AMERICAN ACADEMY OF
FAMILY PHYSICIANS

STRONG MEDICINE FOR AMERICA

June 20, 2011

The Honorable Joseph R. Biden
The Vice President
The White House
1600 Pennsylvania Avenue
Washington, DC 20500

Dear Mr. Vice President:

As you proceed with the important bipartisan discussions on proposals to address the federal deficit, the American Academy of Family Physicians, representing 100,300 family physicians, residents, and medical students nationwide, has a number of recommendations on how to rebalance our health care system to restrain costs that are adding to the federal deficit.

The AAFP recognizes the need to control the growth of federal spending on Medicare and Medicaid. However, we strongly recommend that proposals to address rising costs in the health care system also should attempt to improve care for our patients including the elderly, disabled and low-income and working families. Entitlement reform could serve as an opportunity to reduce spending on overpriced treatments and procedures. It also could be a way to assure patients of the primary care that will help reduce their need for such treatments.

In the fee-for-service payment model that dominates our health care system, doctors and hospitals are paid more for doing more. There is little incentive in the current model to coordinate care or to manage chronic disease. We urge you to recommend reforming physician payment to alter these incentives to pay for better care, rather than just more care.

If any budget proposal is to restrain the growth in health care spending successfully, it must also support programs that build the family physician and primary care workforce, pay for quality and outcomes of medical care and ensure everyone has access to that care. Specifically, we urge you to recommend a Medicare fee schedule that would support a rate for primary care services delivered by primary care physicians that is at least 3 percent higher than payment for non-primary care.

In addition, the AAFP urges you to recommend an increase to 20 percent for the Medicare Primary Care Incentive Payment included in the *Affordable Care Act* (ACA). This important provision recognizes the value that primary care brings to the health care system with an incentive for qualified primary care physicians who are delivering primary care services.

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Medicare Payment Formula Flaws and Recommendation
As the Medicare Payment Advisory Commission (MedPAC) recommended in its June 2011 report:

> … in exchange for eliminating the future fee cuts, new policies that improve and stabilize the fee schedule, restrain cost growth, and promote primary care and better coordination across sectors could be implemented. Such policies could create incentives for high-quality, patient-centric care that would replace current incentives to increase volume and thus could significantly change the status quo.

The AAFP believes that you should report such recommendations to Congress as part of the comprehensive effort to address the federal deficit and the forces that helped create it.

The AAFP agrees with the observation made by MedPAC in this recent report regarding the current payment system. According to this report,

> Medicare's payment system for physician and other health professional services is flawed in many ways: It continues to call for unrealistically steep fee cuts, it inherently rewards volume over quality and efficiency, and it favors procedural services over primary care, which has serious implications for the nation's future primary care workforce.

Because many public and private payment systems are pegged to Medicare rates, the decisions made by the Centers for Medicare and Medicaid Services (CMS) for payment of services have broad applicability to the payment system. And as MedPAC makes clear, the evidence is compelling that health care delivery built on general access to primary care improves quality and restrains costs.

Consequently, the AAFP advocates for payment reforms that ultimately include a blended payment for primary care delivered within the context of a Patient Centered Medical Home (PCMH). This blended payment consists of:

- fee-for-service for discrete services provided to patients, with a higher payment rate for primary care physicians providing primary care services
- a care management fee for the more global care management and coordination provided to patients, often non-face-to-face, in a patient-centered medical home
- pay-for-performance that rewards efforts to improve health care and that recognizes demonstrated value to the patient.

As an important first step, we must have long-term relief for physicians from devastating reductions in payments resulting from the Medicare Sustainable Growth Rate (SGR) formula.
Unless Congress acts again to override it, the SGR formula used to calculate annual updates will mean a 29.5 percent cut in Medicare payments to physicians and other health care professionals beginning on January 1, 2012. The threat of these drastic payment cuts creates an unstable program for doctors and patients. We urge you to recommend a five-year Medicare schedule that narrows the payment differential between primary care and other physicians in order to provide a degree of this much needed stability.

Restraining Health Care Costs with Primary Care
The evidence that primary care restrains health care costs and improves quality is very clear when that care is delivered in a team-based Patient Centered Medical Home (PCMH). Findings from the Dartmouth Health Atlas Data demonstrate good correlations between having more primary care, particularly family medicine, and having lower Medicare costs and reduced "ambulatory care sensitive" hospitalizations—i.e., hospitalizations that might be avoided by patients with access to primary care. There also is growing evidence that experiments with PCMH and Accountable Care Organizations (ACO)—particularly those that emphasize access to more robust primary care teams—can reduce total costs by 7-10 percent, largely by reducing avoidable hospitalizations and emergency room visits.

Primary care is just 6-7 percent of total Medicare spending, so patient-centered medical home experiments are recouping the entire costs of care in those settings, not just the added investments. These findings hold true in integrated systems like Geisinger, insurance experiments like Blue Cross Blue Shield of South Carolina, or individual system efforts like Johns Hopkins. The key factor in all of these examples is increased investments in the primary care setting.

Based on these early results, we believe primary care will achieve cost restraints that will more than offset the cost of the investment. As a result, the federal government should increase primary care payments so that they represent 10-12 percent of total health care spending, particularly if done in ways that improve access to a broader array of services. An evaluation of a primary care-based ACO by the Robert Graham Center for Policy Studies in Family Medicine and Primary Care (a division of the AAFP) is showing that, over the longer term, these investments could offset inpatient costs by 50 percent or more.

In addition, the Medicare Payment Advisory Commission (MedPAC) has long argued that Medicare's payment system undervalues cognitive health care services like primary care and overvalues medical procedures and technology. We agree. There are many reasons for this, but we think that there is an accepted bias in the system that favors procedures. We also believe this bias makes it difficult to take into account the often declining amount of time and work involved in medical procedures, as physicians become more experienced with them and the associated technology improves. This acceptance leads to overvaluing procedures and undervaluing cognitive services. This imbalance needs to be corrected if health care delivery is going to fulfill the promise of better and more efficient health care.

While AAFP and other primary care physician organizations are strongly committed to the PCMH model, we do not discount other potential payment reforms. However, the evidence shows that to achieve the savings that Congress is looking for, and to improve the quality of health care delivered to millions of patients in the country, reform must include investment in primary care physicians.

Patient Centered Medical Home and Blended Payment

It is commonly understood that fee-for-service alone encourages utilization, does not check avoidable duplication of services, wastes resources and leads to inefficiency and unnecessary costs. Consequently, we believe reforming the Medicare physician payment system with just a different fee-for-service formula will not accomplish the Congressional goals of restraining health care cost increases and improving the quality of health care. The payment system should actively encourage care management and preventive health and reward quality improvement. To do all of that, we have come to believe that payment reform, at least for primary care delivered by a PCMH team, requires the blended payment we described previously:

Over time, the percent of the blended payment attributable to fee-for-service payments should decline, reducing dependence on a system that encourages volume. The blended payment system for medical home teams should facilitate the transformation of practices, so that all of the team's participants perform their own unique tasks in a coordinated way. This means extensive investments not just in health information technology, but also in interoperable systems, and not just with hospitals and other health care centers, but also with community services.

Transition to a New Payment Model

Payment reform should foster this transformation, but it will take time. As stated above, we recommend five years of mandated updates to the physician fee schedule that include the higher payment rate (of at least 3 percent) for primary care physicians (i.e., those who practice family medicine, general internal medicine, geriatric medicine or general pediatric medicine) who deliver primary care and preventive health services. For this transition, Congress should increase the Primary Care Incentive Payment from 10 percent to 20 percent and should continue federal support for the Medicaid requirement that payments to primary care physicians for primary care and preventive health services be at least equal to Medicare's payments.

The goal would be to use this period to implement care management fees and pay-for-performance for primary care physician practices that have become a PCMH. This will provide an opportunity to examine what works and to adopt best practices in a blended payment model. There must be a specific termination date for the mandated payment schedule at the end of this period of stability. With a fixed termination, the mandate to analyze and implement the best alternative will be clear and fee-for-service should be a much less significant portion of physician payment.

Narrowing the Payment Differential

The Council on Graduate Medical Education (COGME) called for improving the payment of practicing primary care physicians to achieve the desired ratio of primary care to subspecialty care. In December 2010, COGME recommended that the average incomes of primary care physicians "must achieve at least 70 percent of median incomes of all other physicians" (currently it is about 55 percent) and suggested that payment policies be modified so that qualified medical students will be able to afford to train as primary care physicians.

FY 2012 Appropriations – Funding for Primary Care

Achieving federal budget savings by rebalancing the ratio of primary care to subspecialists in the physician workforce (currently only about 30 percent of the physician work force is primary care) will require a continued investment to strengthen our nation's primary care workforce.

The AAFP recommends a strong commitment to programs administered by the Health Resources and Services Administration, Agency for Healthcare Research and Quality and others that are essential to training our physician workforce, recruiting physicians to practice in underserved areas and supporting them with research into evidence-based medical practice. In particular, the AAFP supports federal programs to improve the health of our patients, families and communities by promoting primary care medicine training programs (*Public Health Service Act* Title VII, Section 747) and the National Health Service Corps (NHSC), which fosters innovations that improve quality and support efforts to provide health care access to underserved Americans.

***Affordable Care Act* (ACA)**

The AAFP supports a number of critical investments made by the ACA. Specifically, we urge you to protect the funds to establish the Center for Medicare and Medicaid Innovation to test and evaluate payment and service delivery models to reduce expenditures under Medicare, Medicaid and CHIP, while preserving or enhancing the quality of that care. We recommend that the CMS Innovation Center coordinate the various health care delivery testing programs to ensure comparability and thoroughness of the data. The physician community believes strongly in the value of evidence, and it is the responsibility of the Innovation Center to provide credible, reliable and usable evidence for health system delivery reform.

In addition, the AAFP supports the funds set aside by the ACA to support the vital work of health workforce training and placement, disease prevention, and Patient-Centered Outcomes Research. In particular, we support the Prevention and Public Health Fund, which has been used to support primary care medicine training programs. The innovative Teaching Health Centers program also funded by the ACA is helping to increase primary care physician training capacity. Teaching Health Centers will train primary care residents in non-hospital settings where most care is delivered.

The Community Health Center Fund, authorized by the ACA, provides resources for the National Health Services Corps, which has long served to provide access to health care to underserved Americans. NHSC also provides important student debt relief to attract new physicians into primary care specialties.

The Patient-Centered Outcomes Research Trust Fund authorized by the ACA is needed to improve the quality, safety, efficiency and effectiveness of health care for all Americans. The work of the new Patient-Centered Outcomes Research Institute is needed to support clinical decision-making, reduce costs, advance patient safety, decrease medical errors and improve health care quality and access. The AAFP strongly supports high quality

comparativeness effectiveness research. If we wish to improve patient care and control costs in this country, this type of research is crucial. It is only with it that we can provide evidence-based information to patients and physicians for use in making health care decisions.

Medical Liability Reform

According to the Congressional Budget Office (CBO), medical liability reform could lower costs for health care both directly and indirectly: by lowering premiums for medical liability insurance and by reducing the use of diagnostic tests and other health care services recommended principally to reduce the potential exposure to lawsuits. CBO estimates that enacting the *Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2011* (HR 5) would reduce deficits by almost $14 billion over the 2011-2016 period and by about $57 billion over the 2012-2021 period. We support reducing liability insurance premiums and the costs of defensive medicine by enacting key provisions modeled on California's highly effective *Medical Injury Compensation Reform Act of 1975*, known as "MICRA."

The current medical liability system fails both patients and health care providers. Liability reform must more equitably and quickly compensate those truly injured in the course of medical care without needlessly diverting health care dollars. By reducing liability insurance premiums and exorbitant legal fees associated with litigation and by ending the need to practice defensive medicine, we can decrease the cost of health care.

Student Interest Deferral

The AAFP is concerned that any proposal to end the in-school interest subsidy on Federal Stafford loans for graduate and professional students will greatly increase the medical student debt burden and urge you to oppose this effort. Increasing medical student debt not only harms individuals with these loans; it also threatens patient care. Medical students with high debt burdens are less likely to pursue primary care specialties, exacerbating the primary care workforce shortage. This increased financial burden may even prevent students from low-income or minority backgrounds from attending medical school, reducing the diversity of the physician workforce.

Conclusion

Family physicians share your commitment to restoring the economic prosperity of this nation by addressing the growing federal deficit. We urge you to recommend including sound and appropriate investments in the primary care infrastructure outlined above that support more efficient health care for all and thus help tackle the long-term debt of the federal government. The AAFP and family physicians across the country remain ready to help you in this critical responsibility. If we can provide further assistance, please contact the AAFP Director of Government Relations, Kevin Burke, at kburke@aafp.org.

Thank you for your sustained commitment to improving the fiscal condition of our nation.

Sincerely,

Lori Heim

Lori Heim, MD, FAAFP
Chair, Board of Directors