AMERICAN ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

May 25, 2012

The Honorable Dave Camp
Chairman, Ways and Means Committee
U.S. House of Representatives
Washington, DC 20515

Dear Representative Camp:

Thank you for the April 27 letter from you and your colleagues on the House Ways and Means Committee soliciting AAFP's views on improving the quality and efficiency of the Medicare physician payment system. On behalf of the 105,900 members of the American Academy of Family Physicians, I am pleased to provide responses for the Committee in its work to address the flaws in the current Medicare payment system. Because many public and private payment systems are pegged to Medicare rates, the decisions made by the Centers for Medicare and Medicaid Services (CMS) for payment of services have a broad applicability to the payment system generally. Therefore, reforming the flawed Medicare payment formula that CMS administers is a necessary part of our collective responsibility to restrain health care costs and to assure our patients and your constituents that we have a health care delivery system that is built on a foundation of primary care.

According to the Institute of Medicine (IOM), primary care is *"the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community."* In a letter (dated March 12, 2012) to the Acting Administrator of the Centers for Medicare and Medicaid Services (CMS), we defined primary care more descriptively: "Primary care today is much more proactive, complex and strategic, including treatment of illness even before symptomatic presentation, extensive screening and prevention and counseling, comprehensive, coordinated, and continuous care." The AAFP is the only physician organization whose entire membership has been trained to provide this primary medical care.

Consequently, AAFP has been particularly pleased to see growing data that supports the value of primary care as a necessary component to improving health care outcomes and restraining health care costs, especially when that care is delivered in a team-based Patient Centered Medical Home (PCMH). For example, findings from the Dartmouth Health Atlas Data demonstrate strong geographic correlations with having more primary care, particularly family medicine, and having lower Medicare costs and reduced "ambulatory care sensitive" hospitalizations; i.e., hospitalizations that should not happen if patients have good access to primary care.

There is also growing evidence that experiments with PCMH and Accountable Care Organizations (ACO)—particularly those that emphasize improved access to more robust primary care teams—can reduce total costs by 7-10 percent, largely by reducing avoidable hospitalizations and emergency room visits. More recently, the

11400 Tomahawk Creek Parkway • Leawood, KS 66211-2680 • 800.274.2237 • 913.906.6000 • Fax: 913.906.6075 • fp@aafp.org

Commonwealth Fund studied the effect on Medicare spending if the 10-percent additional payment for primary care services provided by primary care physicians were made permanent and the study concluded:

> *…the fee increase would increase primary care visits by 8.8 percent, and raise the overall cost of primary care visits by 17 percent. However, these increases would yield more than a six-fold annual return in lower Medicare costs for other services—mostly inpatient and post-acute care—once the full effects on treatment patterns are realized. The net result would be a drop in Medicare costs of nearly 2 percent. These findings suggest that, under reasonable assumptions, promoting primary care can help bend the Medicare cost curve.*

Private sector payers are ahead of the federal government in this regard. Wellpoint, for example, has reported: "We know, from our work with pilot programs, that strengthening the primary care relationship makes a meaningful difference in patient quality, outcomes and cost." North Dakota Blue Cross/Blue Shield reported to the Patient Centered Primary Care Collaborative that the results of their PCMH pilots for three major chronic illnesses showed that emergency room visits were 30 percent lower in PCMH and inpatient hospitalizations were 18 percent lower for their patients in a PCMH. In what they called "groundbreaking results," the New Jersey Blue Cross/Blue Shield reported that the beneficiaries who participated in their medical home program, compared to those who did not, showed significant improvement in quality and cost:

Quality Measures
- 8% higher rate in improved diabetes control (HbA1c)
- 6% higher rate in breast cancer screening
- 6% higher rate in cervical cancer screening

Cost and Utilization Indicators
- 10% lower cost of care (per member per month)
- 26% lower rate in emergency room visits
- 25% lower rate in hospital readmissions
- 21% lower rate in hospital inpatient admissions
- 5% higher rate in the use of generic prescriptions

As the Committee examines how to address the need for greater quality and efficiency in the Medicare system, we encourage you to keep in mind the value of primary care in achieving those important goals.

Rewarding Quality and Efficiency

1. *How does your organization think quality, efficiency, and patient outcomes should be incorporated into the Medicare physician payment system? (Please include details on experiences with non-Medicare payers that could be instructive.)*

   Response: The National Quality Forum (NQF) is an organization created to develop and assess quality measures in health care. The NQF describes the three-step process they use to achieve quality improvement. The first step is convening expert members across the healthcare industry, including patients, to define quality with uniform standards and measures that apply to the many facets of care patients receive. The second step is to report and analyze information gleaned from measuring performance to pinpoint where patient care falls short. The third step is for caregivers themselves to examine information about the care they are providing and use it to improve.

One of the most recent efforts that the NQF has created is the Measure Applications Partnership (MAP). The MAP is a public-private partnership that the NQF has convened to provide input to the Department of Health and Human Services (HHS) on the selection of performance measures for public reporting and performance-based payment programs. NQF was selected by HHS to fulfill a provision in the Affordable Care Act to convene multi-stakeholder groups to:

- Identify the best available performance measures for use in specific applications.
- Provide input to HHS on measures for use in public reporting, performance-based payment, and other programs.
- Encourage alignment of public and private sector efforts.

In convening MAP, NQF brings together stakeholder groups in a unique collaboration that balances the interests of consumers, businesses and purchasers, labor, health plans, clinicians and providers, communities and states, and suppliers.

2. *To what extent has your organization developed and/or facilitated the use of:*
   a. *Quality and outcome measures?*

   Response: As you can see below in the section on alternative payment models, AAFP strongly endorses broad implementation of the Patient Centered Medical Home as a transformation of the health delivery system that will likely improve health outcomes and restrain cost growth. The AAFP, along with the American Academy of Pediatrics, the American College of Physicians and the American Osteopathic Association, developed this model of delivery system reform and, in 2007, the four organizations agreed to the Joint Principles of a Patient Centered Medical Home. A critically important part of this care delivery model is the incorporation of quality measures and the careful monitoring of costs and patient outcomes. The AAFP provides its members with on-line tools that a health care team, led by a family physician, can use to determine what is necessary for the specific practice to become a qualified medical home.

   One of the key features of the PCMH is the use of metrics to monitor and improve the quality and efficiency of patient care. In addition, the AAFP has created TransforMED, a separate agency to transform health care delivery to achieve optimal patient care, professional satisfaction and success of primary care practices. TransforMED promotes the use of specific metrics for practice finances, clinical care and workflow/efficiency. The objectives of TransforMED are:

   - To develop high-performance primary care practices through a transformative process of practice redesign focused on patient care and practice team satisfaction
   - To generate transportable new knowledge about the practice transformation process
   - To generate means to allow for the continued financial viability of the organization

   b. *Evidence-based guidelines?*

   Response: All of the NQF measures are derived from evidence-based guidelines. In addition, AAFP recommends that emphasis be given to more longitudinal measures, i.e., measures that are focused on patient oriented outcomes of care. Process-of-care measures are more helpful at the local level for quality improvement.

c. *Patient registries?*

Response: The AAFP supports registries that are used at the point of care as a method of providing better service to patients and ensuring that they receive evidenced based care on a timely basis. An effective registry tells the health care team who the team's patients are and what they each need. To the extent that health plans require data from the registry as a feature of payment, AAFP believes that the data should be based on measures that actually matter to patients, which are outcome-oriented. Point of care registries serve the dual purpose of increasing the reliability and consistency of patient care while generating data for quality measure reporting as a by-product.

d. *Continuous quality improvement programs or strategies?*

Response: The AAFP has a deeply rooted commitment to quality improvement and has provided members with tools and information about the science of improvement, using data to drive decision making and optimizing the use of health information technology. Using point of care registries for the most common clinical conditions provides an excellent example of this systematic approach.

e. *Electronic health records?*

Response: Health information technology must support the core business, clinical and communication functions in the physician's practice. In addition to recording important clinical information the electronic health records should support quality measurement, organize data into useful knowledge and improve the efficiency of care. Electronic records should also be able to check for medication interactions, help with age and weight appropriate dosage selection and produce a care plan efficiently.

3. *What clinical improvement activities have been developed and are supported by your organization or have otherwise been used effectively by your members?*

Response: A recent example of an important clinical improvement activity is the Choosing Wisely Campaign, which is part of a multi-year effort initiated by the American Board of Internal Medicine Foundation to help physicians be better stewards of finite health care resources. Originally piloted by the National Physicians Alliance through a *Putting the Charter into Practice* grant, nine medical specialty organizations, including the AAFP, along with Consumer Reports, have identified five tests or procedures commonly used in their field, whose necessity should be questioned and discussed. The resulting "Five Things Physicians and Patients Should Question" is designed to spark discussion about the need for—or lack of—many frequently ordered tests or treatments.

4. *Have non-Medicare payers recognized or rewarded these clinical improvement activities? If so, how?* Commercial payers have begun to reward quality patient outcomes and improved organizational effectiveness demonstrated by the patient centered medical home though novel payment arrangements. Care management and care coordination are now being funded by a "care management fee" that is in addition to fee-for-service payment and intended to cover the cost of non-visit based care that supplements the face-to-face visits in the office and promotes a team approach.

5. *Is there anything else your organization would like to share with the Committee on how to reward physicians for high quality, efficiency and patient outcomes?* Any new payment system must foster a

shared sense of responsibility for cost and quality across the community of care. Comprehensive primary care that provides a patient centered medical home environment must be central and properly valued by the system. The AAFP advocates for a blended payment model that includes components of fee-for-service, a care management fee (paid prospectively on a PMPM basis) and incentives to achieve quality improvement goals.

Alternative Payment Models

1. *Are there quality-enhancing alternatives to fee-for-service, such as bundled payments and shared savings models that your members have experience with or are developing with private payers?*
    a. *If so, what are the pros and cons of such approaches?*
    b. *If not, are there alternatives to fee-for-service that are relevant and feasible for your members?*

Response: There is growing and compelling evidence that a health care system based on primary care, as described by the IOM above, will help control costs, increase patient satisfaction and improve patient health. Because this transformation to a health delivery system based on primary care is so important, the AAFP advocates for payment reforms that ultimately include a blended payment system for primary care delivered within the context of a Patient-Centered Medical Home (PCMH). This blended payment consists of these elements:

- A care management fee that compensates for expertise and time required for primary care activities (like management and coordination of care) that are not direct patient encounters
- Fee-for-service payment for those discrete services and procedures that are provided to the patient in the ambulatory setting
- Pay-for-performance that will reward efforts to improve all the elements of health care and that recognizes demonstrated value to the system.

Over time, the percent of fee-for-service payments should be decreased as the care management fee and pay-for-performance are increased, thus moving away from a dependence on a system that encourages volume. This blended payment system for medical home teams should facilitate the transformation of practices, so that all of the team's participants perform their own unique tasks in a coordinated way. This means extensive investments not just in health information technology but also in interoperable systems, not just with hospitals and other health care centers, but also with community services. The growing experience of family physicians in the private sector's experimentation with the Patient-Centered Medical Home points very strongly to better health care and greater efficiency as a result of these investments.

Patient Involvement and Regulatory Relief

1. *How does your organization think physicians can encourage beneficiaries to seek appropriate, high-value health care services?*

Response: The most effective way to encourage patients of any health plan to seek appropriate high-value health care services is for the patient to have a trusting relationship with his or her primary care health team. The role of the primary care team is not to be a gate-keeper to the health care system, as envisioned by the managed care model of the 1990s. Such a function destroys the relationship of the family physician and the patient. Instead, the primary care team functions best as a gateway that provides assistance and coordination to the patient. With effective and interoperable electronic health records, the

family physician can help the patient keep track of prescriptions, treatments and appointments in multiple health care settings. With a broad health care team, the family physician can provide primary care services in a single setting that minimizes additional costs and can help prevent hospitalizations and re-admissions to hospitals.

2. *Are there administrative and regulatory burdens that your organization sees as barriers to fundamental delivery system reform? If so, please describe.*
3. *Are there unnecessary administrative and regulatory burdens that your organization sees as taking valuable time away from seeing patients and/or increasing costs to the Medicare program? If so, please describe.*

Response: AAFP has recently outlined these issues to CMS and to HHS. I would refer you and your staff to our response to Secretary Sebelius, submitted on June 29, 2011, regarding the proposals entitled, "Reducing Regulatory Burden; Retrospective Review under Executive Order 13563" and to our comments to Acting CMS Administrator Tavenner on December 7, 2011, on the proposed "Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction."

The principal issues that our members are concerned about are:

- **Time wasted on prior authorization paperwork**

  A significant unfunded mandate burdening family physicians is the frequent phone calls, faxes, and forms physicians and their staff must manage to obtain prior authorization from a Prescription Drug Plan (Part D) or a Medicare Advantage Plan (Part C). Frequent formulary changes by the health plan and their time-consuming pre-authorization requirements impede the practice of medicine. The AAFP suggests that CMS require Part D and Part C plans to reimburse physicians for prior authorizations that exceed a specified number or that are not resolved within a set period of time; prohibit repeated prior authorizations for ongoing use of a drug by patients with chronic disease; prohibit prior authorizations for standard and inexpensive drugs; and require that all plans use a standard prior authorization form.

- **Overlapping documentation and certification**

  In trying to detect, prevent, and apprehend the criminals that attempt to fraudulently bill the Medicare and Medicaid programs, HHS subjects all physicians to multiple and often overlapping documentation and certification requirements. Each day, family physicians spend enormous amounts of time completing a wide range of certification paperwork for home health services and durable medical equipment. Navigating these requirements successfully takes considerable time away from patient care. Instead of treating all Medicare and Medicaid billing physicians as if they are criminals until proven otherwise, the AAFP suggests CMS develop comprehensive yet understandable policies that first target individual providers who are repeat offenders and we urge CMS to reevaluate the disorganized Medicare documentation and certification requirements.

- **Harmonizing incentive programs**

  Another way to successfully address HHS regulatory burdens felt by family physicians would be to harmonize all of the codes, quality measures, operating rules, feedback reports, and timelines associated with the Physician Quality Reporting System (PQRS), Medicare electronic prescribing incentive program, and the Medicare and Medicaid electronic health records (EHR) incentive programs. Since each program was created piecemeal by separate laws, physicians are frustrated and confused by the several inconsistencies within these incentive programs. The AAFP

recognizes that HHS has already taken steps to align these programs, and we urge HHS to continue further with these efforts.

Thank you, Chairman Camp, for the opportunity to address these important issues. We would be pleased to provide any additional detail that the Committee would need. Please feel free to contact the AAFP Director of Government Relations, Kevin Burke, at kburke@aafp.org or by phone at 202-232-9033.

Sincerely,

Roland A. Goertz, MD, MBA, FAAFP
Board Chair

Cc: Members of the Ways and Means Committee