



AMERICAN ACADEMY OF
FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

April 29, 2011

The Honorable Fred Upton
Chairman

The Honorable Henry Waxman
Ranking Member

The Honorable Joe Barton
Chairman Emeritus

The Honorable John Dingell
Chairman Emeritus

The Honorable Joseph Pitts
Chairman, Subcommittee on Health

The Honorable Frank Pallone
Ranking Member, Subcommittee on Health

The Honorable Michael Burgess
Vice Chairman, Subcommittee on Health

Energy and Commerce Committee
2125 Rayburn Building
U.S. House of Representatives
Washington, DC 20515

Dear Representatives:

Thank you for your letter of March 28 offering the American Academy of Family Physicians (AAFP) the opportunity to comment on the question of what kind of payment system should replace the Medicare physician fee schedule. On behalf of the 97,600 members of the AAFP, I commend your bipartisan commitment to finding a solution to this critically important issue. 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. Reforming the flawed Medicare payment formula is a necessary part of the 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.

The AAFP advocates for payment reforms that include a blended payment system for primary care delivered within the context of a patient-centered medical home (PCMH). By this, we mean a system that consists of three elements:

President

Roland A. Goertz, MD
Waco, TX

President-elect

Glen Stream, MD
Spokane, WA

Board Chair

Lori J. Heim, MD
Vass, NC

Directors

Jeffrey J. Cain, MD, *Denver, CO*
Thomas Allen Felger, MD, *Granger, IN*
George Wm. Shannon, MD, *Columbus, GA*
Reid Blackwelder, MD, *Kingsport, TN*
Conrad L. Flick, MD, *Raleigh, NC*
Laura Knobel, MD, *Walpole, MA*

Barbara Doty, MD, *Wasilla, AK*
Richard Madden, Jr., MD, *Belen, NM*
Robert Wergin, MD, *Millford, NE*
Russell Kohl, MD, (New Physician Member), *Vinita, OK*
Heidi Meyer, MD, (Resident Member), *Tucson, AZ*
Kevin Bernstein (Student Member), *Quakertown, PA*

Speaker

Leah Raye Mabry, MD
San Antonio, TX

Vice Speaker

John S. Meigs, Jr., MD
Brent, AL

Executive Vice President

Douglas E. Henley, MD
Leawood, KS

www.aafp.org

- Fee-for-service payment , with a higher payment rate for primary care physicians
- A care management fee that compensates for expertise and time required for primary care activities that are not direct patient encounters
- Performance bonuses based on a voluntary pay-for-reporting/performance system.

To achieve this payment reform, we recommend that Congress establish a transition period of 5 years with mandated payment conversion factors (with higher rates for primary care physicians) for the Medicare fee-for-service payment. In addition, we recommend, during this transition, continuing the Primary Care Incentive Payment, increasing this to 20 percent, and permanently extending the program making Medicaid payments equal to Medicare rates for primary care and preventive health services offered by primary care physicians. During this limited transition period, the CMS Innovation Center should coordinate programs to test delivery system reforms and provide comparable data to demonstrate the most effective reforms in specific settings and systems.

The Flawed Sustainable Growth Rate Formula

The current formula for determining Medicare's physician fee-for-service payment schedule is greatly affected by the Sustainable Growth Rate (SGR). The biggest flaw in the SGR, and hence in the Medicare payment system, is that it attempts to control the volume of services at the *individual* physician level by imposing payment penalties *globally* across all physicians.

The theory is that when volume increases exceed established targets, payment rates should decline, signaling to medical practices that they should reduce services. But the incentive is perverse. A medical practice needs to meet certain fixed costs, and as payment rates decline, the logical economic decision at some point is simply to quit providing services because payments are not covering those fixed costs. This is particularly true for primary care physicians whose practices are predicated on cognitive clinical decision-making and who operate typically on extremely thin margins. At the same time, there is a shortage of primary care physicians and a need for more as Baby Boomers enter the Medicare system and the *Affordable Care Act* extends coverage to millions of otherwise uninsured individuals.

This dilemma touches on the fundamental problem with fee-for-service: payment is based solely on what procedure is provided to the patient, not the value of the service, and thus encourages volume growth. Fee-for-service recognizes medical care as a series of things physicians do. The doctor performs an EKG, or removes a cyst from the patient's eye lid, or provides a session of therapy, or guides parents through childbirth. The physician has provided the patient a service and is paid for doing so by a formula determined by Congress (in the case of Medicare) and by other payers.

But what the formula cannot do is pay for thought, analysis, deduction, discussion and persuasion and for the value that comes from managing the care of the whole person, as well as the value that comes from avoiding unnecessary care. It also cannot adequately value care coordination, non face-to-face encounters, group visits, guided patient self-management and other non-traditional mechanisms to deliver care. When a patient walks into a primary care office with a complaint – whether an earache, a pain in the stomach or a persistent cough –

there are countless possibilities for what may be the underlying cause or causes. It takes knowledge, perception, experience and insight to conduct the right exam that will lead to an accurate diagnosis and effective intervention. But a fee-for-service payment system undervalues these cognitive skills and does not pay for them, apart from a limited, generalized “Evaluation and Management” set of office visit codes.

Comprehensive primary care does, of course, include some procedural activities for which a fee-for-service payment is appropriate within the current payment construct. However, such procedures are not the core of primary care, which is a specialty that goes beyond such procedures both in behavior and value. A patient sees a primary care physician to understand his or her current health condition, to have perplexing symptoms evaluated, to learn how to take responsibility for her or his own health which may include a change in diet and exercise patterns to prevent disease. A patient also sees a primary care physician to help understand how to manage chronic diseases – like diabetes, asthma, osteoporosis, depression – often all at once, rather than separately. Fee-for-service pays for individual actions, whereas primary care physicians coordinate these otherwise separate actions and help prevent diseases that would otherwise require expensive procedural treatments.

Consequently, fee-for-service does not value comprehensive care in which the family physician provides most of what the patient’s needs, including appropriate referrals. What is the value of managing a patient’s multiple chronic conditions in such a way that he or she may continue to lead a productive life? What is the value of helping a patient successfully manage his or her health in such a way as to avoid costly hospitalizations and procedural services? Fee-for-service has no answers to these questions.

The Value of Primary Care

The evidence for the value of primary care in restraining health care costs and improving quality is very clear when that care is delivered in a team-based Patient Centered Medical Home. For example, findings from the Dartmouth Health Atlas Data demonstrate good 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.

Primary care is just 6-7 percent of total Medicare spending, so medical home experiments are recouping the entire costs of care in those settings, not just the added investments. These findings hold true in integrated systems like Geisinger, insurance experiments like Blue Cross Blue Shield of South Carolina, or individual system efforts like Johns Hopkins. The key factor across all of these is increased investments in the primary care setting. Based on the early results of these experiments, we believe that to achieve the savings that primary care will generate, which will more than offset the cost of the investment, we should increase primary care payments, so that they represent 10-12 percent of total health care spending, particularly if

done in ways that improve access to a broader array of services. An evaluation of a primary care-based ACO by the Robert Graham Center for Policy Studies in Family Medicine and Primary Care (a division of the AAFP) is showing that over the longer term, these investments could offset inpatient costs by 50 percent or more.

The Medicare Payment Advisory Commission (MedPAC) has long argued that Medicare's payment system undervalues primary care and overvalues procedures and technology. We agree. There are many reasons for this, but we think that there is an accepted bias in the system that favors procedures and which makes it difficult to take into account the often declining amount of time and work involved in procedures, as physicians become more experienced with them and the associated technology improves. This leads to an overvalued payment for procedures and undervalued cognitive payments.

While AAFP, and other primary care physician organizations, are strongly committed to the PCMH model, we do not discount other potential payment reforms. But the evidence shows that to achieve the savings that Congress is looking for, and to improve the quality of health care delivered to millions of patients in the country, reform must include investment in primary care.

Patient Centered Medical Home

Since fee-for-service alone encourages utilization, does not check avoidable duplication of service, wastes resources and leads to inefficiency and unnecessary costs, we believe reforming the Medicare physician payment system with just a different fee-for-service formula will not accomplish those Congressional goals of restraining health care cost increases and improving the quality of health care. The payment system should actively encourage care management and preventive health and reward quality improvement. To do all of that, we have come to believe that payment reform, at least for primary care delivered by a PCMH team, requires these components:

- fee-for-service for discrete services provided to patients;
- a care management fee for the more global care management and coordination provided to patients, often non-face-to-face, in a patient-centered medical home; and
- 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.

Transition to a New Payment Model

Payment reform should foster this necessary transformation. But such transformation will take time. We recommend five years of mandated updates to the physician fee schedule that include a higher payment rate (of at least 2 percent) for primary care physicians (defined as those with specialty designations of family medicine, general internal medicine, geriatrics, and general pediatric medicine) who deliver primary care and preventive health services. For this transition, Congress should increase the Primary Care Incentive Payment from 10 percent to 20 percent and should continue federal support for the Medicaid requirement that payments to primary care physicians for primary care and preventive health services be at least equal to Medicare's payments.

The goal would be to use this period to implement care management fees and pay-for-performance for primary care physician practices that have become a Patient Centered Medical Home. This will provide an opportunity to examine what works in this regard and to adopt those best practices in a blended payment model. There must be a specific termination date for the SGR at the end of this period of stability and analysis. With a fixed termination to the extension, the mandate to implement the best alternative will be clear, and when this transition period is completed, fee-for-service should be a much less significant portion of physician payment.

Meanwhile, it is important to increase the Primary Care Incentive Payment to 20 percent and maintain the support for making Medicaid payments for primary care and preventive health services offered by primary care physicians at least equal to Medicare's payments for the same services. Both of these programs signal to medical students that the largest payer of health care services believes in the value of primary care to the health of the nation. The continuation of these programs is an important statement for those students who are deciding their specialty training now. Facing staggering debt loads, students who would otherwise prefer to concentrate on providing primary care are instead making the decision to choose a specialty that will generate enough earnings to pay for their student loans. Medicare's need for primary care physicians will only grow as the Baby Boom population in the U.S. ages, so these two programs are just part of the effort to show more students that they can afford to be the physicians which they want to become and which the nation needs.

During this period of stability, it will be crucial to encourage as much innovation as possible. The new CMS Center for Innovation will be a key focus of this effort. Whether it is the new Accountable Care

Organizations, the Patient Centered Medical Home or bundled payment experiments, the CMS Center for Innovation should coordinate all of the system tests. The CMS Innovation Center has the potential to be an extremely valuable tool to test potential payment reforms that could generate substantial savings for Medicare and improved quality of health care delivery. We believe that this Center can help CMS create market-based, private sector-like programs that can significantly bend the health care cost curve because it has effective authority to implement promising pilots and demonstrations. We recommend that the CMS Innovation Center should coordinate the various health care delivery testing programs to ensure comparability and thoroughness of the data. The physician community believes strongly in the value of evidence

and it is the responsibility of the Innovation Center to provide credible, reliable and usable evidence of health system delivery reform.

Finally, when the implementation data is available, we would encourage Congress to engage in another discussion with the physician community, with public and private payers and with the consumers, to determine not just what works, but also what is preferable. In the final analysis, health care is such an important part of the economy and everyone's personal lives that we should try to find general agreement in whatever becomes the final replacement for the current physician payment system.

Summary

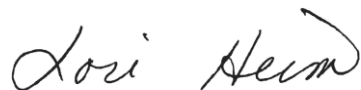
The AAFP advocates for Medicare payment reforms that include a blended payment system for team-based Patient Centered Medical Homes and similar reforms based on primary care. This blended payment is one that consists of:

- Fee-for-service payment
- Care management fee that compensates for expertise and time required for primary care activities that are not direct patient encounters
- Performance bonus based on a voluntary pay-for-reporting/performance system.

To achieve this payment reform, we recommend that Congress establish a transition period of 5 years with mandated payment conversion factors (with a higher rate for primary care physicians who provide primary care and preventive health services) for the current Medicare formula. In addition, we recommend continuation of the Primary Care Incentive Payment, increased to 20 percent, and of the Medicaid payment of Medicare rates for primary care and preventive health services offered by primary care physicians. During this limited transition period, the CMS Innovation Center should coordinate programs to test delivery system reforms and provide comparable data to demonstrate the most effective reforms in specific settings and systems.

We are pleased to continue to work with you and others in Congress who hope to make the needed changes to restrain health care costs and improve its quality in this nation. Thank you for your long-standing commitment to make health care better.

Sincerely,

A handwritten signature in cursive script that reads "Lori Heim".

Lori Heim, MD, FAAFP
Board Chair