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Concerning

Medicare Physician Payment

How to Build a More Efficient Payment System

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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 hearing on Medicare Physician Payment. The AAFP appreciates the work that this subcommittee has undertaken to examine how Medicare pays for services physicians deliver to Medicare beneficiaries. We also share the subcommittee's concerns that the current system is inefficient and that it discourages quality improvement. For these reasons, 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.

AAFP currently has over 57,000 members in active practice, the vast majority of whom are in small and medium size practices.. We anticipate that this will be the typical construct of family medicine well into the future. Most people in this country receive the majority of their care from physicians in these care settings. Currently, about a quarter of all office visits in the U.S are made to family physicians, and the average family medicine practice has about a quarter of its patients who are Medicare beneficiaries. Finding a more efficient and effective method of paying for physicians services delivered to Medicare beneficiaries is a necessary endeavour, 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. And while family physicians immensely enjoy caring for their patients, they are not enthusiastic about the Medicare program. This program 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. The prospect of annual cuts in payment resulting from the flawed payment formula is discouraging. The regulatory approach is punitive, and physicians live in fear of violating rules they don't even know about. In the current environment, physicians know that they will face a 4.4 percent cut in January 2006, and that without Congressional action to repeal the Sustainable Growth Rate formula and create a structure for sustainable 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.

Eliminating the SGR

The current Medicare payment system for physicians is entirely unworkable. Congress needs to repeal the Sustainable Growth Rate (SGR) 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 (MEI). Such payments should be linked to health care quality and efficiency and should reward the most desired patient and physician behavior.

Measures of quality and efficiency should proceed logically from structural measures to process measures to outcome measures. Clinical care measures must be evidence-based. Physicians and other providers should be directly involved in determining the measures used for assessing their performance.

Aligning Incentives
A new system, sensitive to the costs of providing the care that will help improve health must align incentives, encourage evidence-based practice, 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 inappropriate utilization or services that are unnecessary, redundant or known to be ineffective.

Promoting the Medical Home
When the Medicare program was established, physician reimbursement was based solely on a fee-for-service system, one that fostered distorted incentives by rewarding individual physicians for ordering tests and performing procedures. There was no incentive or reward for physicians to coordinate the tests, procedures, or patient health care generally. This payment method, which largely still remains in effect today, has resulted in an expensive, fragmented Medicare program.

Due to this outdated payment scheme, Medicare does not adequately reimburse 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 that patients understand and is cost-effective for the Medicare program.

The current reimbursement approach was based on the best efforts of policymakers at the time and reflects the concerns then for meeting the costs of extended hospital stays. However, it does not make sense in 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 that Medicare adequately reimburse physicians for the care coordination services they provide to patients in managing and organizing their care.

Such reimbursement should go to the personal physician designated by the patient to serve as the patient's medical home. While there are a number of reimbursement methods possible to pay for this care coordination, one recommended for consideration is a blended model; i.e., combining fee-for-service and a per-beneficiary, per-month stipend for care coordination.

The Need for 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 swamp Medicare's ability to provide health care. Currently, 82 percent of the Medicare population have at least one chronic condition

and two-thirds have more than one illness. However, the 20 percent of beneficiaries with five or more conditions account for two-thirds of all Medicare spending.

There is strong evidence that the Chronic Care Model, (developed by Ed Wagner, Robert Wood Johnson Foundation) would improve health care quality and cost-effectiveness, integrate patient care, and increase people's satisfaction. This tested model is based on the fact that most health care for the chronically ill takes place in primary care settings, such as family physicians' offices. The model focuses on six components: (1) self-management by patients of their disease; (2) an organized and sophisticated delivery system; (3) strong support by the sponsoring organization; (4) evidence-based support for clinical decisions; (5) information systems; and (6) links to community organizations. The chronic care model has been tested in more than 39 studies and has repeatedly shown its value.

Care Coordination Has Roots in Primary Care Medicine

While we believe reimbursement should be provided to any physician choosing to coordinate care, 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* (IOM, 1996). Family physicians are trained specifically to provide this coordinated health care.

Lessons from Abroad: Primary Care Has Health and Economic Benefits

Unlike all other developed countries, the US does not have a health care system based on primary care. 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 workforce. And, compared to those in other developed countries, Americans spend the highest amount per capita on healthcare but have the worst healthcare outcomes. More than 20 years of evidence have shown that having a primary care-based health system has both health and economic benefits. A 2004 study comparing the health and economic outcomes of the physician workforce in US states reached the same conclusion (*Health Affairs*, April 2004).

US Primary Care Physicians Are Already Linked with Patients

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 14 times as many people are seen in primary care physicians' offices in the US than in hospitals (*New England Journal of Medicine*, 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 2000 Medical Expenditure Panel Survey). And, while data shows that people with chronic conditions see more subspecialists, they also increase their time spent with a primary care physician (Medicare Standard Analytic File 1999).

Finally, people benefit from having a medical home even if they have no insurance and regardless of their health status. These individuals get more appropriate preventive care and receive more appropriate prescription drugs than those without a usual source of care. They also avoid receiving their primary health care in a costly emergency room. In contrast, people without this usual source have more problems getting health care and neglect to seek appropriate medical help when they need it.

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 medical home are healthier and use fewer medical resources than those who do not. A more efficient payment system would be one then that encourages patients to establish this medical home with a physician empowered with the responsibility of coordinating the patient's care.

Physicians and Pay-for-Performance

The AAFP supports moving to pay-for-performance in the Medicare program with the goal of continuously improving care of patients. As we recently stated in a joint letter to Congress with our colleague organizations ACP, AAP and 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 toward transformation of medical practice, to strengthen the infrastructure of medical practice to support pay-for-performance, 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, AAFP has a framework for a phased in approach for Medicare.

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

First of all, we know that 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 that 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.

The AAFP was the first medical specialty society to join the National Quality Forum (NQF). And along with ACP, AHIP and 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 that it approves – measures developed by the Physician Consortium, NCQA and others. AQA is designed to promote a uniform set of evidence-based performance

measures for primary care physicians regardless of the payment source. The AQA determines 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 has contracted is critical to improving quality, minimizing errors, and reducing the reporting costs borne by medical practices. Measures that ultimately are utilized in a Medicare pay-for-performance program should follow this approach.

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. We have learned from the Integrated Healthcare Association's (IHA) experience in California that physicians and practices that invested in EHRs and other electronic tools to automate data reporting were both more efficient and achieved better quality results, and did so at a more rapid pace than those that lacked advanced HIT capacity. The AAFP created the Center for Health Information Technology (CHiT) in 2003 to facilitate adoption and optimal use of health information technology with the goal of improving the quality and safety of medical care and increasing the efficiency of medical practice. We now estimate that over 25 percent of family physicians are utilizing EHRs in their practices, which is more than twice the number from this time last year. Through a practice assessment tool on the CHiT website, physicians can assess their readiness for EHRs. We know from the HHS-supported EHR Pilot Project conducted by the AAFP that practices that had a well defined implementation plan and analysis of workflow and processes had greater success in implementing an EHR.

We also know that cost can be a barrier to IT adoption and have 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 Certification Commission for Health Information Technology (CCHIT) which certifies EHRs. The AAFP sponsored the development of the Continuity of Care Record 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. Our Board of Directors has set an ambitious goal of having 50 percent of family physicians using EHRs by the end of 2005. We are committing our organizational resources to help our members achieve this goal.

The success of value-based purchasing (or pay for performance) is fundamentally connected to the assignment by the patient of a medical home with a physician coordinating care and the reporting of health care data. But that reporting, which is the basis of pay for performance, cannot effectively happen without a widespread use of interoperable health information technology. The current system lacks this widespread health information technology in doctors' offices, which makes it nearly impossible to attribute data to doctors and practices accurately. These are twin impediments to improved quality and performance measurement in this country. The Medicare

payment system must provide appropriate incentives for physicians' practices to invest in this technology and the federal government must do more to assure the standards needed for effective interoperability.

The AAFP quality initiatives span efforts to emphasize measures like quality improvement, office redesign, and integration of the chronic care model. Here are two examples. Through our Practice Enhancement Program, teams of physicians and their office staff participate in an intense educational experience accompanied with pre and post course work to acquire the practical tools, skills and knowledge to implement the planned care model into their everyday practices. Through the web-based METRIC (Measuring, Evaluating and Translating Research into Care) program, family physicians assess their systems in practice, review charts and enter patient data, receive feedback on their performance, implement a quality improvement plan, re-measure and reassess. Two module topics currently are available: diabetes and coronary artery disease.

The AAFP takes seriously the responsibility to work with our members to continuously improve their clinical care and office infrastructure to better meet the needs of their patients.

Our consistent message to Congress is that if it is not done well, a value-based purchasing program will not only fail to improve health care quality but could unravel the preparation and progress that medical specialty societies have carefully undertaken on their own.

"Doing it well" means phasing in a value-based purchasing program that provides incentives for structural and system changes, that encourages reporting of data on performance measures and ultimately rewards continual improvements in clinical performance. Yet, moving the Medicare program in this direction cannot be accomplished in an environment of declining physician payment; Congress must take steps to stabilize physician payment through positive updates by repealing the current flawed formula and replacing it with one based on the cost of practice, as proposed by MedPAC. Furthermore, because of its financing structure with Part A and Part B, we believe it is important that Congress require a report on Medicare program savings on the Part A side resulting from Part B quality improvement efforts so that physicians are not penalized into the future as a result of focusing solely on the Part B silo.

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 2006, based on recommendations of MedPAC, reversing the projected 4.4-percent reduction, as noted above. 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 that 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 plus funds to provide incentives through pay-for-performance programs, 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, such as the provision of preventive services and performing HbA1c screening for diabetics. 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, insurance plans, etc. 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.

The voluntary quality reporting initiative recently announced by CMS, has the effect of undermining an organized, incremental comprehensive transition to pay-for-performance. The measures identified have been randomly selected, do not lend themselves well to electronic reporting, may, in fact, require medical record abstraction, have not been vetted through a consensus-development process that is essential to acceptance and success, and are not all based in scientific evidence. The AAFP

supports transition of the Medicare program to value-based purchasing and has been a leader among medical societies in the development of the necessary quality measures. The foregoing notwithstanding, the Academy must oppose the CMS voluntary reporting initiative as it undermines the organized, incremental transition to the pay-for-performance methodology and is slated for implementation just as the 4.4 percent reduction of Medicare payment becomes effective.

In conclusion, AAFP encourages Congressional action to reform the Medicare physician reimbursement system in the following manner:

- Repeal 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 (MEI), as MedPAC has recommended;
- Adopt, encourage and pay for care coordination for Medicare beneficiaries. The physician's practice that is designated to be the patient's personal medical home shall be receive a per-member, per-month stipend in addition to fee-for-service;
- Ensure that 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, structural and outcomes measures;
- Payment should be linked to health care quality and efficiency and should reward the most desired patient and physician behavior.

The Academy commends the Subcommittee for its initiative in attempting to identify a more efficient Medicare payment methodology for physician services. Moreover, AAFP is eager to work with the committee toward the needed system changes that will improve the efficiency of the program but also the effectiveness of the services delivered to our nation's elderly.