AMERICAN ACADEMY OF FAMILY PHYSICIANS

STRONG MEDICINE FOR AMERICA

June 10, 2013

The Honorable Fred Upton, Chairman
Committee on Energy and Commerce
U.S. House of Representatives
Washington, DC 20515

Via: SGRComments@mail.house.gov

Re: Discussion Draft Bill to Repeal and Reform SGR

Dear Chairman Upton:

On behalf of the American Academy of Family Physicians (AAFP) and its 110,600 members, I write to provide a response to your requested feedback on the discussion draft bill to repeal and reform the sustainable growth rate (SGR) formula. The AAFP appreciates that the committee seeks input regarding specific ways in which this dysfunctional formula can be replaced. We also commend you for your leadership in tackling this long-standing problem of how physicians are paid.

The Energy and Commerce Committee, the Ways and Means Committee and the Senate Finance Committee have all described the effort in which you are engaged as moving from volume-based to value-based payment. Family physicians agree payment that reflects quality improvement and better patient care is the appropriate goal and the AAFP will continue to work with Congress to achieve that goal. We appreciate your investigation into performance measures and your solicitation of our views on how such a performance-based system might work. But we recommend that performance measurement not be the only component of reform, if you want that reform to be effective. You need to include payment for the coordination of care across delivery settings and for complex conditions. Finally, the system should include payment for services rendered, which is what fee-for-service does. But the AAFP believes (and the evidence shows) the balance of these three elements – namely, fee-for-service, care coordination and performance improvement – should be focused on primary care.

For example, as we detailed in our letter to the Centers for Medicare & Medicaid Services (CMS) on March 27, the AAFP recommends that the physician fee schedule include a new category of Evaluation and Management (E/M) codes that reflect the intensity and complexity of the primary care office visit. In addition the AAFP recommends that Congress encourage primary care physician practices to become Patient Centered Medical Homes (PCMH). Those practices that function as PCMHs should receive a per-patient, per-month care coordination fee that supports the management of complex medical cases to ensure quality and efficient use of health care resources through services that often are provided outside of a face-to-face visit. And finally, physicians who lead a PCMH health care team

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should be responsible for demonstrating quality improvement in their patients' health care. Pay for performance would thus be the third feature of an effective payment system.

In exploring performance-based payments, you have requested feedback on two sets of questions which are based on the first two implementation stages in the outlined payment system.

Questions for Comment on Phase I

1. What is an appropriate period of payment stability in order to develop and vet measures and build the necessary quality infrastructure?

AAFP Comment: In replacing the SGR, we have recommended a period of stable and predictable rate increases not because physicians need additional time to develop and evaluate quality measures, but because they need to be able to determine what business investments make the most sense in the transformation of their practices. The AAFP recommends 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.

Moreover, these positive rate increases must contain a higher payment rate (at least 2 percent higher) for primary care services offered by primary care physicians. This differential payment rate is necessary because of the historical bias in fee-for-service against non-procedural health care delivery. Primary care is mostly non-procedural, but the evidence clearly shows that a health care system built on primary care will provide better care overall and will do so more efficiently.

2. Considering the different levels of provider readiness, how do we balance the need for a stable period enabling providers to build and test the necessary quality infrastructure, while still incentivizing early innovators to move to Phase II, with opportunities for quality-based payment updates?

AAFP Comment: The AAFP believes all specialties including primary care have had ample time and opportunity to develop relevant clinical quality measures and thus no special consideration should be given. Nonetheless, a defined period of stability will provide additional time for further measure development. The measure development should be multi-specialty in origin to assure the resulting measures are comprehensive and evidence-based. 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. The AAFP also believes that the measures and quality indicators should apply to the service and not the individual medical professionals involved in care.

Furthermore, the AAFP believes Congress should direct CMS to work with medical specialty societies and their certifying boards to establish and maintain a set of measures which support national health priorities.

3. What does a meaningful, timely feedback process look like for providers? What are adequate performance feedback intervals?

AAFP Comment: The AAFP believes if payment is to be tied to quality, feedback must be timely and actionable, which means feedback must come as close to real-time as possible but no less than quarterly. Only when feedback is close to real-time does it help shape clinical decision-making, improve patient care, and increase efficiency.

It is also important to recognize that the data used for payment and feedback need to be as accurate as possible, from the first submission or collection point, in order to meet rapid turn-around requirements which are not likely met with claims data due to "scrubbing time."

4. How should Peer Provider Cohorts be defined to ensure adequate specificity while preserving adequate comparison group size and ability to develop appropriate measurement sets? For example, is using the American Board of Medical Specialties (ABMS) list adequate? and
5. Should the list of Peer Provider Cohorts also include patient, procedural, or disease-specific cohorts in addition to the traditionally-defined specialty groupings? Pros of this approach are that it would offer a more relevant basis for measure development and comparison between physicians, since many physicians perform outside of or in a narrow range of the "stereotype" description of their primary specialty. Cons are that it may create too vast of an array of cohorts. This may dilute the ability to develop meaningful quality measurement sets and comparison groups and impose excessive financial and administrative burden on the physician group as well as upon CMS. In addition to answering, please provide rationale.

AAFP Comment: Identifying Peer Provider Cohorts is an interesting concept but one that requires considerable investigation. As such, it may be not possible to answer these questions with sufficient detail at this time. The AAFP believes that every patient should be getting the right care for their illness or disease, and this is more important than how many patients a practice has with any one particular disease or condition. Patients can be referred to other practices or sub-specialties for resources not available in one practice, and the measures used should reflect this reality.

6. Under the proposed revision of SGR which emphasizes best quality practices, non-physician providers who are currently paid under the Medicare payment system are also expected to be rated on quality measures. Do these non-physician providers need unique measurement sets compared to physician providers?

AAFP Comment: As previously mentioned, the AAFP believes that measures and quality indicators should apply to the service and not the individual medical professionals involved in care. Thus, non-physician providers should be required to meet the same benchmarks and standards as physicians delivering the same care.

Questions for Comment on Phase II

1. Understanding that the proposed payment system relies on reporting, how should existing programs such as, but not limited to PQRS, EHR/Meaningful Use, VBM be transitioned into the new system? Are there aspects of the current systems that should be retained, modified, or discarded?

AAFP Comment: The AAFP believes these programs were initiated to move the health system toward emphasizing value over volume. Thus, we recognize these programs as incremental steps designed to hasten this evolution. Once a value-based payment system is ready to be implemented, these programs should end. Congress should refrain from imposing additional layers of requirements with which physicians must comply. In the opinion of AAFP, it is essential that coordinated reporting requirements and measures with compatible and reliable systems translate into decreased administrative burden for practices.

2. How do we align and integrate quality measurement and reporting with existing and developing specialty registries? How can registries support provider feedback and streamline provider reporting burden? and
3. What Clinical Improvement Activities best promote high quality clinical care and should those activities be required as an integral part of a quality-based payment system?

AAFP Comment: Many family medicine practices are considered "small;" therefore, the AAFP believes they should be allowed to aggregate measurement data. However, the AAFP is concerned about unintended consequences that could emerge since physicians have little control over how other medical groups select their patients or practice. We also 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 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 electronic health records 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.

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. What process or processes could be enacted that would ensure quality measures/measurement sets maintain currency and relevance with regard to the latest evidence-based clinical practices and care delivery systems? How would these processes ensure that quality measures evolve with data accumulation and advancement in measure development science, and appropriately account for the relative value of measures as they relate to best possible patient care?

AAFP Comment: The AAFP supports consensus-based measures validated or endorsed by an objective third-party entity such as the National Quality Forum. Such an entity can and should ensure the relevance and currency of measures. The measures developed should reflect the best available evidence from reliable, objective sources like the U.S. Preventive Services Task Force. The AAFP believes annual review of measures is excessive and unnecessary. Moreover, we believe it is not necessary to include in statutory language the frequency with which measures are reviewed.

5. Quality measures are categorized into process, structural, and outcome measures. Should these measures be differentially weighted in a quality scoring system? If so, how?

AAFP Comment: As quality measurement has evolved, the early focus was on structural and process measures, which helped create the foundation for more sophisticated quality improvement activities. But initially and appropriately the emphasis was on ensuring the correct tests and measures were employed when indicated.

Nevertheless, it must be recognized that varying levels of understanding of quality measurement and improvement exists among physician practices currently. And many are just now becoming progressively accustomed to the use of process and structural measures. While not the gold standard of outcomes measurement, the employment of structure and process measures does offer the practice a better chance of achieving desired intermediate and long-term patient outcomes. Thus, all three measure types are needed, but the emphasis must be on transition to the use of patient outcome measures.

Having said that, ways must be identified to deal with attribution as measuring patient outcomes can be clouded when patients change providers. Additionally, the effects of care delivered by one provider may be seen many years later in another physician's practice.

Also, because physicians have more control over process and structural measures and less control over a patient's compliance, the role of the patient is an important consideration that must be addressed in the equation. Patient participation in shared decision-making and patient adherence to the treatment plan are important metrics that cannot be overlooked.

6. From a variety of backgrounds, providers newly enter (or re-enter) the Medicare system throughout the year. Since these providers have no reference baseline with regard to quality reporting in the Medicare system, how should the system account for their payment during their "observation" year?

AAFP Comment: Since currently there is no known "observation" year when a provider enters the Medicare system, it is not possible to respond to this question with specificity. However, in pursuing a method of determining a baseline with regard to quality reporting, we would urge policymakers to be aware of and sensitive to the effects such requirements could have on solo and small primary care practices in rural and urban underserved areas.

7. Should public and multi-stakeholder input be used during the measure development and selection processes? If so, are there current CMS or non-CMS mechanisms that could be applied? and
8. In the interest of transparency, a public comment opportunity is vital to the quality measure development and approval process. Are there current mechanisms that are both substantive and nimble enough to meet the policy framework in the discussion draft of the legislative language?

AAFP Comment: The AAFP recognizes the importance of patient/consumer input and notes that it is routinely incorporated into measure development processes employed by the National Quality Forum and the American Medical Association Physician Consortium for Performance Improvement. Public input is important especially for the identification of patient-centered outcome measures.

9. Methods linking quality performance to payment incentives must be fair to providers and faithful to the goals of a value-based payment system. Many strategies have been proposed; examples include comparing providers to each other versus to benchmarks. Please suggest method(s) of quality-based payment which meet the goals of fairness and fidelity, and one that promotes provider collaboration and sharing of best practices to achieve a learning healthcare system.

AAFP Comment: The AAFP believes it is appropriate to reward improvement in quality over time but this is probably a stronger and more effective metric than quality compared to peers. Measuring providers by benchmarks and paying on the basis of quality will meet the goals of fairness and fidelity while simultaneously promoting provider collaboration and sharing of best practices.

However, identifying the specific metrics to be used is not without difficulty and should be approached carefully. For example, it would be problematic to base performance goals on a study or studies that had ideal, controlled settings and access to resources not universally available. In addition, since severity of illness, comorbidities and patient preferences create a vast number of clinical variables, accurate risk-adjustment is essential.

Additional Considerations

The AAFP urges the Committee to consider this as an opportunity to reform the physician payment system more broadly and more effectively. The evidence has clearly shown that a fundamental problem with how the U.S. pays for health care is due to the imbalance between primary care and specialty care.

When health care delivery is built on a strong foundation of primary care, efficiency and quality are high. However, a system that pays for health care based only on services provided fosters inefficiency through fragmentation, which can threaten quality as well. While the fee-for-service component of the physician payment system must be reformed, we would encourage the Committee to consider how Medicare also can pay for care coordination and for quality improvement. Real payment reform, if intended to support a primary-care based delivery of health care, should include a per-patient, per-month payment for the management of care and a payment for quality improvement, as well as a fee-for-service payment that fairly compensates physicians for acute-care services.

The AAFP continues to believe that the traditional practice model needs to evolve into be more team-based and patient-centered. In 2007, the AAFP, the American Academy of Pediatrics (AAP), the American College of Physicians (ACP), and the American Osteopathic Association (AOA) agreed on principles that should guide our members in transforming their practices to become a PCMH. The AAFP describes the PCMH as:

> *… a transition away from a model of symptom and illness based episodic care to a system of comprehensive, coordinated primary care for children, youth and adults. Patient centeredness refers to an ongoing, active partnership with a personal primary care physician who leads a team of professionals dedicated to providing proactive, preventive and chronic care management through all stages of life. These personal physicians are responsible for the patient's coordination of care across all health care systems facilitated by registries, information technology, health information exchanges, and other means to ensure patients receive care when and where they need it. With a commitment to continuous quality improvement, care teams utilize evidence-based medicine and clinical decision support tools that guide decision making as well as ensure that patients and their families have the education and support to actively participate in their own care. Payment appropriately recognizes and incorporates the value of the care teams, non-direct patient care, and quality improvement provided in a patient-centered medical home.*

Since 2006, the AAFP, other primary care physician organizations, and hundreds of other industry leaders and consumer representatives who recognize the value of the PCMH have worked together as part of the Patient-Centered Primary Care Collaborative (PCPCC) whose purpose is to promote the PCMH to employers who provide health care coverage and to health insurance plans. The reasons that primary care physicians have become such strong supporters of the PCMH are found in a report issued in 2012 by the PCPCC, *Benefits of Implementing the PCMH: A Review of Cost and Quality Results*, which updated earlier reviews of the cost and quality data derived from implementation of the PCMH in both private and public health plans. The report offered an important observation: "Data demonstrates that the PCMH improves health outcomes, enhances the patient and provider experience of care, and reduces expensive, unnecessary hospital and emergency department utilization." We believe this is only the beginning of the improvements the PCMH will offer our patients and communities.

Three years ago, the AAFP articulated the *Principles for Physician Payment Reform to Support the Patient-Centered Medical Home*, and we would recommend your consideration of this position paper during your deliberations on payment reform.

The AAFP has made a significant investment in helping members make the difficult, costly, and disruptive changes that they need to undertake to become a PCMH. For example, because a fully functioning system of health information technology is crucial for an effective PCMH, ten years ago the AAFP created its Center for Health Information Technology. The Center has helped AAFP members and others evaluate and adopt the electronic health record (EHR) that serves the practice and their patients. We are pleased that with the help of the Center, some 80 percent of family physicians in the nation are using certified EHR technology.

Additionally, in 2005, the AAFP established TransforMED to assist our members and others in making this transformation of health care delivery to become effective PCMH. Since 2005, TransforMED has:

- Guided transformation efforts in 677 primary care practices
- Impacted more than 12,445 physicians and other health care clinicians
- Supported organizational change in 34 residency programs
- Incorporated PCMH elements in 46 Federally Qualified Health Centers
- Touched the lives of over 25 million patients

Both TransforMED and the TransforMED Patient-Centered Model have their origins in the recommendations of the Future of Family Medicine report, which called for the creation of a national organization that would evaluate, support, and guide family and primary care practices to adopt a new, integrated model of care. The experience that TransforMED has accumulated has informed many of the recommendations that the AAFP offers to the Committee, but the most important is that reforming fee-for-service is only the beginning of the job needed to achieve the efficiency and quality for which Congress is looking.

We would also like to note the following improvements upon current law [or regulation] that AAFP believes support the provision of quality health care delivery for Medicare beneficiaries:

- Providing incentives for patients to use the PCMH, which is reimbursed using the blended payment model (FFS when visits are necessary, a risk-adjusted, per-patient per-month care coordination fee, and payment for quality improvement).
- 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.[2,3,4]
- 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.
- Enacting professional liability reform that holds physicians harmless when they adhere to the standard of care is essential.
- Eliminating of the use of "sampling and extrapolation" by recovery audit contractors (RACs) will ease the administrative burden and foster a more patient-centric physician practice environment.
- Including in any permanent fix to the SGR a differential of at least 2% for primary care physicians

Conclusion

The discussion draft 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. And, as mentioned above, the patient needs to be a motivated partner to improve her/his own health. Patients need to be educated on, and incentivized to use, the Patient-Centered Medical Home.

For primary care**,** in addition to the employment of the blended payment model, which includes fee-for-service payment for face-to-face visits, an accurately risk adjusted per-member/per-month care management fee, and an incentive for achieving quality benchmarks, the AAFP believes patients should be incentivized to use the PCMH by elimination of out-of-pocket expenses for services received through the medical home. The AAFP believes that the evidence is clear that the way to achieve savings is to firmly base health care delivery on primary care.

The 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.[5,6,7]

The 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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