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# Policy Brief on Physician Payment Innovations and Medical Liability Reform

Submitted to

Senate Finance Committee

In follow up to the July 11, 2012 Physician Roundtable

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[www.aafp.org](http://www.aafp.org)

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## RECOMMENDATIONS

Based on the roundtable discussion, the robust and growing evidence including a wealth of private sector experience, AAFP offers the following scenario as a short and mid-term resolution template for the Senate Finance Committee with respect to physician payment and medical liability reform.

1. Fix the flawed and dysfunctional sustainable growth rate formula and resolve the back debt associated with the SGR;
2. Provide a positive update for the period and institute a differential payment that reimburses primary care physicians at least 2 percent higher than other professionals;
3. Institute a risk-adjusted care management payment using data amassed from private sector, ACA and Medicare experience;
4. Performance enhancement programs (e.g., PQRS) should continue for the short term at the current level; ultimately pay-for-performance programs should be linked to patient management services, population management and reduction in the rate of annual growth of cost of care.
5. Medicaid/Medicare payment parity for primary care physicians delivering primary care services should be made permanent;
6. The Primary Care Incentive Payment (PCIP) should be made permanent.
7. Medical liability reforms should be enacted on the federal level to lower costs related to liability insurance including a limit on payments on "non-economic damages," strict limits on attorneys' fees, a statute of limitations for actions of one to three years after injury, with an absolute limit of six years for minors, and a requirement that expert affidavit that must be provided by a specialist who possesses knowledge and expertise and practices in the same medical specialty as the defendant.

The American Academy of Family Physicians representing over 105,900 members is pleased to provide this follow-up information to the Senate Finance Committee with respect to the topics discussed at the committee roundtable conducted July 11. AAFP President, Glen Stream, MD was honored to participate in the roundtable at which he urged Congress to help rebuild primary care through a variety of payment improvements, like establishing a higher payment rate for primary care fee-for-service, offering primary care physicians a care management fee and adding a quality improvement feature to physician payments. This sustained focus on payment for primary care is designed to create efficiencies and better health. Evidence that primary care provides better care and lowers overall costs is abundant and growing. Citing the Commonwealth Fund finding that the Primary Care Incentive Payment (PCIP), if made permanent, would yield a six-fold return, Dr. Stream urged the committee to incorporate different and better payments to primary care physicians in the replacement for the sustainable growth rate (SGR) formula.

Several other physician organizations participating in the roundtable echoed this support for primary care, and together, we urge the committee to create stability in the physician payment marketplace, provide a positive differential for primary care services and encourage alternative care delivery patterns including the Patient Centered Medical Home (PCMH).

A number of alternative delivery initiatives being undertaken in the private sector illustrate how that optimal care when rewarded can result in higher quality at lower costs.

- Paying primary care physicians an upfront care management fee such as is being done by **Michigan Blue Cross and Blue Shield** makes a considerable difference. The payer reported a reduction of 17 percent in in-patient admissions, a 6 percent decline in the 30-day readmission rate and 4.5 percent decrease in ER visits. Advanced imaging declined by 7 percent.
- **Aetna** ties provider reimbursements to improved population health and reductions in the total cost of care. In doing so, they realized 45 percent fewer acute admits, 50 percent fewer acute days, and 56 percent fewer readmissions in 2011 compared to statewide unmanaged, risk-adjusted Medicare populations.
- In a study involving a large-scale commercial population of 200,000 members, **ActiveHealth** disease management achieved a 2.1 percent decrease in the cost trend in members meeting criteria for disease management interventions and an overall reduction in covered charges of \$3.10 per member per month across the entire population.
- **CareFirst BCBS DC's** PCMH is an innovative program designed to provide primary care providers with new incentives and tools to provide higher quality, lower cost care to plan members. Incentives to PCPs, including an immediate 12 percent increase in their fees as well as additional compensation for the development and monitoring of patient-specific care plans for their sickest patients, reinforce the central role of primary care in helping members manage their health risks as well as guide their care when they experience major illness, especially involving chronic conditions such as coronary artery disease, congestive heart failure, diabetes, COPD, asthma and high blood pressure. Incentive awardees achieved an average 4.2 percent savings against expected 2011 care costs; the cost of care for all CareFirst members attributed to PCMH participants was 1.5 percent lower than had been projected for 2011.
- **WellMed**, a network of practices in San Antonio, developed a highly effective Accountable Care Organization to care for Medicare Advantage patients. In a comparison of their patients with a matched sample of Medicare beneficiaries from Texas, the Robert Graham Center for Policy Studies in Family Medicine and Primary Care (Graham Center) found that WellMed patients in a medical home are 35 percent less likely to be hospitalized and 37 percent less likely to visit an emergency department. There were also significant differences in whether patients received preventive screening and chronic care services including age-appropriate colon cancer screening (53 percent vs. 9.8 percent); annual cholesterol screening for patients with diabetes (77 percent vs. 71.7 percent); and annual cholesterol screening for people with ischemic heart disease (76 percent vs. 63.5 percent).

- **Horizon Blue Cross/Blue Shield of New Jersey** has a patient-centered medical home demonstration that includes 24,000 members. In its first year, it has already shown notable improvement in the quality of care. Specifically, the plan has demonstrated an 8 percent higher rate in diabetes control, a 6 percent higher rate in breast cancer screening and a 6 percent higher rate in cervical cancer screening. Emergency room visits fell by 26 percent; hospital readmissions fell by 25 percent; and hospital in-patient admissions dropped by 21 percent leading to a decline in per-member, per-month cost of care of 10 percent.
- **Blue Cross/Blue Shield of Texas**, in 2011, implemented "Medical Home" pilots with several provider groups in Texas. The patient-centered health care delivery model has noted a 23 percent lower rate of hospital readmissions and savings of approximately \$1.2 million in annual health care costs.
- **Idaho Blue Cross/Blue Shield** reported \$1 million savings in medical claims for its patients in a PCMH. The Idaho Medical Home Collaborative (IMHC) was created by an executive order of Governor Butch Otter on September 3, 2010. The IMHC is a collaboration of public payers, private health insurers, primary care physicians, and many other interested stakeholders to implement the patient-centered medical home model of care in a statewide pilot project. The intent is to transform Idaho's health care system into a higher performing health care model that delivers higher quality, increased efficiency, and lower overall cost. The IMHC's 2-year pilot involves 20 to 30 primary care practices of all sizes and locations and incorporates multiple payers, public and private, as well as multiple primary care providers including pediatrics, internal medicine, and family medicine.
- **Illinois Health Connect:** In 2006, the state of Illinois implemented a primary care case management program (PCCM) called Illinois Health Connect (IHC) with a complementary disease management component called Your Healthcare Plus (YHP) as an effort to reduce Medicaid spending and to move toward a Patient Centered Medical Home (PCMH) model. IHC now covers 70 percent of Illinois Medicaid patients (1.9 million enrollees). The Robert Graham Center for Policy Studies in Family Medicine and Primary Care (RGC) conducted an external evaluation of IHC and YHP to assess its effectiveness in reducing costs and inappropriate utilization, as well as improving outcomes.

The RGC found substantial cost savings (\$1.5 billion) for both IHC and YHP programs, despite the addition of nearly 1 million people to the Medicaid rolls over that period, as well as declines in Medicaid hospitalization rates, bed-days and Medicaid beneficiary ER visits. Quality improved for nearly all metrics under IHC during 2007 – 2010.

A summary of this evaluation is under consideration at *Health Affairs*, in which the RGC concluded that this novel PCMH effort is associated with a bend in the cost curve, a bend with increasing effect in the later implementation years. A better understanding of cost and utilization will provide evidence for how Illinois and other states can best plan and pay for future healthcare delivery services. The IHC program uses a blended payment model (fee-for-service, capitated payments, and quality bonuses) that is common to many PCMH efforts, so the evaluation will also inform medical home demonstrations underway in more than 40 states, most of which have not been fully evaluated.

- **WellPoint, Inc.** recently launched a [major new initiative to increase reimbursement for primary care physicians](#) who keep patients healthier and lower costs. The insurer is investing \$1 billion to increase doctors' fees by about 10 percent and pay them for services that currently aren't covered.

WellPoint has made a major investment in primary care by increasing revenue opportunities for participating primary care physicians, enhancing information sharing, and providing care management support from WellPoint clinical staff. The new program also incorporates best practices from the company's multiple medical home pilots.

WellPoint's patient-centered primary care program builds and expands upon its successful medical home programs that have proven to make a meaningful difference in patient quality, outcomes and cost. Some WellPoint pilots experienced an 18 percent decrease in acute inpatient admissions and a 15 percent decrease in total ER visits while improving compliance with evidence-based treatment and preventative care guidelines.

Primary care physicians participating in this WellPoint program will be able to earn additional revenue through general increase to the regular fees paid to physician practices for specific services; payment for "non-visit" services currently not reimbursed, with an initial focus on compensation for preparing care plans for patients with multiple and complex conditions; and shared saving payments for quality outcomes and reduced medical costs.

The above examples, along with additional outcomes studies, have been published in a new report from the Patient-Centered Primary Care Collaborative (PCPCC) titled: "Benefits of Implementing the Patient Centered Medical Home, 2012" which can be found at: <http://www.pcpcc.net/guide/benefits-implementing-pcmh>

In his testimony before the roundtable, Dr. Stream pointed out that quality measures in primary care, particularly those involving chronic conditions, have a very long timeline for payback. So, the measures are proxies for the right care and the results of that care (outcomes) may not be evident for years. This fact makes the results of the private sector innovations even more impressive in so quickly showing what can be done to improve quality and restrain the total cost of care. In essence, reduction in the total cost of care is the measure by which the private sector is judging the success of these initiatives.

Innovative payment methods for primary care will enable practices to transform how their care is designed and delivered, not only for Medicare patients, but also for non-Medicare patients as well. The higher the percentage of patients enrolled in a PCMH model of care, the higher the likelihood that a physician will be able to transform the entire practice.

Practice transformation leads to increased patient and physician satisfaction with the delivery model, a benefit that ranks nearly as high as income among family physicians. When these indicators are present, the data suggests that interest in primary care as a specialty increases. Thus, through such initiatives, the primary care physician workforce shortage can be addressed.

AAFP supports an approach to SGR reform similar to the bipartisan-sponsored *Medicare Physician Payment Innovation Act* (HR 5707) as a short and mid-range strategy as it provides a modest update in the near term, with decreasing updates in the out years for those not transforming their practices to conform to recognized alternative delivery systems.

With respect to concerns raised by a number of senators during the roundtable about the adequacy of the primary care workforce, another bipartisan bill introduced in the House of Representatives could serve as a model for Senate action. HR 3667 authorizes a pilot project to test innovation in graduate medical education (GME) funding for primary care. Once again, it is the private sector that informs this legislation as it would authorize testing of four existing locally grown models of funding primary care training while simultaneously increasing accountability for GME dollars. The triple aim of the pilot study would be to determine if directing GME funding to these existing models could result in an increase in primary care physicians trained, improved distribution of primary care physicians and primary care physician training contemporary with alternative delivery systems of care.

In addition to the innovations underway in the private sector detailed in our lengthy statement of July 11, we can look to provisions in the *Affordable Care Act* (ACA) that are striving to attain goals similar to the private sector. The Primary Care Incentive Payment (PCIP) is the 10-percent bonus payment to primary care physicians for the primary care services they provide to Medicare patients. This modest payment (we estimate it is an average annual payment to a family physician of about \$3500) sends an important signal not just to family physicians and other primary care providers, but also to medical students who must decide whether to pursue a career in primary care. The Graham Center, in a study for the Macy Foundation, determined that growth in the income gap between primary care and specialty care is the strongest factor in predicting student and resident career choice. In its twentieth annual report the Commission on Graduate Medical Education (COGME) recommended that steps be taken to address the disparity between specialty income and primary care. Currently primary care physicians experience average income in the range of 50-55 percent of specialists. COGME recommended that the primary care physician income should approach at least 70 percent of specialists. The PCIP is a small but crucial part of the remedy to this discrepancy.

The Commonwealth Fund recently published a study that the PCIP, if made permanent, would modestly increase the costs of primary care but save much more in other related health care costs. James Reschovsky, Ph.D., and colleagues, in a study published on March 21, 2012, found that making the primary care bonus permanent would boost the number of primary care visits by 8.8 percent, while also raising the overall cost of primary care visits. But these increases would yield more than a **six fold annual return** in lower Medicare costs for other services—mostly reductions in hospitalizations, outpatient services, and post-acute care—once the full impact on treatment patterns is realized. The net result would be a drop in Medicare costs of nearly 2 percent or \$10 billion in annual savings. (Total Medicare spending in 2009 was \$502 billion. [MedPAC, June 2011].) That these findings are consistent with the experience being reported by the private sector, is significant.

Related to the PCIP, there is a similar feature of the health reform legislation that will be in place only for 2013 and 2014, unless Congress acts to extend it. This is the provision that increases Medicaid payment for primary care and some preventive health services to a rate at least equal to that of Medicare for the same services. Again, this sends a message to medical students that primary care matters for all patients, regardless of their income and health status. The AAFP believes that Congress should extend both payment provisions to assure that they will have the long-lasting effect of encouraging medical students to choose primary care careers; an extremely important and necessary development if we are to have a sufficient primary care workforce to care for the Medicaid expansion envisioned by the ACA.

Numerous respected organizations, institutes and think tanks conclude that primary care physicians' income should be increased, their practices transformed and patients be incentivized to utilize a usual source of care such as the Patient Centered Medical Home. Moreover, these recommendations are being operationalized in the private sector. AAFP urges the committee to craft a remedy for the flawed sustainable growth rate formula that embraces these evidentiary findings and private sector initiatives.

### **Medical Liability**

The AAFP considers medical liability reform one of our highest priorities. We are grateful to Chairman Baucus and Ranking Member Hatch for inviting our suggestions to address with the professional medical liability problem.

Today's medical liability system fails both patients and physicians. It is needlessly subjective and shamefully costly. About half of the medical liability lawsuits filed are frivolous, and only about 5 percent of those injured by medical care actually receive compensation. Excessive damage awards, rising malpractice premiums and defensive medical practices have greatly contributed to increases in health care spending with scant value added. We have long advocated for limits on non-economic damage awards as well as on awards for total damages, damages for dependent care, wrongful death benefits and limited punitive damage awards. In addition, we must limit attorneys' contingency fees and require that awards be reduced by the amount of compensation from collateral sources.

The AAFP has also called for allowing periodic payment of future damages at a defined award limit, replacing joint and several liability with proportionate liability among the defendants in a case, and a reduced statute of limitations for commencing professional liability actions to one to three years after injury, with an absolute limit of six years for minors. It is also important that an expert witness must meet strict criteria and that any expert affidavit must be provided by a specialist with knowledge and expertise and practices in the same medical specialty as the defendant as called for by AAFP policy. Further, we support legislation to redefine medical negligence and liability, including specific designations concerning implied warranty and informed consent.

We recommend that an affidavit from a physician stating the physician's opinion that the claim has merit must accompany the filing of any claim. We also suggest that information concerning collateral sources of income and the tax status of awards be made admissible in evidence and that 60 days advance notice of the intention to sue be required. We affirm a physician's right to recover from plaintiff reasonable legal costs and attorney's fees in successful defense of professional liability suits and support eliminating the *ad damnum* clause in the filing of lawsuits. In addition, we should require that insurance companies provide information regarding economic versus non-economic damages and settled versus verdict cases to state and national regulators. The AAFP has also called for establishing a clear and convincing standard of evidence in medical liability cases in an effort to stabilize the liability premiums.

The AAFP supports incentives for states to establish Alternative Dispute Resolution Systems or health courts and consider increased disciplinary authority of state boards of medical examiners. We have also supported legislation to authorize health to provide a genuine alternative dispute resolution system which might both control costs and expedite proceedings.

Although the medical liability demonstrations announced by the Agency for Healthcare Research and Quality (AHRQ) in June of 2010, were quite modest, we support the effort to find alternatives to the current medical tort system. We must explore alternatives to the current system and find ways to more equitably and quickly compensate those truly injured in the course of medical care without needlessly diverting health care dollars.

We look forward to learning from AHRQ the findings from those demonstrations and continue to call for meaningful medical liability reform to put an end to frivolous lawsuits and to allow for a fair recovery by the negligently injured patient. The AAFP believes these goals can be met in a way compatible with protecting and preserving the rights of an injured patient to a fair resolution.

AAFP reaffirms its pledge to provide cooperation and assistance to the Senate Finance Committee as it pursues meaningful and permanent reform of Medicare physician payment and medical liability.

### **Recommendations**

Based on the foregoing evidence, the ample and expanding literature supporting the cost-effectiveness of primary care, and on the discussions at the Senate Finance Committee Roundtable, AAFP offers the following scenario as a short and mid-term resolution template for the Senate Finance Committee with respect to physician payment and medical liability reform.

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