AMERICAN ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

April 15, 2013

The Honorable Dave Camp, Chairman
Committee on Ways and Means
The Honorable Fred Upton, Chairman
Committee on Energy and Commerce
U.S. House of Representatives
Washington, DC 21515

Re: Proposal to Repeal and Reform SGR
Second iteration

Dear Chairmen Camp and Upton:

On behalf of the American Academy of Family Physicians (AAFP), which represents more than 105,900 family physicians and medical students nationwide, I write in response to the request for comments on the second iteration of the proposal by your two committees to repeal and reform the sustainable growth rate formula.

The AAFP appreciates that the committees seek input regarding specific ways in which the current dysfunctional formula can be replaced. We also commend you for the rapid rate at which you appear to be progressing.

The current version of the committees' proposal seems to assume that performance measures alone lead to higher quality health care. It is our experience that performance measures can be used to improve targeted areas of health care delivery, but quality improvement is more complicated and more individual than can be reflected in performance measures alone. Therefore, while we agree that pay-for-performance should be included in payment reform, we understand that it alone is not sufficient to lead to general improvement in quality. Payment reform needs to include revisions to fee-for-service, especially higher payment rates for primary care and payment for the coordination of care. Quality improvement also includes issues such as investments in regional health care infrastructure, tighter requirements for the interoperability of health care technology, promotion of greater inter-professional education and community-based training, and near real-time feedback on quality reporting measures.

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The committees' proposal also envisions a fee-for-service payment system that moves to efficiency measures to achieve savings for the health care system. Most efficiency measures achieve short-term savings that accrue to the health care system broadly, and often do not accrue to the individual practice. Efficiency measures without gain-sharing across the health care system are likely to be ineffective. The AAFP believes that the evidence is clear that the way to achieve savings is to firmly base health care delivery on primary care.

In your second iteration of the repeal and reform proposal, you list twelve specific questions to which you seek responses. Following our comments on Phase I and Phase II, I will address these questions in order.

Phase I – period of stable, predictable updates

AAFP Comment: In replacing the SGR, a period of stable and predictable rate increases is absolutely necessary. Moreover, these positive rate increases must contain a higher payment rate for primary care services offered by primary care physicians. In addition, the length of time for the period of stability must be identified. We have recommended five years of stability to give physician practices sufficient time to evaluate how their investments in technology, team based and patient centered care and administration have affected the quality of the health care they are providing and the viability of their business model that accomplishes this practice transformation.

Phase II -- Portion of Payment Based on Quality through Update Incentive Program (UIP)

AAFP Comment: The operability of phase II will depend on the measures used and the feedback made available from CMS. With respect to the former, AAFP supports consensus-based measures validated or endorsed by an objective third-party entity such as the National Quality Forum to assure the rigor of using best evidence. With respect to data feedback, the information must be timely, which means as close to real-time as possible but no less than quarterly. The closer the feedback is to real-time, the more likely it will be that such data could be used to shape clinical decision-making, improve patient care, and increase efficiency.

Responses to the 12 questions

1. *How should the Secretary address specialties that have not established sufficient quality measures?*

   AAFP Comment: AAFP believes these specialties have had ample time and opportunity to develop measures and no special consideration should be given. A defined period of stability will provide additional time for measure development. The measure development should be consensus-based and should not empower the Secretary to set measures as this could forestall the development of comprehensive and evidence-based measures. One exception should be the Maintenance of Certification (MOC) program by the American Board of Medical Specialties, which should qualify as a proxy for physician quality when the care is delivered through an Accountable Care Organization (ACO), a Patient Centered Medical Home (PCMH) or similar models including the Comprehensive Primary Care Initiative (CPCI). AAFP also believes that the measures and quality indicators should apply to the service and not the individual professionals involved in care, so that non-physician practitioners (NPPs)

should be required to meet the same criteria and standards as physicians delivering similar care.

Congress should direct CMS to work with specialty certification boards and specialty societies to establish and maintain a set of measures which support national health priorities.

2. *Is it appropriate to reward improvement in quality over time in addition to quality compared to peers?*

   AAFP Comment: AAFP believes it is not only appropriate to reward improvement in quality over time but this is probably a stronger and more effective metric than quality compared to peers.

3. *Are there sufficient clinical practice improvement activities relevant to your specialty? If not, does your organization have the capability to identify such activities and how long would it take?*

   AAFP Comment: Quality improvement activities which qualify for Part IV of the American Board of Family Medicine's Maintenance of Certification (MOC) program should be deemed sufficient clinical practice improvement activities for family physicians.

4. *Should small practices have the ability to aggregate measurement data to ensure that there are adequate numbers of patient events to reliably measure performance? If so, how?*

   AAFP Comment: Because many family medicine practices could be considered "small," AAFP believes they should be allowed to aggregate measurement data. However, we have concerns about unintended consequences that could emerge due to physicians having little or no control over how other groups select patients or practice. We also would wonder if attribution problems could multiply in situations where data are aggregated. Accurate risk adjustment is critical when data are aggregated.

   The AAFP believes that the use of fully integrated, point-of-care registries, distinct from other clinical registries, will not only reduce data collection burdens that practices experience daily but also offer the opportunity to provide more reliable, consistent, and evidence-based care to patients with chronic conditions.[1] Furthermore, the existence of a central database from which researchers and payers can pull data for various reasons would reduce the burden associated with researching quality improvement efforts. The AAFP emphasizes the need for EHRs that have the capacity to turn data into meaningful information to demonstrate quality.

   For targeted quality improvement purposes for all patients with a particular condition, physicians utilizing a clinical registry should be able to report easily and electronically the required number of patients or the requisite percentage. Broad based outcomes, however, must be evaluated through population analysis rather than sampling.

Also, continuing medical education (CME) activities are increasingly being developed so that analysis can be performed on gap and outcomes measures. The AAFP believes that pre- and post-analyses of CME related measures are an essential part of a lifelong learning program for physicians. These are increasingly aligned with Maintenance of Certification efforts and function as tools for clinical improvement and should be recognized as such.

Phase III –Reward for Efficient Resource Use

Questions:

5. *How much time is needed to refine the methodology for determining and attributing efficient use of health care resources?*

   AAFP Comment: The amount of time necessary to refine the methodology for determining and attributing efficient use of health care resources is a product of the complexity of the undertaking and the physician cohorts to which any individual methodology would be applicable. We need to have more information about how and by whom "efficiency" is defined and the precise definition assigned. At this time, it is also not clear who would be eligible, and AAFP believes that population is likely to expand with time. Nor is it clear that the referenced methodology for incentivizing efficiency is bonus only, penalty only, or both bonus and penalty. Since this is undefined territory, it is impossible to offer a reasonable and supportable prediction at this time.

   We would emphasize that payment for efficiency requires review of all of the components of health care delivery, not just a physician practice. For example, investment in preventive care and the management of chronic diseases will lead to reductions in hospitalizations.

6. *Is it preferable to only have a payment implication based on efficiency for providers that meet a minimum quality threshold?*

   AAFP Comment: Based on our current knowledge and interpretation, which assumes the above refers to a bonus or incentive (i.e., no penalty) for practicing beyond a minimum quality threshold, AAFP believes that it is preferable to only have a payment implication based on efficiency so designed. However, we would hasten to point out that if efficiency is the sole measure, the proposal runs the risk of returning to the days of managed care and HMOs and the resulting problems.

Provider Opt-Out for Alternate Payment Model (APM) Adoption

Questions for APM Adoption:

7. *What do you believe will be necessary to support provider participation in new payment models?*

   AAFP Comment: For primary care**,** in addition to the employment of the blended payment model, which includes a base fee-for-service, an accurately risk adjusted per-member/per-month care management fee, and an incentive for achieving quality

benchmarks, AAFP believes patients should be incentivized to use the PCMH by elimination of out-of-pocket expenses for services received through the medical home.

8. *What is a reasonable time frame for CMS to approve and adopt APMs?*

   AAFP Comment: This, too, depends on the precise APM being developed and approved. AAFP believes the blended payment model described above is ready now. Sufficient demonstrations and studies, along with an abundance of literature published in peer-reviewed journals, justify this implementation immediately.[2,3,4]

9. *Should providers be able to participate in more than one payment model?*

   AAFP Comment: Just as physicians are currently allowed to assess and decide which insurers (commercial and public) are accepted by the practice, providers should continue to be allowed to participate in any payment approach which they deem appropriate for their business model. This physician choice is an important element in the development of new payment models, since it is a way the market can help determine the relative merits of any APM.

Improvements on Current Law

Questions:

10. *What improvements upon current law do you believe will be required to support alternate payment model adoption?*

    AAFP Comment: See response to #7 above.

11. *What improvements upon current law will help ease the administrative burden upon medical providers and allow more time caring for Medicare beneficiaries?*

    AAFP Comment: Professional liability reform that holds physicians harmless when they adhere to the standard of care is essential. Further, elimination of the use of "sampling and extrapolation" by recovery audit contractors (RACs) is an improvement that will ease the administrative burden and foster a more patient-centric physician practice environment.

12. *What improvements upon current law would support the provision of quality health care delivery for Medicare beneficiaries?*

    AAFP Comment: The following improvements upon current law [or regulation] would support the provision of quality health care delivery for Medicare beneficiaries:
    a. Providing incentives for patients to use the PCMH, which is reimbursed using the blended payment model.
    b. Permanently increasing payment for primary care services by adoption of separate primary care evaluation and management (E/M) codes with higher values that reflect the complexity and intensity of the services provided by primary care physicians and the patients served, as the AAFP has asked CMS to do in the 2014 payment rule.[5,6,7]

c. Reforming funding methods for workforce training for primary care by employing a "money follows resident" model and providing direct funding for training in nonhospital settings. For example, see the *Primary Care Workforce Access Improvement Act* (HR 487), introduced by Rep. Cathy McMorris Rodgers.

AAFP appreciates the opportunity to provide these comments and make ourselves available for any questions you might have or clarifications you might need. Please contact Kevin Burke, Director of Government Relations, at 202-232-9033 or kburke@aafp.org.

Sincerely,

Glen Stream MD

Glen Stream, MD, MBI, FAAFP
Board Chair

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