



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 Payment
Building A Contemporary Payment System

July 27, 2006

AAFP Headquarters
11400 Tomahawk Creek Parkway
Leawood, KS 66211-2672
(800) 274-2237 • (913) 906-6000
Email: fp@aafp.org



AAFP Washington Office
2021 Massachusetts Avenue, N.W.
Washington, DC 20036-1011
(202) 232-9033 Fax (202) 232-9044
Email: capitol@aafp.org

Introduction

This statement is submitted on behalf of the 94,000 members of the American Academy of Family Physicians to the House Energy and Commerce Subcommittee on Health as part of its hearings on Medicare Physician Payment held Thursday, July 27, 2006. 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. 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 people in this country receive the majority of their health care from physicians in small or medium size practices and in ambulatory care settings. 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 beneficiaries with a large variety of health conditions is a necessary and difficult endeavor, 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 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 it is based on a reimbursement scheme that is designed to reward procedural volume and to discourage comprehensive, coordinated management of patients. More broadly, the prospect of annual cuts in payment resulting from the flawed payment formula, as described in MedPAC's testimony, is discouraging. In the current environment, physicians know they will face a 4.7 percent cut in January 2007, and without Congressional action to repeal the Sustainable Growth Rate (SGR) formula and create a structure for reliable financing, they face steadily declining payments into the foreseeable future, 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.

SGR Must Be Scrapped

The current Medicare payment system for physicians does not work. The SGR formula must be repealed and replaced with a stable and predictable annual

update based on changes in the costs of providing care as calculated by the Medicare Economic Index (MEI), which is an analysis of an accurate market basket and a reflection of inflation within the health care sector. Such payments should be linked to health care quality and efficiency and should reward the patient and physician behavior that provides the best results.

Aligning Incentives

Measures of quality and efficiency should include a mix of outcome, process and structural measures. Clinical care measures must be evidence-based. Physicians should be directly involved in determining the measures used for assessing their performance.

A new system, sensitive to the costs of providing care, must align 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*.

Care Coordination and a Patient-Centered Medical Home

When the Medicare program was established, provider payment was based solely on a fee-for-service system. This produced distortions by rewarding individual physicians for ordering tests and performing procedures. There was no 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.

Due to this out-of-date payment scheme, Medicare does not adequately compensate physicians who do manage and organize their patient's health care. Currently, there is no direct compensation to physicians for the considerable time and effort to coordinate health care in a way patients understand and is cost-effective for the Medicare program.

The current payment approach exacerbates problems within the present health care system, which is both extremely costly and includes increasingly greater numbers of chronically ill people who need coordinated care.

To correct these inverted incentives, the American Academy of Family Physicians recommends Medicare also adequately pay physicians for care coordination services. Such payment should go to the personal physician chosen by the patient to perform this role. While there are a number of compensation methods possible to pay for this care coordination, one recommended is a blended model that combines fee-for-service with a per-

beneficiary, per-month stipend for care coordination and meaningful incentives for delivery of high-quality and effective services.

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 chronic care model, with its emphasis on care-coordination, has been tested in more than 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.

Lessons from Abroad

By not using a system of health care based on primary care physicians coordinating patients' care, the U.S. Medicare system pays a steep price. 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 US 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. Most recently, a study comparing the health and economic outcomes of

the physician workforce in US states reached the same conclusion (*Health Affairs*, April 2004).

Primary Care Physicians in the U.S.

Most Americans receive the majority of their health care in primary care settings. According to the 2001 update of "The Ecology of Medical Care," more than 12 times as many people are seen in primary care physicians' offices in the US than in hospitals (The Robert Graham Center for Policy Studies in Family Practice and Primary Care, July 2001).

Primary care physicians also see the most patients. Despite making up less than one-third of the physician workforce, primary care doctors care for more people than subspecialists, and take care of those who never see another provider (National Ambulatory Medical Care Surveys, 1980-1999 and Medical Expenditure Panel Survey, 2000). While data show that people with chronic conditions see more subspecialists, they also increase their time spent with a primary care physician (Medicare Standard Analytic File, 1999).

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 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 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.

Value-Based Purchasing

The AAFP supports moving to value-based purchasing (or 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.

The AAFP is involved in several efforts that are fundamental to moving toward a pay-for-performance system.

First of all, we know 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 for Performance Improvement. 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.

The AAFP was the first medical specialty society to join the National Quality Forum (NQF). And along with ACP, America's Health Insurance Plans (AHIP) and the Agency for Healthcare Research and Quality (AHRQ), the AAFP is a founding organization of the Ambulatory Care Quality Alliance (AQA). However, it is important to distinguish between the role of the NQF and that of AQA. 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, NCQA and others. The AQA's purpose is to determine which of the measures approved through the NQF consensus process should be implemented initially (the starter set), 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 also aids in reducing errors and allows for ongoing care assessment and quality improvement in the practice setting – two additional goals of the recent IOM report. 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 physicians 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 price point. 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 2006.

Both House committees of jurisdiction have successfully passed legislation that would begin to develop a federal HIT infrastructure. In order to accerlerate reporting, the AAFP encourages 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 4.7-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 sort 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, payors 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 formula known as the Sustainable Growth Rate formula 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, encourage and pay for care coordination for Medicare beneficiaries. The physician designated as the patient's medical home shall receive a per-member, per-month stipend in addition to fee-for-service.
- Ensure pay-for-performance programs occur in the context of positive annual updates; that they reward physicians for reporting the "starter set" of performance measures developed by the Ambulatory care Quality Alliance; and that such programs do not force physicians to compete for limited withholds.
- Pay-for-performance incentives should be based on process, structure and outcomes measures.
- 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 initiative in attempting to identify a more efficient Medicare payment methodology for the physician services. Moreover, the AAFP is eager to work with the committee toward the needed system improvements that will improve not only the efficiency of the program but also the effectiveness of the services delivered to our nation's elderly.