



STATEMENT
of the
American Academy
of Family Physicians

To the

House Ways and Means Subcommittee on Health

Concerning

Patient-Centered Medical Home:

An Essential Option to Improve Quality and Efficiency

in the Medicare Program

Presented by:

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President

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Chairman Stark, and members of the subcommittee, I am Dr. Rick Kellerman of Wichita, Kansas, and I am president of the American Academy of Family Physicians representing 93,800 members nationwide. On behalf of the Academy, thank you for this opportunity to share with the subcommittee the proposals that AAFP believes to be important elements of physician payment reform under Medicare.

The AAFP appreciates the work this subcommittee 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Medicare beneficiaries and we share the subcommittee's concerns that the current system is inefficient, inaccurate and outdated. Finding a more efficient and effective method of reimbursing physicians for services delivered to Medicare beneficiaries with a large variety of health conditions is a necessary but difficult endeavor, and one that has tremendous implications for millions of patients and for the Medicare program itself.

We particularly appreciate your asking us to discuss what we are calling the Patient-Centered Medical Home as a component of a Medicare program that offers better health care more efficiently. Family physicians believe that the restructuring of Medicare payment should be done with the needs of Medicare patients foremost in mind. Since most of these patients have two or more chronic conditions that call for continuous management and that depend on differing pharmaceutical treatments, Medicare should focus on how physicians integrate the health care these patients receive from different providers and settings, with the goal of preventing duplicative tests and procedures and assuring the availability to each provider of the most accurate and complete information regarding each patient. We do not believe that the Patient Centered Medical Home is business as usual, but rather a significant step toward added value for the patient, for the complex array of health care providers and for the Medicare program.

Current Payment Environment

The environment in which U.S. physicians practice and are paid is challenging at best. Medicare 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. This formula has produced payment rates that have declined, except for Congressional intervention, by 5-7 percent annually for the last five years. As a result, the Medicare payment rate for physicians has fallen to the 2001 level. These steep annual cuts resulting from the flawed payment formula serve to undermine confidence in the Medicare program. In this current environment, physicians know that, without annual Congressional action, they will face a 10-percent cut in the Medicare payment rate for 2008 and cuts in the 5-percent range annually thereafter. Clearly, the

Sustainable Growth Rate (SGR) formula belies its name and simply is not sustainable.

Primary Care Physicians in the U.S.

This persistent payment imbalance has led to a decline in the numbers of graduates from US medical schools choosing primary care medicine. As a result, 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.

However, more than 20 years of evidence shows that having a health care system based on primary care benefits the economy and the patients' health. Three years ago, a study comparing the health and economic outcomes of the physician workforce in the U.S. reached this conclusion (*Health Affairs*, April 2004). By using a system of health care that is not predicated on primary care physicians coordinating patients' care, the U.S. health care system pays a steep economic price and our Medicare beneficiaries pay a steeper one in terms of their quality of life.

The businesses that purchase health insurance for their employees are recognizing the value of a health care system based on primary care. For example, Martin-Jose Sepúlveda, MD, who is the Vice President for Global Well-being Services and Health Benefits for IMB, Corp., recently wrote "Why should major companies support patient-centered primary care? Because research shows that patient-centered primary care results in better health care, lower costs, greater satisfaction with the health-care system and more equal access to health care for all citizens."

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.

Care Coordination and a Patient-Centered Medical Home

From the outset, the Medicare program has based physician payment on a fee-for-service system. As a result, Medicare currently is a system of misaligned incentives which rewards individual physicians for ordering more tests and performing more procedures. The system provides no incentive for physicians to coordinate the tests, procedures, or patient health care generally and it puts very little emphasis on preventive services and health maintenance. This payment method has produced an expensive, fragmented Medicare program.

To correct these inverted incentives, the AAFP recommends that beginning in 2008, Medicare compensate physicians for care coordination services. The Institute of Medicine (IOM) has repeatedly praised the value of, and cited the need for, care coordination as has the Medicare Payment Advisory Commission (MedPAC). 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 in the Patient-Centered Medical Home.

The patient-centered, physician-guided medical home is being advanced jointly by the AAAP, the American Academy of Pediatrics (AAP), the American College of Physicians (ACP) and the American Osteopathic Association (AOA). This model 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 providers and settings of the health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services) 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 in a culturally and linguistically appropriate manner.
- **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. To this end, the AAAP, AAP, ACP and AOA are in discussions

with the National Committee for Quality Assurance (NCQA) on creating such a recognition program for the Patient-Centered Medical Home.

- **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.

A reimbursement system with appropriate incentives for the patient and the physician recognizes the time and effort involved in ongoing care management. The AAFP commends the Congress for incorporating the medical home demonstration into the Medicare physician payment provisions of the *Tax Reform and Health Act*. However, the statutory composition of the provision including the requirement of the development of a procedural code and establishing a value for same, will unduly delay the implementation of the medical home. Code development and valuation alone can take two plus years. Thus the results from a three-year demonstration will not be available until well beyond 2011. Because of the strength of the existing literature describing the effectiveness (both health and economic) of the medical home, AAFP would urge the committee to authorize the Centers for Medicare and Medicaid Services (CMS) to adopt the Patient-centered Medical Home as an interim component of physician payment while awaiting the implementation of and results from the demonstration project.

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.

Patient-Centered Medical Home: A Gateway, not a "Gatekeeper"

It is important to note that the patient-centered Medical Home differs from the so-called "gatekeeper" model employed in the '80s and '90s. The PC-MH model expands access rather than decreases it as a capitated gatekeeper model could. The PC-MH model does not interfere with patient choice or patient self-referral but it offers appropriate incentives for physicians and patients to use resources more appropriately. The Academy believes this is what patients want and need and the mechanism that can improve quality of care and quality of life for beneficiaries and increase cost-effectiveness for the Medicare program.

In fact, patients and payers alike want a medical "network administrator" for their employees, beneficiaries and patients. AAFP, AAP, ACP and AOA have also conferred with major employers, like IBM, in determining what these employers envision as an appropriate medical home for their employees. The primary care physician organizations have been working with IBM in Austin, Texas, to create a demonstration project for their employees that will examine the characteristics of a successful patient-centered medical home. And AAFP, ACP, AOA and the National Association of Community Health Centers have joined with the ERISA

Industry Committee, the National Business Group on Health and several major employers to form the Patient Centered Primary Care Collaborative to advance the medical home as a way to improve the health care system generally.

The Cost-Effectiveness of the Medical Home

We understand the very difficult budget constraints that Congress faces as you try to determine how to improve Medicare. The restructuring of payment that we are suggesting will include an additional investment in the short term. But there is ample evidence already that the potential savings are large and near-term. Community Care of North Carolina (CCNC) is a state-wide health care delivery program developed by Allan Dobson, MD, Assistant Secretary for the North Carolina Department of Health and Human Services. The program provides a primary care medical home for all the Medicaid recipients in the state. It joins health care providers, like hospitals and nursing homes, and necessary social service providers, like substance abuse and mental health services, with the local physicians. The system pays the physician practice an additional per-patient, per-month fee to coordinate the care of the Medicaid patients, while also paying a regional network administrator, who makes sure the necessary technical and ancillary services (like transportation, health education counselors and trained translators) are available within the region.

The state legislature has received a report from an independent audit by Mercer that showed from July 1, 2003 to June 30, 2004 the state spent \$10.2 million on the CCNC program, but saved \$124 million compared to the previous fiscal year and \$225 million if the same population was served by the fee-for-service only system. The conclusion is that for every Medicaid dollar spent on the medical home in North Carolina, the state is saving \$8. We realize that the Congressional Budget Office is reluctant to include savings in how it calculates the cost of a program, but a realistic view of what Medicare patients need shows that a medical home will provide them their health care at less cost to them and to the system. Somehow, CBO should take that into account.

Information Technology in the Medical Office Setting

An effective system emphasizing coordinated care is predicated on the presence of health information technology, i.e., the electronic health record (EHR) 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 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 Web site, 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 care coordination, 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. While the federal government has already made a financial commitment to this technology, the funding, unfortunately, 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, low interest loans or tax credits for those physicians committed to integrating an HIT system in their practice.

Aligning Incentives

In replacing the outdated and dysfunctional SGR formula, Congress should look to a method of determining physician reimbursement that is sensitive to the costs of providing care, creates a stable and predictable economic environment, and aligns 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. Just as importantly, the reformed system should 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 IOM in its 2001 publication *Crossing the Quality Chasm*.

Another IOM report released in autumn of 2006 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 rapidly 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 they should 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.

Aligning the incentives requires collecting and reporting data through the use of 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.

Quality 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 is skeptical that the incentive of 1.5 percent of a physician's covered charges for collecting and reporting quality measurement data will be sufficient to cover the actual cost of operationalizing such a program. However, we are

generally and conceptually supportive of the policy and will monitor its implementation closely.

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 2008, consistent with recommendations of MedPAC. Congress should establish a floor for such updates in subsequent years.
- *Phase 2*
Following the implementation of the Physician Quality Reporting Initiative, 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*
Pay-for-reporting transitions to pay-for performance and particular effort is made to ensure that the quality bonus is sufficient to cover the costs of administration as well as providing sufficient incentive to participate. Medicare continues to 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. 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.

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, patient registries, threshold for rewards, etc., remain to be determined.

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

It is time to stabilize and modernize Medicare by recognizing the importance of, and appropriately valuing, primary care and by embracing the patient-centered medical home model as an integral part of the Medicare program.

Specifically, 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.
- Phase in value-based purchasing by starting with the Physician Quality Reporting Initiative. Analyze compensation for reporting and ensure that it is 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.