



AMERICAN ACADEMY OF  
FAMILY PHYSICIANS  
STRONG MEDICINE FOR AMERICA

November 12, 2013

Senator Max Baucus  
Chairman, Committee on Finance  
U.S. Senate  
Washington, DC 20510

Representative Dave Camp  
Chairman, Committee on Ways and Means  
U.S. House of Representatives  
Washington, DC 20515

Senator Orrin Hatch  
Ranking Member  
Committee on Finance  
U.S. Senate  
Washington, DC 20510

Representative Sander Levin  
Ranking Member  
Committee on Ways and Means  
U.S. House of Representatives  
Washington, DC 20515

RE: Discussion Draft on SGR Repeal and Medicare Physician Payment Reform

Dear Senators Baucus and Hatch and Representatives Camp and Levin:

On behalf of the 110,600 family physicians and medical students who are members of the American Academy of Family Physicians (AAFP), thank you for developing your bicameral, bipartisan proposal to repeal the Sustainable Growth Rate (SGR) formula in the Medicare Physician Fee Schedule. We appreciate the significant work and thought that this proposal represents, and we commend you for your outstanding leadership in taking on this formidable challenge.

For more than a decade the AAFP has advocated for the repeal of the Medicare SGR and the implementation of a physician payment formula that was stable, predictable, and supportive of innovations in care delivery. We also have advocated for changes in delivery and payment models that place a greater emphasis on primary care as the foundation of the nation's health care system and provided the necessary resources for physicians and other providers to better coordinate their efforts in collaboration with patients and their care givers. Finally, we have long called for the identification and adjustment of over- and under-valued services in the Medicare physician fee schedule, the alignment of quality improvement programs as a means of eliminating duplication in the health care system, and the importance of ensuring success among solo, small group, and rural physician practices.

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Your proposal, while not perfect, makes significant and demonstrable strides towards achieving the goals outlined above. We believe the policies included in your proposal enable individual family physicians and primary care physician groups to move away from the episodic-based delivery model that has defined American medicine for the past four decades towards new and innovative delivery models that are patient-centric, focused on quality, and more efficient in their function. For these reasons we are pleased to offer our support for your proposal assuming that the legislative language, financing, and overall legislative proposal are consistent with the summaries we have reviewed. Additionally, we are pleased to offer a series of important recommendations on how the proposal can be improved to better achieve our joint goals and assure support from the broader family medicine and primary care physician community.

1. SGR repeal and 10-year period of stability

The AAFP appreciates your leadership in recognizing the importance of repealing the failed SGR formula. Even after repeal, however, updates of zero percent through 2023 will pose significant challenges to family physician practices—especially small and solo practices, which are often in rural and critical-access areas. Although many family physician practices are now recognized as a patient-centered medical home (PCMH), and others are moving aggressively to transform into the medical-home model, many will not be able to move away from the fee-for-service model in the near term, for financial or other reasons beyond their control. For those practices in particular, zero-percent updates over ten years will lead to undue financial strain in the face of rising operating costs, and could severely threaten access for millions of Medicare beneficiaries to primary care.

For these reasons, the AAFP accepts the long-term payment freeze, but only in conjunction with the adoption of other policies that demonstrate Medicare's recognition of the critical value of primary care in the face of a changing demographic profile. First, Congress should establish a separate conversion factor for primary care that is at least two percent higher than that for other services. A dedicated conversion factor for primary care is consistent with recommendations of the Medicare Payment Advisory Commission (MedPAC), which recognize the financial strains unique to family medicine, as well as the Medicare payment gap between primary care and other specialties.<sup>1</sup>

Second, Congress should require a periodic review of how medical practices and their patients are affected by such updates over time. If this review demonstrates a decline in the ability of patients to access primary care physicians or a significant reduction in the viability of primary care practices, the fee-for-service baseline payment rate should be appropriately increased for primary care services.

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<sup>1</sup> MedPAC letter to Committees of Jurisdiction dated Oct. 14, 2011, Recommendation No. 1 (recommending separate primary-care conversion factor that is higher than that for other specialties since "access risks are concentrated in primary care"), *updated* April 10, 2013.

Third, the AAFP asks the Committees to instruct MedPAC to study the need for a new set of dedicated codes for primary care—codes that will more precisely capture the range of complex activities performed by primary-care physicians than the current set of evaluation-and-management codes billed by all physicians regardless of specialty.

Finally, as part of this effort to recognize the value of primary care, Congress should extend both the Medicare Primary Care Incentive Payment (PCIP) program and the enhanced Medicaid payment for primary care beyond their respective expiration dates of December 31, 2015, and December 31, 2014.

## 2. Value-Based Performance (VBP) Payment Program

The AAFP appreciates the proposal to merge three existing Medicare quality improvement activities into one program. We support sunsetting the Physician Quality Reporting System (PQRS), the value-based modifier (VBM) and the Medicare Electronic Health Record (EHR) Incentive Programs at the end of 2016 and including the payment adjustments within these programs in the overall physician payment pool. We also strongly urge Congress to align and simplify the significant administrative demands of these programs, whether administered as one program or as three. One of the most consistent observations that family physicians make about developments in the Medicare program is the seeming inevitability of ever-increasing administrative requirements, which divert physicians and their staff from the delivery of patient care. Additionally, due to the diversity in patient mix, quality improvement programs place a disproportionate burden on primary care practices. Merging these three reporting systems into a single program will be useful only if doing so also supports greater efficiency in physician practices.

With respect to the proposed assessment categories for the VBP Program, the AAFP makes the following observations and recommendations: First, we recommend that the development of all quality measures, regardless of source, be subject to an independent multi-stakeholder evaluation. Second, we urge Congress to direct CMS to allow successful participation in the American Board of Family Medicine (ABFM) maintenance of certification (MOC) as an additional clinical improvement activity category. Finally, given the expertise of the Centers for Medicare and Medicaid Services (CMS) in administering the existing programs, and for purposes of flexibility as experience is gained with the new VBP program, we recommend that Congress not prescribe specific numerical weightings for the four proposed categories of the VBP Program, but instead delegate that decision to CMS.

The AAFP also is concerned that the structure of the new VBP program is budget neutral, if that means that practices are not measured by their results in improving quality and controlling costs against themselves, but rather against the performance of all other physicians. The AAFP will struggle to endorse a system under which a practice that makes significant strides in clinical practices, quality improvement, resource management, and meaningful use of an EHR sees little or no financial

acknowledgment due to similar or greater improvements among peer physicians. After all, investments in practice improvement often come at significant cost and Medicare's goal should be to improve the quality and efficiency of care for patients—not to create a hypercompetitive environment among physicians that will encourage fragmentation and discourage consultation. At a minimum, any comparison of performance among physicians must be carefully adjusted to reflect differences in the complexity of the patient population being treated so that it does not disadvantage physicians caring for patients with multiple chronic conditions or underserved populations who may be at greater risk of poor health and outcomes. And recognizing that practice improvements often give rise to Medicare savings outside of the physician payment pool—for example through fewer visits to hospital emergency rooms, and fewer hospital admissions—the AAFP recommends that Congress expand the scope of budget neutrality to total Medicare program spending and not limit it to just the physician fee schedule of Part B.

In light of the fact that only a quarter of the AAFP's members are in practices recognized as a PCMH, we particularly appreciate the proposal to assist small practices (i.e., those with 10 or fewer eligible professionals) located in a health professional shortage area (HPSA) or rural area improve performance and facilitate participation in an advanced Alternative Payment Model (APM). The process for becoming a PCMH is a resource-intensive effort, and when coupled with the cost of implementing and maintaining an EHR system, can quickly become cost-prohibitive for many practices. Given that many primary-care practices lack the capital reserves to commit to this transformation, technical assistance will be particularly helpful. We suggest, however, that \$50 million over five years is not reasonably calculated to do the job that Congress intends; the AAFP recommends that Congress dedicate at least \$500 million to this effort, and to remove the geographic limitations so that all solo and small practices be made eligible for assistance. We also recommend that these funds be prioritized for primary-care practices. The AAFP recognizes the challenging budget environment in Congress; at the same time, given the magnitude of the cost of repealing the SGR formula and the importance of aggressively moving away from fee for service system, we consider \$500 million to be a necessary and appropriate level of investment.

Finally, certain practices will not be in a position to make such a transition even with additional federal assistance—for example physicians who are in the first few years of practice or those close to retirement. For these and other special circumstances, we support the inclusion of a hardship exemption that would allow certain practices to bypass the VBP program.<sup>2</sup>

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<sup>2</sup> For example, the Medicare Physician Payment Innovation Act of 2013 (H.R. 574, 113th Cong.) provides the Secretary with authority to grant an exemption from negative updates to practices on a case-by-case basis due to hardship caused by “limitations in the nature of a medical practice, limitations in the number of Medicare beneficiaries that may be served by the provider, or other special circumstances.”

### 3. Alternative Payment Model Participation

The AAFP applauds your proposal to encourage practices to adopt alternative payment models that depart from the fee-for-service system. We strongly support the inclusion of the Patient-Centered Medical Home (PCMH) as one of those models. The AAFP is a longstanding advocate for the advancement of the PCMH model, which is an approach to providing comprehensive primary care for children, adolescents, and adults. Critical principles within the PCMH model are access to a personal physician who leads the care team within a medical practice, a whole-person orientation to providing patient care, integrated and coordinated care, and a focus on quality and safety. Through the medical home model, practices seek to improve the quality, effectiveness, and efficiency of the care they deliver, and to ensure that the activities within the practice are focused on meeting patient needs first. The PCMH model seeks to foster a relationship of trust between the care team and the patient, and to actively engage patients as partners in their health care.

According to [Guidelines](#) for PCMH Recognition and Accreditation Program released by the AAFP, American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association, we support relying on existing PCMH standards such as the National Committee for Quality Assurance (NCQA), the Accreditation Association for Ambulatory Health Care, The Joint Commission, or URAC, which are entities that are already formally recognizing primary care practices as PCMHs. We urge Congress to reference the Patient-Centered Primary Care Collaborative [summary](#) of evidence and results from medical home demonstrations taking place within the United States.

The AAFP commends the proposed five-percent bonus payment for the years 2016-2021 if the practice is an APM that involves “two-sided financial risk and a quality measurement component” or if it is a PCMH that has been certified as maintaining or improving quality without increasing costs. The AAFP questions why the proposal would discontinue the 5-percent bonus at the end of 2021, and after another year with 0-percent update in 2022, institute a 2-percent update in 2023. We suggest either continuing the 5-percent bonus for an additional year in 2022, or else incorporating another smoothing mechanism to provide a seamless transition from the 6-year bonus period into 2023.

### 4. Care Management

The AAFP also greatly appreciates the Committees’ recognition of the critical need for Medicare to reward practices for services beyond single face-to-face encounters with the patient. Although CMS is currently devoting resources to establishing payment for complex chronic care management (CCCM) services at the regulatory level in the CY2014 Medicare Physician Fee Schedule, codifying this in statute will send a powerful signal that Congress recognizes the critical role that such care management will play in delivering better care at lower cost—particularly for those patients who consume

disproportionately large amounts of medical care. Ultimately, the AAFP views the CCM code—whether established through regulation or by statute—as a bridge to the adoption of a risk-adjusted per-member per-month care-management fee, as currently provided in the Medicare Comprehensive Primary Care Initiative (CPCI) demonstration.

AAFP appreciates the recognition that only one professional or group practice should receive payment for these services provided to an individual. For purposes of such attribution, the AAFP supports requiring advanced beneficiary consent, since we believe patients receiving care should be encouraged to prospectively select their primary care physician. This attribution process should be sufficiently easy to use that it does not discourage physicians from billing for this service.

Again, given the number of practices who have yet to make the transition to PCMH, but who are still performing critical non-face-to-face services, AAFP also recommends that Congress establish a pathway that would allow physicians who are not in a PCMH-certified practice to demonstrate that they meet the standards to bill and to be paid for these proposed new codes.

#### 5. Accurate Valuation of Services

The AAFP supports the proposal to accelerate the work currently underway to adjust misvalued codes. The establishment of an annual target will effectively incentivize the physician community and payers to speed up the process of determining the accurate valuation of services. This provision directs CMS to set a target of reducing payments by an amount equal to at least one percent of the estimated amount of expenditures under the physician fee schedule. If the target is met, the one-percent savings would be redistributed in a budget-neutral manner within the fee schedule. If that target is not met, then the amount of savings that would otherwise have been achieved will be taken out of the fee schedule.

AAFP agrees that the one-percent target is an appropriate minimum level of targeted savings. AAFP also urges Congress, per MedPAC's recommendation, to establish a disinterested panel of experts to perform the work of identifying, reviewing, and recommending updates to CMS, through a transparent public process that is data-driven and otherwise forensically defensible. If the one-percent target is met, AAFP agrees that the savings should be distributed within the fee schedule. If the target is not met, however, we strongly urge Congress to hold harmless the value of those services that Medicare should be protecting in order to preserve, support and value a strong primary care foundation, namely: evaluation-and-management services, preventive services, and care-management services.

In addition, although AAFP applauds the Committees' move toward a more forensically sound method of updating misvalued codes in the fee schedule, we believe that the proposal to penalize practices 10 percent for failing to submit information is excessively punitive. At a minimum, we urge Congress to exempt small practices of 10 eligible

professionals or fewer from this requirement, to protect them from the administrative burdens that compliance would create.

The AAFP remains ready to assist you in leading Medicare to a payment system based on the value of the health care provided rather than the volume of services delivered. As we move forward in the legislative process, please feel free to contact Andrew Adair ([aadair@aafp.org](mailto:aadair@aafp.org)), with the AAFP's Government Relations staff.

Sincerely,

A handwritten signature in black ink, appearing to be 'J. Cain', with a long horizontal flourish extending to the right.

Jeffrey J. Cain, M.D., FAAFP  
Board Chair