AMERICAN ACADEMY OF FAMILY PHYSICIANS

STRONG MEDICINE FOR AMERICA

June 22, 2009

Dear Senator:

On behalf of the 94,600 members of the American Academy of Family Physicians, I am pleased to submit the following comments on your draft bill, *The Affordable Health Choices Act*. The AAFP has called for fundamental reform of the US health care system for two decades and we commend Congress and the Administration for their leadership and commitment to find solutions to this complex national priority. Finally, we appreciate including efforts to improve primary care throughout the draft bill.

In general, the AAFP is highly supportive of many sections of this draft legislation. Our comments will be on those sections not only consistent with our policy but also of most interest to family physicians.

Again, thank you for the opportunity to provide comments on your far-reaching health care reform legislation. We offer our support in the upcoming negotiations on a final bill and look forward to working with the committee on legislation that will provide health care coverage to all and a system based more strongly on primary care.

Sincerely,

Jams D. King, MD, FAAFP
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AAFP RESPONSE TO "THE AFFORDABLE HEALTH CHOICES ACT"

Title I – Quality, Affordable Health Coverage for All Americans
Part I – Provisions Applicable to the Individual and Group Markets

Sections 2701-2706
This section would reform the individual and group health insurance markets in all 50 states to promote availability of coverage for all individuals and employer groups.

AAFP position: The AAFP has long-supported health care coverage for all. As a result, we support Option A in the section-by-section, which states, "rating by age will be permitted to vary by no more than a factor of two to one" to allow the broadest number of people to be covered. We support the prohibition of preexisting condition exclusions; guaranteed availability and renewability of coverage along with the "clear accounting for costs" by health insurance plans.

Section 2707 – Ensuring the Quality of Care
This section requires health insurance plans to "develop and implement a reimbursement structure for making payments to health care providers that provides incentives for care management; care coordination and chronic disease management (including use of the medical home model), wellness and health promotion activities, child health measures, activities to improve patient safety and reduce medical errors, as well as culturally and linguistically appropriate care."

AAFP position: We agree with the committee's support for the value of a payment structure based on incentives for care management and coordination. It is this reliance on care management and coordination – the comprehensiveness of primary care and its whole person orientation -- that will make the difference in improving quality and cost efficiency. However, financial incentives for care management and care coordination will realize their best intent when combined with further incentives for primary care.

Section 2708, Coverage of Preventive Health Services
This section requires only minimal cost-sharing for services recommended by the US Preventive Services Task Force, CDC and HRSA.

AAFP position: The AAFP long has supported this principle and, in fact, recommends no co-payments/ "first dollar coverage" for these services.

Section 131 – No Changes to Existing Coverage
This section allows individuals to continue their existing coverage, if desired.

AAFP position: We support the right of individuals to maintain their current coverage in the face of major system change.

Subtitle B – Available Coverage for All Americans

Section 141, Assumptions Regarding Medicaid
This section assumes the Finance Committee will make expansions to Medicaid eligibility.

AAFP position: We believe that in the short-run, a 100 percent match for administrative costs is generally positive for states. However, our concerns focus more on long-term issues. Specifically, we are concerned about where the dollars will come from to finance these changes.

Nearly every state has some sort of balanced budget requirement and only seven are allowed to carry a deficit forward.

If Medicaid eligibility were to be lifted across the board to 150 percent of the federal poverty level, then more than 30 percent of American households potentially could become eligible (using pre-recession Census estimates). If domestic wealth distribution trends were to continue over the next 10 years as they have over the previous 30, the number of potentially eligible individuals would be larger.

Without a significant infusion of money into the Medicaid system, states would be forced into traditional cost control measures: reductions in nursing home, HCBC, optional services and provider payments. While we understand that states have been reexamining the delivery of Medicaid services lately and there has been a slight trend towards revaluing primary care, we want newly enrolled individuals to have true access to care and not just expansions that cannot be funded. Nevertheless, we do not believe that expanding Medicaid is the answer to expanding coverage as Medicaid payment historically has been extremely low.

Title XXXI – Affordable Health Choices for All Americans

Section 3101 Affordable Choices of Health Benefit Plans
This section allows each state to have an “Affordable Health Benefit Gateway” to “facilitate the purchase of health insurance at an affordable price by individuals and groups.” This includes qualified health plans, Medicaid, CHIP and other federal programs.

<u>AAFP position</u>: The AAFP supports the flexibility for each state provided later in Section 3104. We also agree with the requirement that the federal government step in after four years to establish a gateway if a state has not done so.

While we realize the concept of a public plan option is undergoing serious discussion, and that many alternatives still are being explored, the AAFP recently approved a position to support the concept of a public health plan option under certain conditions.

- The administrators of the public plan must be accountable to an entity other than the one identified to govern the marketplace.
- The public plan cannot be Medicare.
- The new public plan must be actuarially sound.
- The public plan cannot leverage Medicare (or any other public program) to force providers to participate.
- The public plan should not be required to use Medicare payment rates.
- The insurance market rules and regulations governing the public plan must be the same as those governing private plans.
- The public plan cannot be granted an unfair advantage in enrolling the uninsured or low-income individuals who will presumably be eligible for subsidies in the new marketplace.
- Public and private insurers should be required to adhere to the same rules regarding reserve funds.
- The public plan would also need to contribute to value-based initiatives that benefit all payers.

In addition, the AAFP also supports the concept of a national health board, with independence and authority, which would oversee a new public health plan if implemented and eventual

oversight of all public health plans with a composition to be determined from the public/private sector but not being fully government-based."

AAFP position: Regarding health information technology, the AAFP strongly supports interoperability, and, as such, supports provisions requiring the Secretary to consult with the National Coordinator for HIT to develop interoperable, secure standards and protocols that help individuals enroll in federal and state health and human services programs. Regarding Gateways, specifically, we support the use of an Internet website to allow state residents to identify one in their state.

AAFP position: Regarding "criteria for certification," the AAFP supports the use of regulations to establish criteria to certify health plans as "qualified health plans." These plans would be required to provide coverage for essential health care benefits.

(m) Rewarding Quality Through Market-Based Incentives
This section sets out a payment structure increasing reimbursement or incentives that qualified health plans can employ for improving health, including quality reporting, case management, care coordination, chronic disease management, medication and care compliance, including use of the medical home model; prevention of hospital readmissions and implementation of wellness and health promotions.

AAFP position: Again, we strongly agree with these provisions, which will increase reimbursement and incentives for means to improve health, particularly the use of the medical home. Specifically, we need financial incentives for these pay-for-performance activities, as addition to the fee for service reimbursements. We support a care management fee for primary care practices and primary car services via the patient-centered medical home.

Section 3103 – Seeking the Best Medical Advice on Benefit Design
This section establishes a "Medical Advisory Council" to make recommendations on covered benefits and ensure that the "actuarial gross value of the benefits to equal to the actuarial gross value of the benefits provided under a typical employer plan.

AAFP position: The AAFP supports Option A in the section-by-section, which would establish a special council to recommend benefits and would allow their recommendations to be submitted to Congress.

We believe that an outside panel is preferable to the other options, which include a framework established by the Secretary including no federal board whatsoever; allowing flexibility with ranges of actuarial value; allowing modifications based on the number of states adopting the benefits, or creating a new board to develop recommendations that the states could decide whether to adopt. An outside panel hopefully would be less prone to political concerns and ensure equality among benefit plan offerings.

Subtitle C – Making Coverage Affordable

Section 3111 – Support for Affordable Health Coverage
This section establishes subsidies for individuals to purchase health insurance on a sliding scale.

AAFP position: The AAFP supports sufficient subsidy amounts so that individuals can purchase meaningful coverage but does not have policy on a specific amount.

Subtitle D – Shared Responsibility for Health Care
Part VIII – Shared Responsibility Payments

Section 59B – Shared Responsibility Payments
This section requires individuals to have health coverage that meets minimum standards.

AAFP position: Academy policy states that "health care will be a shared responsibility of individuals, employers, government, and the private and public sectors". Thus, we applaud this portion of the bill as a means to ensure all individuals have coverage.

Subtitle E – Improving Access to Health Care Services

Section 171 – 173
These sections increase funding for the Federal Qualified Health Centers (FQHC) and the National Health Service Corps (NHSC). In addition, Section 172 adds language to the Public Health Service Act stating that "Required primary health services and additional health services may be provided either at facilities…determined appropriate by the center to meet the needs of its patients."

AAFP position: The AAFP supports additional funding for the FQHCs and the NHSC not only because these centers serve so many individuals but also because they are staffed, to a great extent, by family physicians. Certainly we support language requiring that primary care services be provided to these patients.

Subtitle C - Other Provisions Relating to HIT

Section 3021 – HIT Enrollment Standards and Protocols
This section requires the Secretary to work with the HIT Policy and Standards Committees to develop interoperable and secure standards and protocols that facilitate enrollment of individuals in health programs. Both the HIT Policy and Standards committee would approve these standards and protocols.

AAFP position: In a review of the appointees to the HIT Policy and HIT Standards Committees, we were concerned with the lack of representation of small and medium sized practices in the work of these committees. Without an identified representative on either committee, we want to make sure the voice of the constituency that delivers over 80 percent of the health care in the United States is heard, as it is critical for success of the work of the committees. Consequently, we recommend requiring input from providers of small and medium-sized practices, to either the HIT Policy and Standards Committees, or the Secretary, to review these standards and protocols.

Title II – Improving the Quality and Efficiency of Health Care
Subtitle A – National Strategy to Improve Health Care Quality

This subtitle "requires the Secretary to establish a national strategy and support infrastructure to improve the quality of the US health care system." The national strategy requires the Secretary to identify priorities, such as health care provided to people with high-cost chronic diseases; improve infrastructure and innovative methods for quality improvement; have the greatest potential for improving health outcomes and patient-centeredness of health care; reduce health disparities; address gaps in quality and health outcomes, comparativeness effectiveness data

and data aggregation, including the use of registries; identify areas that can improve rapidly; improve federal payment policy to emphasize quality; and enhance health care data to improve quality, transparency and outcomes.

AAFP position: In general, the AAFP supports the goals incorporated in this section. The Interagency Working Group on Health Care Quality, a federal entity to collaborate on planning and implementing quality improvement activities, seems like a natural agency to coordinate these activities. We also appreciate the requirement that entities applying for grants to develop quality measures include "the views of those providers or payers whose performance will be assessed by the measure."

In addition, the AAFP supports the provisions that establish a public reporting system that "assesses the continuity and coordination of care" and the statement that any system "minimizes the burden of collection and reporting of these measures." We support the AQA criteria for public reporting of quality/performance data, which can be found at the end of this document or at www.aqaalliance.org/reportingwg.htm.

The AAFP does not support Option A, which would add Sen. Judd Gregg's version of the WIRED Act. Our longstanding concern with that legislation is that it has been focused more on large hospitals than on small and medium-sized physician offices where most health care takes place.

The AAFP supports the requirement that the Government Accountability Office conduct periodic evaluations of the implementation of the data-collection process. Specifically, we support the provisions that determine "whether standards under the system provide for an opportunity for physicians and other clinicians and institutional providers of services to review and correct findings," as well as the extent to which quality measures "assess the continuity and coordination of care for patients."

Subtitle B – Health Care Quality Improvements

Section 211 – Health Care Delivery Research

This subtitle establishes health quality initiatives to reduce medical errors, improve patient safety, promote evidence-based medicine and disseminate best care practices. It establishes a Patient Safety Research Center with the Agency for Healthcare Quality and Research to carry out these functions.

AAFP position: The AAFP supports the tenets of this section. We consistently have advocated for the development of best practices and their dissemination and support requirements that the Center focus on "team-based health care delivery" among others. We also support identifying physicians who deliver high-quality care and the dissemination of this information.

We also would add common conditions that are seen every day by our members to your list of processes or systems on which to focus research and dissemination activities. Despite the numerous randomized clinical trials that are conducted each year, around the world, there still is a surprisingly large gap between what we know and what we need to know to provide optimal care. This is true even in highly-prevalent illnesses such as diabetes and depression.

Section 212 – Grants to Establish Community Health Teams to Support a Medical Home Model

This section establishes grants to entities to set up "Community Health Teams" to provide support to primary care providers and offer capitated payment to primary care providers as determined by the Secretary.

AAFP position: In particular, we support the provisions that require the health teams to "support medical homes, defined as a mode of care that includes personal physicians, a whole person orientation, coordinated and integrated care, safe and high quality care through evidence-based medicine, appropriate use of health information technology and continue quality improvements; expanded access to care and payment that recognizes added value to patients in a patient-centered care." This definition is in line with the Patient-Centered Medical Home that we, along with other primary care organizations, strongly support, and we thank you for its inclusion in your draft legislation.

We also support provisions that "provide support necessary for local primary care providers to coordinate and provide access to high-quality health care services; provide access to appropriate specialty care and inpatient services; provide quality-driven cost-effective, culturally appropriate, and patient- and family-centered health care; promote effective strategies for treatment planning, monitoring health outcomes and resources use, treatment decision support, organizing care to avoid duplication of services; provide local access to the continuum of health care services in the most appropriate settings.

However, we do not support provisions in this section that allow assistance to be provided to local primary care providers to "provide access to pharmacist-delivery medication therapy management services, including medication reconciliation." We consistently have advocated for a team approach to patient care but are unclear as to the ramifications of this provision. We support this concept only as it relates to pharmacists being part of the expanded team based approach to care via the patient-centered PCMH model.

(d) Requirement for Primary Care Providers
This provision requires a provider who contracts with a care team to provide a care plan to the care team for each patient participant and provide access to participant health records/primary care practices and meet regularly with the care team to ensure integration of care.

AAFP position: We do not support this section. The care plan is the responsibility of the primary care team in partnership with the patient and family. However, the language appears as though an outside entity would prepare the care plan, i.e., when a physician and practice were contracting out a service. If this is the case, then it should be the responsibility of the contracted entity to develop the care plan, which would then be reviewed and approved by the primary care physician. Otherwise, it would be a huge burden on our members if they had to develop the plan when contracting out for these services.

Section 213 – Grants to Implement Medication Management Services in Treatment of Chronic Disease
This section establishes a program within the Patient Safety Research Center to provide grants to entities to implement medication management services provided by licensed pharmacists, as a collaborative, multidisciplinary, inter-professional approach to the treatment of chronic diseases for targeted individuals, to improve the quality of care and reduce overall cost in the treatment of such diseases.

AAFP position: While we understand the committee's desire to improve care quality and reduce cost, we are concerned with this section for the following reasons. In general, we believe that

this section is not about supervision, but rather about requiring medication management services. This is not something we support as a requirement for patient-centered medical homes. Physicians should decide when a pharmacy consult is necessary.

We understand that with the increased emphasis on the use of prescription medication, the expanding role of the pharmacy professional directly affects family physicians. In a collaborative environment, the pharmacist is a logical member of a team and qualified to deal with issues of drug usage, medication efficacy, and medication use patterns.

While we realize many states allow physicians and pharmacists to enter into voluntary written arrangements to manage the drug therapy of patients, we believe the interests of patients are best served when their care is provided by a physician or through an integrated practice supervised directly by a physician. AAFP policy clearly states that in all instances supervision by a physician is a paramount concern.

The central principle underlying physician supervision is that the physician retains responsibility for the care of the patient. Physician supervision means that the pharmacist only performs medical acts and procedures that have been specifically authorized and directed by the supervising physician. This aspect of the policy is applicable in those instances where a collaborative (or integrated) approach is being utilized to optimize drug therapy.

There is a growing body of research indicating that physicians and pharmacy professionals working in a collaborative environment can make positive contributions to patient health. Certain areas have been identified which seem amenable to the presence of a pharmacy professional. The program basics are similar in each instance. Pharmacist participation entails monitoring compliance, reviewing drug therapy, recommending changes in drug regimens, and education in behavior modification.

The AAFP recognizes the unique expertise of the pharmacist. Because of this expertise there are areas of professional activity where by law the pharmacist practices independently and other areas where that expertise is best exercised in an environment with physician supervision. While pharmacy professionals should not prescribe drugs or alter in any manner a prescription written by a physician, they have valuable contributions to make in a team environment with a strong pharmaceutical component.

Thus, we support the provision that a plan must be “formulated according to therapeutic goals agreed upon by the prescriber and the patient or caregiver.” However, we do not support pharmacists “performing an initial comprehensive medication review to identify, resolve, and prevent medication-related problems.” This should be the responsibility of the primary care physician and team.

Section 219 – Center for Health Outcomes Research and Evaluation
This section establishes a Center for Health Outcomes Research and Evaluation to “collect, conduct, support, and synthesize research with respect to comparing health outcomes, effectiveness and appropriateness of health care services and procedures in order to identify the manner in which diseases, disorders, and other health conditions can most effectively and appropriately be prevented, diagnosed, treated, and managed clinically.”

AAFP position: The AAFP strongly supports the inclusion of comparative effectiveness research in the draft bill.

We have two recommendations, however: Part (4), which indicates the Center must "use a broad range of methodologies, including randomized controlled clinical trials, observational studies and other approaches." We believe this provision also specifically should include "practice-based network research." This kind of research must be used in tandem with other methodologies to produce the real-world information produced by physicians in their practices.

Regarding the makeup of the Advisory Council, we recommend that the bill add "Clinical Researchers who conduct practice-based network research."

Section 220 – Demonstration Program to Integrate Quality Improvement and Patient Safety Training into Clinical Education of Health Professionals
This section establishes a program of grants to develop and implement quality improvement and patient safety programs in academic curricula.

AAFP position: The AAFP supports this section as another means to improve quality and patient safety in a reformed health care system. Nevertheless, we recommend adding medical schools and departments, unless that was assumed under (A) "a health professions school."

Title III – Improving the Health of the American People
Subtitle B – Increasing Access to Clinical Preventive Services

AAFP position: The AAFP greatly supports the aims of this entire Title, which focuses on disease prevention, health promotion and an enhanced public health system.

Section 311 – Right Choices Program
This section "establishes a temporary program giving uninsured adults access to preventive services."

AAFP position: While we support this sort of program, our concern is with part (3), Payment of Providers, which requires states to reimburse health care providers "based on the amount paid by the state for similar services under the Medicaid program in the state and not exceeding the reimbursement provided for similar services under the Medicare program."

We consistently have indicated our concern that primary care physicians do not receive adequate payments for their value-added services. In particular, not only is Medicare payment skewed by a distorted, flawed system, but Medicaid pays physicians at an even a lower rate. While we understand the committee's desire to provide these services to individuals, we urge the committee to increase the payment rate under this section.

Specifically, preventive services should be encouraged and incentivized. This should be done via proper (adequate) payments to physicians and no out-pocket-expenses for the patient. Benchmarking payment to somewhere between Medicaid and Medicare is not adequate. Many physicians do not participate in either program because the payment is insufficient to cover costs. Thus, we support only payment that is greater than Medicare (and then more than Medicaid).

Subtitle C – Creating Healthier Communities
The purpose of this Subtitle is to improve health in communities around the US.

Section 324 - Immunizations
The purpose of this section is to allow states to purchase recommended vaccines for adults.

AAFP position: The AAFP has long-endorsed the concept that all children *and adults*, regardless of economic and insurance status, have access to all immunizations recommended by the AAFP, so we appreciate its inclusion.

Title IV – Health Care Workforce
The overall purpose of this Title is to gather data on the health care workforce to meet healthcare needs; increase the supply; enhance education and training; and provide support to the current workforce to improve access and delivery.

AAFP position: The AAFP strongly supports a cohesive, comprehensive strategy to align the US health care workforce with a reformed health care system and thank you for the inclusion of this section.

Section 411 – National Health Care Workforce Commission
The purpose of this section to establish a national commission to "review health care workforce and projected workforce needs."

AAFP position: Along with the other major primary care organizations, we are concerned about the decline in the number of medical students pursuing a career in primary care, at a time when the demand for primary care services will only be increasing. Therefore, we strongly support a national workforce commission to recommend the appropriate numbers and distribution of physicians, including primary care physicians, general surgeons, and other specialties facing critical shortages, policies to achieve such workforce goals, and benchmarks to evaluate the impact of such policies. We support the broad range of membership included in the commission but recommend that Council on Graduate Medical Education (COGME) be added to the list of relevant organizations with which the Commission should consult. We appreciate inclusion of a date certain by which the first recommendations should be made.

Advisory Committee on Training in Primary Care Medicine and Dentistry
This section amends Section 748 to "develop, publish and implement performance measures, which shall be quantitative to the extent possible, for programs under this part; develop and publish guidelines for longitudinal evaluations; and recommend appropriation levels for programs under this part."

AAFP position: We recognize the need for program evaluation metrics and support this section.

Subtitle C – Increasing the Supply of the Health Care Workforce

Section 421 – Federally Supported Student Loan Funds
This section "eases criteria for schools and students to qualify for loans, lowers interest rates, shortens payback periods, and eases the non-compliance provision."

AAFP position: The AAFP has long supported loan repayment and scholarship programs. Along with the other primary care organizations, we support establishing a loan repayment program, not to exceed $35,000 per year, for individuals agreeing to serve as physicians in general internal medicine, general pediatrics and family medicine in areas that are not Health Professional Shortage Areas, but that have a critical shortage of primary care physicians in such fields and excluding these repayments from an individual's gross income.

We also support grants to Critical Shortage Health Facilities for scholarships, not to exceed $35,000 per year, to individuals agreeing to serve as a physician at such facility after completing residency in the fields of family medicine, general pediatrics and general internal medicine and excluding these scholarship funds from an individual's gross income.

While we note that similar provisions exist for a number of providers in this section, we urge you to include them for primary care physicians, as well.

Subtitle D – Enhancing Health Care Workforce Education and Training

Section 431 – Training in Family Medicine, General Internal Medicine, General Pediatrics, and Physician Assistantships
The purpose of this section is to "provide grants to develop and operate training programs, financial assistance of trainees and faculty and faculty development in primary care and physician assistant programs. Priority is given to programs that educate students in team-based approaches to care, including the patient-centered medical home and the amount authorized is $125 million."

AAFP position: The AAFP strongly supports the reauthorization of Title VII Section 747 Training in Primary Care Medicine. The language in the *Affordable Health Choices Act*, however, raises some concerns. The bill as drafted would undermine federal support for Departments of Family Medicine (Academic Administrative Units). Further, it greatly expands the scope of this section into Continuing Medical Education and other issues without an adequate increase in funding to assure its success.

The AAFP has requested $215 million for the programs within Title VII Section 747 for which the *Affordable Health Choices Act* would authorize $125 million. Although the dentistry programs have been removed from Section 747 by the HELP Committee bill, Section 747(a)(1)(G) – page 494, line 19 to page 495, line 12 – would dramatically expand the authority to provide funding for Continuing Medical Education programs. Expanding the program to cover CME without a commensurate increase in the authorized funding seriously threatens primary care training. We urge the Committee to strike CME from this section.

The new section on page 494, lines 5 – 7, "to plan, develop, and operate a program for the training of physicians teaching in community-based settings;" represents a positive step to support training of faculty in the community. This broad new effort also will not succeed without adequate funding.

We support Section 747(a)(1)(E) on page 494, line 8-14 which offers financial assistance for trainee or fellowships for those who wish to teach or conduct research in the three primary care fields. For the first time, research is integrated into Title VII and will help make sure development of researchers is part of family medicine training.

Section 747(c)(2) lines 10 – 15 on page 499 of the bill establishes a set-aside of 15 percent for physician assistant programs. Regrettably, fewer new PAs are entering family medicine. PA programs are producing graduates who are specializing in ways which mirror physician specialization. In contrast, the vast majority of family medicine graduates practice primary care. The Committee should include a set-aside of at least 65 percent for family medicine programs, a level which reflects historic proportion of this section.

We urge the Committee to strike the provision which caps funding for departments in Section 747(c)(3) on page 499. This section limits the Academic Administrative Units funding to $750,000 per year, which stands in stark contrast to the Section 747 grants to departments in the past. In FY08, departments received 21.5 percent of the funds available under Section 747. The bill, as drafted, would limit the authorization to less than one percent of the total dollars.

Section 752 – Continuing Education Support for Health Professionals Serving in Underserved Communities
The purpose of this section is to make grants to entities to improve health care, increase retention, increase representation of minority faculty members, enhance the practice environment, and provide information dissemination and educational support to reduce professional isolation through the timely dissemination of research findings."

AAFP position: The AAFP supports any type of assistance to help providers in underserved areas. In particular, we support using grant funds that make primary care a priority.

Section 455 – Primary Care Extension Program
The purpose of this section is to "educate and provide technical assistant to primary care providers about evidence-based therapies, preventive medicine, health promotion, chronic disease management and mental health."

AAFP position: The AAFP is pleased with the inclusion of this section, which will provide primary care providers with assistance to improve quality or redesign their practice or including the principles of the patient-centered medical home. Nevertheless, we suggest the committee add language to ensure there will be sufficient physician input throughout the program.

Title VI – Improving Access to Innovative Medical Therapies
Subtitle A – Biologics Price Competition and Innovation

While we note from the draft legislation that policy is still under discussion on this issue, we wanted to provide the committee with AAFP policy for your information. We do support legislation to authorize the FDA to develop a process for approving follow-on biologics that will take into account the safety, availability and cost of these products.

AQA Principles for
Reporting to Clinicians and Hospitals[1]

The AQA recognizes that reporting information to clinicians on their respective performance is critical for improving quality and patient safety as well as promoting accountability. The following principles are designed to guide the reporting of such information to clinicians and hospitals. These principles reflect the importance of assuring that clinicians receive valid, reliable, and useful information so they can most effectively assess and improve their performance, and meet/exceed agreed-upon targets. They also emphasize the need for physician engagement in the design of reports.

Recognizing that consumers, purchasers and other stakeholders also need better information to enable them to make informed decisions about treatment, coverage and other matters related to their health care, a separate set of principles has been developed to guide public reports.[2] The principles set forth in this document should be considered in conjunction with these other principles as well as principles for performance measurement,[3] and data sharing and aggregation[4] which the AQA has already endorsed.

Content of reports

1. Reports should focus on areas that have the greatest opportunities to improve quality by making care safe, timely, effective, efficient, equitable and patient centered.

2. Reports should rely on standard performance and patient experience measures that meet the AQA Principles for Performance Measurement (e.g., measures should be evidence-based, relevant to patient outcomes, statistically valid and reliable).

3. Reports should include overall composite assessments of individual clinician or group performance as well as assessments of the individual measures used for the overall composite assessment (e.g., quality or cost of care).

4. Performance data should, when available, reflect trend data over time rather than periodic snapshots to optimize data use for quality improvement. Measures used for trending should be stable (e.g., the data definitions or collection methodology do not change between intervals) unless there is compelling evidence or a justifiable reason not to be.

Transparent methods

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[1] A previous version of these principles was initially endorsed by AQA as a Beta set of principles on 4/29/05.
[2] AQA developed separate sets of principles for reports to providers and for reports to consumers, purchasers and other stakeholders due to differences in these reports' purposes, content and formats.
[3] AQA Parameters for Selecting Measures for Physician Performance
[4] AQA Data Sharing and Aggregation Principles

5. Data specifications for reported performance data, such as sample size and methods of data collection and analysis, should be explicit and disclosed to physicians and hospitals.

6. Clinicians whose performance is reported should be able to review and comment on the methodology for data collection and analysis (including risk adjustment). Clinicians and hospitals should be notified in writing in a timely manner of any changes in program requirements and evaluation methods.

7. Sponsors of reports should also make the performance results available to clinicians for review prior to any public release. In order to improve the accuracy of reports, mechanisms need to be in place to verify and correct reported data.

8. To the extent possible, results should accurately reflect all services that are accountable in whole or in part for the performance measured. Attribution should be explicit and transparent.

Portrayal of performance differences

9. Results of individual clinician or group performance should be displayed relative to peers. Any reported differences between individual providers or groups should include the clinical relevancy of the findings.

Report design and testing for usability

10. Practicing physicians should be actively involved in the design of performance reports.

11. Report formats should be designed to be user-friendly and easily understood, and should be pilot-tested before implementation.

12. Data displays in reports should highlight meaningful and actionable differences in performance.

13. Reports should be continually improved so that they are increasingly effective and evaluated for potential unintended consequences.

Collaboration

14. Clinicians and hospitals should collaborate to share pertinent information in a timely manner that promotes patient safety and quality improvement.