

Statement of the American Academy of Family Physicians
Submitted for the Record

to the

House Energy and Commerce Committee
Subcommittee on Health

Concerning

Medicare Physician Payments: 2007 and Beyond

September 28, 2006

Introduction

Mr. Chairman and members of the committee, I am Dr. Tom Weida, Speaker of the Congress of Delegates of the American Academy of Family Physicians (AAFP). I am pleased to be here to testify on an issue of critical importance to the 94,000 members of the American Academy of Family Physicians and the patients we serve.

The AAFP appreciates the Committee's commitment to avoid the looming 5.1 percent payment reduction for fiscal year 2007 and to put plans in place to replace the current unsustainable payment system. We would like to take the opportunity to discuss the provisions of the legislation.

The AAFP appreciates the work this committee has undertaken to examine how Medicare pays for services physicians deliver to Medicare beneficiaries and we share the subcommittee's concerns that the current system is flawed, outdated and unsustainable. For this reason the AAFP supports the restructuring of Medicare payments to reward quality and care coordination. Such a restructuring must be built on a fundamental reform of the underlying fee-for-service system and a revaluing of the services offered by all physicians providing care.

Most Americans receive the majority of their health care in primary care settings. These are often small or medium size practices. Specifically, about a quarter of all office visits in the U.S. are to family physicians, and Medicare beneficiaries comprise about a quarter of the typical family physician's practice. Finding a more efficient and effective method of paying for physicians' services delivered in such diverse settings to Medicare patients with a large variety of health conditions is a difficult but necessary, and one that has tremendous implications for millions of patients and for the specialty of family medicine. The Academy, therefore, is committed to involvement in the design of a new payment system that meets the needs of patients and physicians.

Current Payment Environment

The environment in which U.S. physicians practice and are paid is challenging at best. Medicare, in particular, has a history of making disproportionately low

payments to family physicians, largely because its payment formula is based on a reimbursement scheme that rewards procedural volume and fails to foster comprehensive, coordinated management of patients. More broadly, the prospect of steep annual cuts in payment resulting from the flawed payment formula is, at best, discouraging. In the current environment, physicians know that, without Congressional action, they will face a 5.1 percent cut in January 2007. Clearly, the Sustainable Growth Rate (SGR) formula does not work.

Under the SGR, physicians face steadily declining payments into the foreseeable future – nearly 40 percent over the next six years-- even while their practice costs continue to increase. According to the government's own calculations, the Medicare payment rate for physician services has for several years not kept pace with the cost of operating a small business which delivers medical care.

Primary Care Physicians in the U.S.

While other developed countries have a better balance of primary care doctors and subspecialists, primary care physicians make up less than one-third of the U.S. physician workforce. Compared to those in other developed countries, Americans spend the highest amount per capita on healthcare but have some of the worst healthcare outcomes. More than 20 years of evidence shows that having a primary care-based health system has both health and economic benefits. Two years ago, a study comparing the health and economic outcomes of the physician workforce in the U.S. reached the same conclusion (*Health Affairs*, April 2004). By not using a system of health care based on primary care physicians coordinating patients' care, the U.S. health care system pays a steep price.

Aligning Incentives

Beyond replacing the outdated and dysfunctional SGR formula, a workable, predictable method of determining physician reimbursement, one that is sensitive to the costs of providing care, should align the incentives to encourage evidence-based practice and foster the delivery of services that are known to be more effective and result in better health outcomes for patients. Moreover, the reformed system must facilitate efficient use of Medicare resources by paying for appropriate utilization of effective services and not paying for services that are unnecessary, redundant or known to be ineffective. Such an approach is endorsed by the Institute of Medicine (IOM) in its 2001 publication *Crossing the Quality Chasm*.

Another IOM report released just last week entitled *Rewarding Provider Performance: Aligning Incentives in Medicare* states that aligning payment incentives with quality improvement goals represents a promising opportunity to encourage higher levels of quality and provide better value for all Americans. The objective of aligning incentives through pay for performance is to create payment incentives that will: (1) encourage the most rapid feasible performance improvement by all providers; (2) support innovation and constructive change

throughout the health care system; and (3) promote better outcomes of care, especially through coordination of care across provider settings and time. The Academy concurs with the IOM recommendations that state:

- Measures should allow for shared accountability and more coordinated care across provider settings.
- P4P programs should reward care that is patient-centered and efficient. And reward providers who improve performance as well as those who achieve high performance.
- Providers should be offered (adequate) incentives to report performance measures.
- Because electronic health information technology will increase the probability of a successful pay-for-performance program, the Secretary should explore ways to assist providers in implementing electronic data collection and reporting to strengthen the use of consistent performance measures.

AAFP concurs with these IOM recommendations.

Aligning the incentives requires collecting and reporting meaningful quality measures. AAFP is supportive of collecting and reporting quality measures and has demonstrated leadership in the physician community in the development of such measures. It is the Academy's belief that measures of quality and efficiency should include a mix of outcome, process and structural measures. Clinical care measures must be evidence-based and physicians should be directly involved in determining the measures used for assessing their performance.

Care Coordination and a Patient-Centered Medical Home

From the outset, the Medicare program has based physician and supplier payment on a fee-for-service system. This example of non-aligned incentives has produced distortions by rewarding individual physicians for ordering tests and performing procedures. The system lacks incentive for physicians to coordinate the tests, procedures, or patient health care generally, including preventive services or care to maintain health. This payment method has resulted in an expensive, fragmented Medicare program.

This out-of-date payment scheme does not adequately compensate physicians who do manage and organize their patients' health care. Currently, there is no direct compensation to physicians for the considerable time and effort associated with coordinating health care in a way that is understandable to patients and cost-effective for the Medicare program.

To correct these inverted incentives, the American Academy of Family Physicians recommends Medicare compensate physicians for care coordination services. Such payment should go to the personal physician chosen by the

patient to perform this role. Any physician practice prepared to provide care coordination could be eligible to serve as a patient's medical home.

In its reports, the Institute of Medicine (IOM) has repeatedly praised the value of, and cited the need for, care coordination. And while there are a number of possible methods to build this into the Medicare program, AAFP recommends a blended model that combines fee-for-service with a per-beneficiary, per-month stipend for care coordination in addition to meaningful incentives for delivery of high-quality and effective services. Patients should be given incentives to select a personal medical home by reduced out-of-pocket expenses such as co-pays and deductibles.

The more efficient payment system should place greater value on cognitive and clinical decision-making skills that result in more efficient use of resources and that result in better health outcomes. For example, the work of Barbara Starfield, Ed Wagner and others has shown that patients, particularly the elderly, who have a usual source of care, are healthier and cost less because they use fewer medical resources than those who do not. The evidence shows that even the uninsured benefit from having a usual source of care (or medical home). These individuals have more physician visits, get more appropriate preventive care and receive more appropriate prescription drugs than those without a usual source of care, and do not get their basic primary health care in a costly emergency room, for example. In contrast, those without this usual source have more problems getting health care and neglect to seek appropriate medical help when they need it. A more efficient payment system would encourage physicians to provide patients with a medical home in which a patient's care is coordinated and expensive duplication of services is eliminated.

A reimbursement system with appropriate incentives for the patient and the physician recognizes the time and effort involved in ongoing care management. The Academy commends the committee for its consideration of incorporating the medical home concept into Medicare physician payment reform and, based on the existing literature, would urge the committee to move beyond a demonstration project to permanent adoption of this model by authorizing the Centers for Medicare and Medicaid Services (CMS) to make the Patient-centered Medical Home a permanent part of Medicare.

The patient-centered, physician-guided medical home being advanced jointly by the American Academy of Family Physicians and the American College of Physicians would include the following elements:

- **Personal physician** - each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

- **Physician directed medical practice** – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.
- **Whole person orientation** – the personal physician is responsible for providing for all the patient’s health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.
- **Care is coordinated and/or integrated** across all domains of the health care system (hospitals, home health agencies, nursing homes, consultants and other components of the complex health care system), facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it.
- **Quality and safety** are hallmarks of the patient-centered medical home:

Evidence-based medicine and clinical decision-support tools guide decision making. Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement. Patients actively participate in decision-making and feedback is sought to ensure patients’ expectations are being met.

Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication.

Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model.

- **Enhanced access** to care through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and office staff.

Payment of the care management fee for the medical home would reflect the value of physician and non-physician staff work that falls outside of the face-to-face visit associated with patient-centered care management, and it would pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources. The per beneficiary, per month stipend should be at least \$15, which reflects an average among chronic disease management programs offered by private payers (AAFP

Task Force on the Future of Family Medicine). Most Medicare beneficiaries have one or more chronic illnesses.

Finally, given the increasing prevalence of pay-for-performance in the public and private sector and the advent of Medicare's Physician Voluntary Reporting Program, the AAFP believes the Medicare physician payment system should include a phased-in performance bonus based for voluntary reporting of quality improvement measures.

Reporting

AAFP is supportive of collecting and reporting quality measures and has led the physician community in the development of meaningful measures. Consistent with the philosophy of aligning incentives, the reward for collecting and reporting data must be commensurate with the effort and processes necessary to comply and must be sufficient to obtain the desired response from providers. The Academy believes that one currently contemplated incentive of a quarter of a percent (0.25 percent) for reporting quality would fall short of covering the actual cost of operationalizing such a mandate and is therefore insufficient incentive for participation.. Moreover, CMS has indicated it does not have processes in place to collect, analyze and determine payment on such data by the first of the year. Thus, we are concerned that mandating the collection and submission of quality measures without the administrative infrastructure to be able to reward such data collection and reporting efforts could be counter productive.

To realize the benefits of such a program, it is critical to provide a sound foundation and to have parameters in place to allow data to be effectively analyzed. In addition, legislation should provide adequate incentives to encourage the maximum number of participants to gather a true sample of the population served by the program.

The AAFP supports efforts to transition to value-based purchasing to improve the quality of patient care. We believe that quality, access and positive health outcomes must be the primary goal of any physician reimbursement system. Prevention, early diagnosis and early treatment will simultaneously improve quality of life and ultimately save valuable health care dollars. But implementing data collection and reporting requires an initial investment from the health care provider in the form of electronic data and decision support systems.

A Chronic Care Model in Medicare

If we do not change the Medicare payment system, the aging population and the rising incidence of chronic disease will overwhelm Medicare's ability to provide health care. Currently, 82 percent of the Medicare population has at least one chronic condition and two-thirds have more than one illness. However, the 20 percent of beneficiaries with five or more chronic conditions account for two-thirds of all Medicare spending.

There is strong evidence the *Chronic Care Model* (Ed Wagner, Robert Wood Johnson Foundation) would improve health care quality and cost-effectiveness, integrate patient care, and increase patient satisfaction. This well-known model is based on the fact that most health care for the chronically ill takes place in primary care settings, such as the offices of family physicians. The model focuses on six components:

- self-management by patients of their disease
- an organized and sophisticated delivery system
- strong support by the sponsoring organization
- evidence-based support for clinical decisions
- information systems; and
- links to community organizations.

This model, with its emphasis on care-coordination, has been tested in some 39 studies and has repeatedly shown its value. While we believe reimbursement should be provided to any physician who agrees to coordinate a patient's care (and serve as a medical home), generally this will be provided by a primary care doctor, such as a family physician. According to the Institute of Medicine, primary care is "the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community." Family physicians are trained specifically to provide exactly this sort of coordinated health care to their patients.

The AAFP advocates for a new Medicare physician payment system that embraces the following:

- Adoption of the Medical Home model which would provide a per month care management fee for physicians whom beneficiaries designate as their Patient-centered Medical Home;
- Continued use of the resource-based relative value scale (RBRVS) using a conversion factor updated annually by the Medicare Economic Index (MEI);
- No geographic adjustment in Medicare allowances except as it relates to identified shortage areas;
- A phased-in voluntary pay-for-reporting, then pay-for-performance system consistent with the IOM recommendations.
 - *Phase 1*: "Pay for reporting" based on structural and system changes in practice (e.g., electronic health records and registries)
 - *Phase 2*: "Pay for reporting" of data on evidence-based performance measures that have been appropriately vetted through mechanisms such as the Physician Consortium for Performance Improvement and the Ambulatory Care Quality Alliance (AQA), without regard to outcomes achieved

- *Phase 3:* Incentive payments to physicians for demonstrated improvements in outcomes and processes, using evidence-based measures; e.g., the AQA starter set.

Value-Based Purchasing – Development of Quality Measures

The AAFP supports moving to value-based purchasing (pay-for-performance) in Medicare if the central purpose is to improve the quality of patient care and clinical outcomes. As we have stated previously in a joint letter to Congress with our colleague organizations American College of Physicians (ACP), American Academy of Pediatrics (AAP) and the American College of Obstetricians and Gynecologists (ACOG), “we believe that the medical profession has a professional and ethical responsibility to engage in activities to continuously improve the quality of care provided to patients... Our organizations accept this challenge.” We have committed to work for the improvement of the practice of family medicine, to strengthen the infrastructure of medical practice to support appropriate value-based purchasing, and to engage in development and validation of performance measures.

While several specific issues remain that must be addressed in implementing pay-for-performance in Medicare, the AAFP has a framework for a phased-in approach for Medicare consistent with IOM recommendations.

First, the development of valid, evidence-based performance measures is imperative for a successful program to improve health quality. The AAFP participates actively in the development of performance measures through the Physician Consortium. We believe multi-specialty collaboration in the development of evidence-based performance measures through the consortium has yielded and will continue to yield valid measures for quality improvement and ultimately pay-for-performance. In addition, these measures should provide consistency across all specialties.

Secondly, the National Quality Forum (NQF) or an NQF-like entity can review and clear valid quality measures developed by the Physician Consortium. With its multi-stakeholder involvement and its explicit consensus process, the NQF provides essential credibility to the measures it approves – measures developed by the Physician Consortium.

Lastly, the Ambulatory Care Quality Alliance (AQA) of which AAFP is a founding organization (along with the ACP, America’s Health Insurance Plans and the Agency for Healthcare Research and Quality) determines which of the measures approved through the NQF consensus process should be implemented initially and which should then be added so that there is a complete set of measures, including those relating to efficiency, sub-specialty performance, and patient experience.

Having a single set of measures that can be reported by a practice to different health plans with which the practice is contracted is critical to reducing the

reporting costs borne by medical practices. Measures that ultimately are utilized in a Medicare pay-for-performance program should follow this path.

Information Technology in the Medical Office Setting

An effective, accurate and administratively operational pay-for-performance program is predicated on the presence of health information technology in the physician's office. Using advances in health information technology (HIT) also aids in reducing errors and allows for ongoing care assessment and quality improvement in the practice setting – two additional goals of recent IOM reports. We have learned from the experience of the Integrated Healthcare Association (IHA) in California that when physicians and practices invested in electronic health records (EHRs) and other electronic tools to automate data reporting, they were both more efficient and more effective, achieving improved quality results at a more rapid pace than those that lacked advanced HIT capacity.

Family physicians are leading the transition to EHR systems in large part due to the efforts of AAFP's Center for Health Information Technology (CHiT). The AAFP created the CHiT in 2003 to increase the availability and use of low-cost, standards-based information technology among family physicians with the goal of improving the quality and safety of medical care and increasing the efficiency of medical practice. Since 2003, the rate of EHR adoption among AAFP members has more than doubled, with over 30 percent of our family physician members now utilizing these systems in their practices.

In an HHS-supported EHR Pilot Project conducted by the AAFP, we learned that practices with a well-defined implementation plan and analysis of workflow and processes had greater success in implementing an EHR. CHiT used this information to develop a practice assessment tool on its Website, allowing physicians to assess their readiness for EHRs.

In any discussion of increasing utilization of an EHR system, there are a number of barriers and cost is a top concern for family physicians. The AAFP has worked aggressively with the vendor community through our Partners for Patients Program to lower the prices of appropriate information technology. The AAFP's Executive Vice President serves on the American Health Information Community (AHIC), which is working to increase confidence in these systems by developing recommendations on interoperability. The AAFP sponsored the development of the Continuity of Care Record (CCR) standard, now successfully balloted through the American Society for Testing and Materials (ASTM). We initiated the Physician EHR Coalition, now jointly chaired by ACP and AAFP, to engage a broad base of medical specialties to advance EHR adoption in small and medium size ambulatory care practices. In preparation for greater adoption of EHR systems, every family medicine residency will implement EHRs by the end of this year.

To accelerate reporting, the AAFP joins the IOM in encouraging federal funding for health care providers to purchase HIT systems. According to the US Department of Health & Human Services, billions of dollars will be saved each

year with the wide-spread adoption of HIT systems. The federal government has already made a financial commitment to this technology; unfortunately, the funding is not directed to the systems that will truly have the most impact and where ultimately all health care is practiced - at the individual patient level. We encourage you to include funding in the form of grants or low interest loans for those physicians committed to integrating an HIT system in their practice.

A Framework for Pay-for-performance

The following is a proposed framework for phasing in a Medicare pay-for-performance program for physicians that is designed to improve the quality and safety of medical care for patients and to increase the efficiency of medical practice.

- *Phase 1*
All physicians would receive a positive update in 2007, based on recommendations of MedPAC, reversing the projected 5.1-percent reduction. Congress should establish a floor for such updates in subsequent years.
- *Phase 2*
Following completion of development of reporting mechanisms and specifications, Medicare would encourage structural and system changes in practice, such as electronic health records and registries, through a “pay for reporting” incentive system such that physicians could improve their capacity to deliver quality care. The update floor would apply to all physicians.
- *Phase 3*
Assuming physicians have the ability to do so, Medicare would encourage reporting of data on evidence-based performance measures that have been appropriately vetted through mechanisms such as the National Quality Forum and the Ambulatory Care Quality Alliance. During this phase, physicians would receive “pay for reporting” incentives; these would be based on the reporting of data, not on the outcomes achieved. The update floor would apply to all physicians.
- *Phase 4*
Contingent on repeal of the SGR formula and development of a long term solution allowing for annual payment updates linked to inflation, Medicare would encourage continuous improvement in the quality of care through incentive payments to physicians for demonstrated improvements in outcomes and processes, using evidence-based measures; e.g., the provision of preventive services, performing HbA1c screening and control for diabetic patients and prescribing aspirin for patients who have experienced a coronary occlusion. The update floor would apply to all physicians.

This type of phased-in approach is crucial for appropriate implementation. While there is general agreement that initial incentives should foster structural and

system improvements in practice, decisions about such structural measures, their reporting, threshold for rewards, etc., remain to be determined. The issues surrounding collection and reporting of data on clinical measures are also complex. For example, do incentives accrue to the individual physician or to the entire practice, regardless of size. In a health care system where patients see multiple physicians, to which physician are improvements attributed.

The program must provide incentives – not punishment – to encourage continuous quality improvement. For example, physicians are being asked to bear the costs of acquiring, using and maintaining health information technology in their offices, with benefits accruing across the health care system – to patients, payers and insurance plans. Appropriate incentives must be explicitly integrated into a Medicare pay-for-performance program if we are to achieve the level of infrastructure at the medical practice to support collection and reporting of data.

Conclusion

The AAFP encourages Congressional action to reform the Medicare physician reimbursement system in the following manner:

- Repeal the Sustainable Growth Rate formula at a date certain and replace it with a stable and predictable annual update based on changes in the costs of providing care as calculated by the Medicare Economic Index.
- Adopt the patient-centered medical home by giving patients incentives to use this model and compensate physicians who provide this function. The physician designated by the beneficiary as the patient-centered medical home shall receive a per-member, per-month stipend in addition to payment under the fee schedule for services delivered.
- Begin to phase in value-based purchasing by starting with a pay-for-reporting program. Compensation for reporting must be sufficient to cover costs associated with the program and provide a sufficient incentive to report the required data.
- Ultimately, payment should be linked to health care quality and efficiency and should reward the most effective patient and physician behavior.

The Academy commends the subcommittee for its commitment to identify a more accurate and contemporary Medicare payment methodology for physician services. Moreover, the AAFP is eager to work with Congress toward the needed system changes that will improve not only the efficiency of the program but also the effectiveness of the services delivered to our nation's elderly.