percent.”

References for more information about supercommittee:

<http://www.ombwatch.org/node/11816>

See FAQ at that site.

Excellent YouTube video from Texas Medical Association: <http://ow.ly/1zh5LZ>

Here my tweet about their **Calendar of Doom**.



[DJPNEWS](#) Donald Palmisano

[@texmed](#) thx! Great Video re [#CalendarOfDoom](#) - All Drs need to watch; Dr Floyd at 42-49 min a must see. <http://ow.ly/1zh5LZ> [#hcr](#) [#PPACA](#)

[26 Oct](#)

P.S. for those who wonder why I chose supercommitte rather than Super Committee style, that is the designation of the Associated Press Stylebook.

Here is an [@EmilyMiller](#) tweet about it:



[EmilyMiller](#) Emily Miller

Mucho gracias RT [@AaronProof](#): [@EmilyMiller](#) [#APStyle](#) lists it as one word ("**supercommittee**"). No caps :)

[26 Oct](#)

REFLECTIONS

Liberty & Free Enterprise

● What happened to the hallmark of the free enterprise system, the right to privately contract?

● Is not liberty the absence of coercion? Why are physicians kicked out of Medicare for two years if they privately contract with Medicare patients? Why are the

patients punished by not being able to receive any Medicare payment because they agreed to pay the physician more than Medicare allows. They can't even receive the money set by Medicare for that treatment for a "participating physician".

**Broken Promise on Sec. 1801 of original Medicare
[42 U.S.C. 1395]**

Title 42 Chapter 7 Subchapter XVIII § 1395

§ 1395. Prohibition against any Federal interference

Nothing in this subchapter shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person.

Obviously, the government broke that promise. Robert M. Ball, who served as Commissioner of Social Security under Presidents Kennedy, Johnson, and Nixon, later said, "We soon found that this prohibition had to be interpreted narrowly. We did have to interfere, but the provision illustrates where we started."

A Timeline of Changes

Timeline

- **1965.** Medicare is established.
- **1965-1974.** Medicare pays physicians based on the physician's actual charges. Although payments were subject to Medicare carriers' determinations of a "reasonable" charge, there was no set fee schedule or benchmark that limited payment rates.
- **1975.** The Medicare Economic Index is instituted to set a fixed fee schedule, based on 1973 prices. MEI was planned to limit annual fee increases to increases in the costs of producing physician services and increases in general earnings levels.
- **1984-1991.** Annual Congressional action was required to set Medicare physician fee increases, because policymakers were concerned that prices were rising too quickly.
- **1992.** The Resource Based Relative Value Scale (RBRVS) system is instituted. Physician payments were to be updated annually based on the MEI, plus the application of an adjustment factor (the Medicare Volume Performance Standard CMS [MVPS], predecessor of the Sustainable Growth Rate formula) designed to counteract increases in the volume of services being delivered per beneficiary.

- **1998.** The Sustainable Growth Rate (SGR) system replaced the MVPS as the mechanism to ensure Medicare physician spending did not exceed expenditure targets.
- **2002.** Productivity offset changed from being based on labor productivity to multi-factor productivity.

Source: <http://healthcare-economist.com/2011/01/27/history-of-the-medicare-economic-index-mei/>

More about the current SGR.

Medicare Sustainable Growth Rate (SGR)

Section 1848(f) of the Act, as amended by section 4503 of the Balanced Budget Act of 1997 (BBA) (Pub. L. 105-33), enacted on August 5, 1997, replaced the Medicare Volume Performance Standard (MVPS) with a Sustainable Growth Rate (SGR) provision. Section 1848(f)(2) of the Act specifies the formula for establishing yearly SGR targets for physicians' services under Medicare. The use of SGR targets is intended to control the growth in aggregate Medicare expenditures for physicians' services.

Text from CMS. More info at:

<https://www.cms.gov/SustainableGRatesConFact/.../sgr2010p.pdf>

Centers for Medicare & Medicaid Services
Office of the Actuary
N3-26-04
Centers for Medicare & Medicaid Services
Baltimore, MD 21244

SGR obviously is a failure as all price-fixing schemes are. On January 1, 2012 physicians' fees from Medicare will decrease 27.4% instead of previously announced 29.5%.

See my tweet at www.twitter.com/DJPNEWS



[DJPNEWS](#) Donald Palmisano

Gov [#CMS](#) price-fixing re [#Medicare](#) fees for drs will cut fees 27.4% instead of 29.5% 1-1-2012. Access to care will suffer! Loss [#Liberty](#)

But that decrease in physician payment for care rendered will not occur because of the fear of seniors marching on Washington when they can't find a doctor to treat them. Instead, the issue will be kicked down the road for 12-18 months. Most likely, no definitive action to get rid of SGR until AFTER the November 2012 elections.

The problem with advocating for repeal of SGR with a generic message is one set of chains will be substituted for another set containing another scheme of price-fixing such as a modified Medicare Economic Index (MEI)

Government needs to be a good fiduciary and decide what can be paid for entitlement benefits. If government does a new price-fixing formula with a new alphabet soup name, it is essential that liberty be restored with a return to the free enterprise system. That means the government decides what it can afford to pay and then the patient and physician negotiate payment for any difference in the fee and what government pays. Is that original? No! It is the hallmark of the right of private contract that is one of the essential features of what was known as free enterprise in America. Oh, by the way, Australia does it that way. Government decides what it can pay for a treatment, visit, or operation and then the patient and the doctor negotiate the “gap”. Works well there.

There is a bill in Congress that will restore balance-billing in Medicare without penalty. Representative Dr. Tom Price (R-GA) introduced H.R. 1700, the Medicare Patient Empowerment Act. Also, Senator Lisa Murkowski (R-AK) introduced S. 1042, the Medicare Patient Empowerment Act in the Senate. More details at AMA Website regarding H.R. 1700 and S. 1042:

<http://www.ama-assn.org/ama/pub/advocacy/current-topics-advocacy/practice-management/medicare-patient-empowerment-act.page>

NOTE: Balance-billing in Medicare and the right to privately contract has been AMA policy since the 1980s & 1990s. And, pay attention to this policy in 2009

EXCERPT from **policy passed at Annual 2009:**

H-383.991 Right to Privately Contract (complete text at end of the list of policies.)

Our AMA includes in its top advocacy priorities: (1) the enactment of federal legislation that ensures and protects the fundamental right of patients to privately contract with physicians, without penalties for doing so and regardless of payer within the framework of free market principles with the goal of accomplishing this by 2010

1983

H-380.994 Physicians' Freedom to Establish Their Fees

Our AMA (1) affirms that it is a basic right and privilege of each physician to set fees for service that are reasonable and appropriate, while always remaining sensitive to the varying resources of patients and retaining the freedom to choose instances where courtesy or charity could be extended in a dignified and ethical manner; (2) supports the concept that health insurance should be treated like any other insurance (i.e., a contract between a patient and a third party for indemnification for expense or loss incurred by virtue of obtaining medical or other health care services); and (3) believes that the

contract for care and payment is between the physician and patient. (BOT Rep. JJ, I-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: Sub. Res. 704 and Reaffirmation A-01; Reaffirmation A-09)

1990

H-380.989 Patient and Physician Right to Privately Contract for Health Care

It is the policy of the AMA: (1) that any patient, regardless of age or health care insurance coverage, has both the right to privately contract with a physician for wanted or needed health services and to personally pay for those services; (2) to pursue appropriate legislative and legal means to permanently preserve the patient's basic right to privately contract with physicians for wanted or needed health care services; (3) to continue to expeditiously pursue regulatory or legislative changes that will allow physicians to treat Medicare patients outside current regulatory constraints that threaten the physician/patient relationship; and (4) to seek immediately suitable cases to reverse the limitations on patient and physician rights to contract privately that have been imposed by CMS or the private health insurance industry. (Sub. Res. 20, A-90; Reaffirmed: Sub. Res. 132, A-94; Reaffirmation A-97; Reaffirmed: CMS Rep. 7, A-99; Reaffirmation I-99; Reaffirmation I-00; Reaffirmation A-01; Reaffirmation A-02; Reaffirmation A-05)

1993

H-165.916 Government Controlled Medicine

Our AMA strongly reaffirms its unwavering opposition against the encroachment of government in the practice of medicine as well as any attempts to covertly change the American health care system to a government program with the subsequent loss of precious personal freedoms, including the right of physicians and patients to contract privately for health care without government interference. (Res. 141, I-93; Reaffirmed: Sub. Res. 132, A-94; Reaffirmation A-97; Reaffirmation I-00; Reaffirmation A-01; Reaffirmation A-02; Reaffirmation I-07; Reaffirmation A-09)

1993

H-385.961 Medicare Private Contracting

Our AMA will: (1) continue to pursue legal and administrative efforts to permit patients to contract privately with their physicians in appropriate circumstances; and (2) support repeal of the restrictions placed on private contracts between physicians and Medicare beneficiaries to ensure that there is no interference with Medicare beneficiaries freedom to choose a physician to provide covered services and give priority to this goal as a legislative objective. (BOT Rep. OO, A-93; Reaffirmed: Sub. Res. 132, A-94; Appended: Res. 203, I-98; Reaffirmation A-99; Reaffirmation I-99; Reaffirmation I-00; Reaffirmation I-00; Reaffirmation A-01; Reaffirmation A-02; Reaffirmation A-04; Reaffirmation A-08)

2009

H-383.991 Right to Privately Contract

Our AMA includes in its top advocacy priorities: (1) the enactment of federal legislation that ensures and protects the fundamental right of patients to privately contract with physicians, without penalties for doing so and regardless of payer within the framework of free market principles with the goal of accomplishing this by 2010; (2) the restoration of fairness to the current health care marketplace through changes in statutes and regulations so that physicians are able to negotiate (individually and as defined groups) fair contracts with private sector and public sector health plans. (Res. 203, A-09)

MORE ON THE ISSUE OF WHETHER A PHYSICIAN CAN GET OUT OF MEDICARE, BILL PATIENT BY CONTRACT, AND THEN HAVE PATIENT FILL OUT FORM

The issue deals with options for physicians who treat Medicare patients. AMA has a paper on the AMA Website describing the options. See link:

<http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/medicare/medicare-participation-guide.page>

Yet the sample letter entitled: [Sample letter to patients for practices opting out](#) indicates that NO Medicare funds can be paid to the patient who does a private contract with a physician not in Medicare:

"The beneficiary, or his or her legal representative, understands that no payment will be provided by Medicare for items or services furnished by the physician that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted."

However, there is discussion outside of AMA about giving more details about a physician who does not enroll in Medicare and yet the patient can get reimbursement for covered services by filling out form from CMS [CMS 1490S-ENGLISH](#) -- **More information about that option in the 3rd attachment, "doctors not enrolling in Medicare..."**

QUESTIONS to BE ASKED & ANSWERED

First, the question is whether a patient can receive Medicare payment if the patient and the doctor have a private contract and the physician doesn't participate in Medicare.

Second, if it is possible for the patient to receive funds from Medicare for care delivered by a physician not in Medicare, then the AMA sample contract needs to be changed AND it would be helpful to explain that option in the options paper at

AMA Website.

If it can be shown that is a viable option to do the private contracting and the patient still can get some reimbursement from Medicare even without passage of H.R. 1700, it would be helpful to also go into more detail in the AMA paper on the Website. Most doctors believe that if you get out of Medicare, the doctor and the patient are prevented from getting any funds from Medicare for a covered

This right to privately-contract needs to be front and center in all AMA advertising and advocacy if we are to preserve access to care for patients. Why does AMA spend millions on TV ads that show the SGR has to be repealed BUT does not mention the solution of private-contracting, a top priority of AMA?

ATTEMPTS TO SPREAD THE WORD BY DJPNEWS TWEETS ABOUT THE IMPENDING LOSS OF ACCESS TO CARE IF PRICE-FIXING NOT STOPPED. OTHERS RETWEET AND IT IS HOPED THE PUBLIC WILL UNDERSTAND.

FINAL THOUGHT BEFORE OTHER TWEETS:



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Cyrano by Rostand, Hooker transl: What would you have me do? ...Make my knees callous, and cultivate a supple spine,--...grovel... No..!

[28 Oct](#)

EXAMPLES OF SOME OF MY OTHER TWEETS DEALING WITH MEDICARE PAYMENTS AND THE PATIENT-PHYSICIAN RELATIONSHIP.

[AAPSONline](#) AssocAmerPhys&Surg

RT [@DJPNEWS](#): My Op-Ed today in The Detroit News re [#supercommittee](#) & [#Medicare](#) & [#IPAB](#) <http://tinyurl.com/66ovndo> [#hcr](#) [#PPACA](#) [#debt](#) [#Congress](#)

[9 hours ago](#)



[LaMedSoc](#) LSMS

Editorial by LSMS member [@DJPNEWS](#): "Congress Should Take the Lead on **Medicare** Reform"

detnews.com/article/201111...

[9 hours ago](#)



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My Op-Ed today in The Detroit News re [#supercommittee](#) & [#Medicare](#) & [#IPAB](#) tinyurl.com/66ovndo [#hcr](#) [#PPACA](#) [#debt](#) [#Congress](#)

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Gov [#CMS](#) price-fixing re [#Medicare](#) fees for drs will cut fees 27.4% instead of 29.5% 1-1-2012. Access to care will suffer! Loss [#Liberty](#)

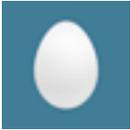
[2 Nov](#)



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Need to advocate **Medicare** Patient Empowerment Act! [#hcr](#) RT [@AmerMedicalAssn](#): [#Medicare](#) ... Physician Payment Formula. [bit.ly/vPO00L](#)

[2 Nov](#)



[sonodoc99](#) Art Fougner

Hello AMA MT [@DJPNEWS](#) Access to care [#Medicare](#) patients at risk; survey re 93,000 Drs [tinyurl.com/3j5w29p](#) [#hcr](#)

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Access to care [#Medicare](#) patients at risk if the price-fixing cuts in payment to Drs take place; survey re 93,000 Drs [tinyurl.com/3j5w29p](#)

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No kidding! Balance-billing [#Medicare](#) - [#Economics](#) & "patient welfare can be lower if balance billing is prohibited." [healthconomicsreview.com/content/1/1/14](#)

[27 Oct](#)



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Attn [#supercommittee](#) : A fix for [#Medicare](#) & hcr [@WSJopinion](#) 3 former presidents [#AMA](#) [tinyurl.com/yb9ge5o](#) [#debt](#) [#Liberty](#)

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D/C price-fixing & allow balance-billing; OR lose access RT [@thehill](#): OVERNIGHT HEALTH: Both parties back **Medicare** cuts bit.ly/sS6h2o

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