AMERICAN ACADEMY OF FAMILY PHYSICIANS

STRONG MEDICINE FOR AMERICA

May 30, 2013

The Honorable Max Baucus
Chairman
Committee on Finance
U.S. Senate
Washington, DC 20510-6200

The Honorable Orrin G. Hatch
Ranking Member
Committee on Finance
U.S. Senate
Washington, DC 20510-6200

Dear Senators Baucus and Hatch:

On behalf of the American Academy of Family Physicians (AAFP) and its 110,600 members, I write to thank you for your letter of May 10, in which you have asked for our input on policies that specifically affect the Medicare physician fee schedule. We greatly appreciate the efforts of the Finance Committee and your leadership in trying to develop an acceptable replacement for the way that Medicare determines physician payment. Your work on the Sustainable Growth Rate (SGR) fix complements that of the House Energy and Commerce and the Ways and Means Committees, who are trying to craft a payment method based on the value of the services provided rather than the volume. Last month, in a letter to the chairmen of those Committees, we provided our recommendations for achieving that goal. We believe you may find some of those suggestions helpful.

However, we understand that you are looking at different issues; specifically:

1. How can Congress improve the accuracy of fee-for-service payments?
2. How can Congress construct a payment formula that would reduce utilization but improve health?
3. How can Congress provide appropriate incentives for physicians to participate in alternative payment models?

To respond to these specific inquiries, 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. The AAFP recommends that the Congress not attempt to restrain utilization by the fee schedule, since the basic flaw of the SGR is to attempt to control individual physician behavior by system-wide incentives and penalties. Instead, to restrain costs, we recommend that Congress encourage primary care physician practices to become Patient Centered Medical Homes (PCMH). And finally, the AAFP recommends that the Congress authorize CMS to provide to those practices that function as PCMHs a per-patient, per-month care management fee that supports the management and coordination 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.

We understand your interest in addressing the inherent flaws in the fee-for-service (FFS) system, and we have several recommendations to offer in that regard. But we urge 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 it is 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 compensates physicians for acute-care services.

We are not proposing that primary care practices be paid more for the same old services. The AAFP has been convinced for some time that the traditional practice model needs to be adapted to become team-based and more 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.

Valuing Physician Services Appropriately

The AAFP has proposed in a recent letter to the Centers for Medicare and Medicaid Services (CMS) that the Agency should establish new payment codes that reflect the intensity and complexity of ambulatory primary care E/M services. We believe that the Committee should strongly support this effort. An evolving body of evidence is revealing that the complexity of the ambulatory E/M services that primary care physicians must provide during a given period of time is sufficiently distinct from existing office or other outpatient E/M codes as to merit their own codes with higher relative values. As we note in our letter to CMS, over the past 20 years, the complexity of an ambulatory primary care patient visit has grown as the number and variety of preventive services delivered during each visit has increased, the demographic diversity of patients has expanded, and medications and other treatments commonly used have evolved to be more central to the ambulatory practice. Other factors leading to the current increased complexity include a larger percentage of patients with multiple chronic conditions, an increase in life expectancy, and a significant and demonstrable shift in the overall percentage of care being provided in the ambulatory setting versus inpatient settings. While all medical care is becoming more complex, the trend is more pronounced in primary care.

The AAFP believes it is essential to correct the fee-for-service system's current undervaluation of primary care E/M services in the office or other outpatient setting, which we see as sufficiently distinct from other such E/M services in terms of complexity per unit of time, or complexity density, as to merit their own codes and higher relative values. If this needed correction to the current FFS system is not accomplished, evolving alternative payment models will actuarially include this bias against primary care which exists in the FFS system today.

Reducing Unnecessary Utilization

The AAFP does not recommend using the fee schedule to control utilization. The SGR has demonstrated the fundamental flaw in thinking that reducing specific, individual payments to account for exceeding general volume targets will discourage over-utilization. Instead, we encourage Congress to think about what it would want to pay for – improved health care delivered as efficiently as possible. We would assert that the best way to achieve this goal is to foster the development of primary care practices that are PCMHs.

The Robert Graham Center, as early as November 2007, in a report titled *The Patient Centered Medical Home: History, Seven Core Features, Evidence and Transformational Change*, described the key elements of a PCMH as comprised of:

- A personal physician who is trained to provide first contact, continuous and comprehensive care based on an ongoing relationship with the patient

- A physician-directed medical practice, in which the personal physician leads a team of individuals who collectively take responsibility for the ongoing care of their patients
- Whole-person orientation, which requires that the personal physician be responsible for providing all of the patient's health care needs or take responsibility for appropriately arranging care with other qualified professionals
- Care that is coordinated and integrated across all elements of the complex 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)
- Evidence-based systems that assure quality and safety, which are hallmarks of the medical home
- Enhanced access to care which is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.
- Appropriate payment which recognizes the added value provided to patients.

These characteristics help to demonstrate why the PCMH is showing improved quality of care and greater efficiency. If a patient has a personal relationship with a physician and uses the health-care team of a PCMH, the result is stronger management of the patient's health care needs, which leads to less duplication, fewer unnecessary procedures, more and better communication between various health care professionals and even community services, effective management of chronic disease, more successful preventive health care, and less hospitalizations.

Incentivizing Participation in Alternative Payment Models
In addition to the enhanced fee-for-service payment for primary care E/M, the Congress should establish a care-management fee for PCMH practices, along with more effective performance payments based on real-time data. While there are many variations to the PCMH that are being tested and proven in the private sector, and while CMS is attempting to fulfill its Congressional mandate to pilot several alternative payment and delivery models, including the PCMH, the AAFP believes that the evidence of improved quality and efficiency is sufficiently compelling to recommend that Congress authorize the payment of a care-management fee for those practices that are functioning as a PCMH.

Thank you once again for the opportunity to offer the Senate Finance Committee our views on this critically important issue of fee-for-service reform. As an organization of 110,600 members who provide most of the primary care to this nation, the AAFP remains greatly concerned about the inherent flaws in how we value primary care in our current payment system. We deeply appreciate your commitment to reform the fee-for-service component of that system, and we urge you to look beyond it for broader structural reforms. As the Committee moves forward with this important task, we are pleased to continue to offer our assistance. Please feel free to contact Kevin Burke, AAFP Director of Government Relations, at kburke@aafp.org.

Sincerely,

Glen Stream MD

Glen Stream, MD, MBI, FAAFP
Board Chair