

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 213
(A-08)

Introduced by: Georgia Delegation

Subject: Payment Neutrality Between Medicare Advantage and Traditional Fee-for-Service Medicare

Referred to: Reference Committee B
(Craig W. Anderson, MD, Chair)

1 Whereas, The Balanced Budget Act of 1997 (BBA) and the Medicare Prescription Drug,
2 Improvement, and Modernization Act of 2003 (MMA) changed the payment methodologies for
3 Medicare HMO and other Medicare managed care programs (Medicare Advantage Program)
4 resulting in large payment increases; and
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6 Whereas, Private plan participation in Medicare was originally intended as a way to achieve
7 efficiency through care coordination and other innovations in the delivery of care; and
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9 Whereas, As initially designed, Medicare managed care plans were to be paid 95% of projected
10 fee-for-service (FFS) spending for each enrollee; and
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12 Whereas, Over time, this original vision of Medicare Advantage (MA) has been compromised
13 and ultimately undermined by successive payment increases to plans; and
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15 Whereas, Medicare pays far more for each beneficiary who opts for an MA plan than it would if
16 they stayed in FFS; on average, 13% above traditional fee-for-service Medicare costs; and
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18 Whereas, Payment increases have been so large that plans no longer need to be efficient to
19 attract enrollees; and
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21 Whereas, This misalignment in payment, promotes inefficiencies and increases the burden on
22 taxpayers and beneficiaries, who must pay higher Part B premiums, whether they are in
23 managed care plans or not; and
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25 Whereas, Such overpayments contribute to undermining the long-term sustainability of the
26 Medicare program; therefore be it
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28 RESOLVED, That our American Medical Association urge the US Congress and the Centers for
29 Medicare and Medicaid Services to adhere to the principle of financial neutrality--paying the
30 same amount, adjusting for risk, regardless of which Medicare option a beneficiary chooses and
31 setting the basis of payment in Medicare Advantage at 100 percent of fee-for-service Medicare
32 rates. (Directive to Take Action)

Fiscal Note: Implement accordingly at estimated staff cost of \$1,188.

Received: 05/07/08

RELEVANT AMA POLICY

H-330.928 Managed Medicare Reimbursement

The AMA advocates that Medicare managed care plans (eg, Medicare HMOs, Medicare Choice plans, etc.) that use the RBRVS do so in a manner that maintains the relativity of the RBRVS utilized in the traditional Medicare program. (Sub. Res. 819, I-97; Reaffirmation I-05)

H-400.955 Establishing Capitation Rates

(1) Our AMA believes Geographic variations in capitation rates from public programs (e.g., Medicare or Medicaid) should reflect only demonstrable variations in practice costs and correctly validated variations in utilization that reflect legitimate and demonstrable differences in health care need. In particular, areas that have relatively low utilization rates due to cost containment efforts should not be penalized with unrealistically low reimbursement rates. In addition, these payments should be adjusted at the individual level with improved risk adjustors that include demographic factors, health status, and other useful and cost-effective predictors of health care use. (2) Our AMA will work to assure that any current or proposed Medicare or Medicaid (including waivers) capitated payments should be set at levels that would establish and maintain access to quality care. (3) Our AMA seeks modifications as appropriate to the regulations and/or statues affecting Medicare HMOs and other Medicare managed care arrangements to incorporate the revised Patient Protection Act and to ensure equal access to Medicare managed care contracts for physician-sponsored managed care organizations. (4) Our AMA supports development of a Medicare risk payment methodology that would set payment levels that are fair and equitable across geographic regions; in particular, such methodology should allow for equitable payment rates in those localities with relatively low utilization rates due to cost containment efforts. (CMS Rep. 3, A-95; CMS Rep. 7, I-95; Modified and Reaffirmed: Sub. Res. 120, A-97; Reaffirmation A-99; Reaffirmed: CMS Rep. 4, I-99; Reaffirmation A-00; Reaffirmation A-05)