American Academy of Family Physicians

President
Rick D. Kellerman, MD
Wichita, Kansas

President-elect
James D. King, MD
Selmer, Tennessee

Board Chair
Larry S. Fields, MD
Flatwoods, Kentucky

Speaker
Thomas J. Weida, MD
Lititz, Pennsylvania

Vice Speaker
Leah Raye Mabry, MD
San Antonio, Texas

Executive Vice President
Douglas E. Henley, MD
Leawood, Kansas

Directors
Judith Chamberlain, MD
Brunswick, Maine

Ted Epperly, MD
Boise, Idaho

Virgilio Licona, MD
Brighton, Colorado

Brad Fedderly, MD
Fox Point, Wisconsin

Lori Heim, MD
Lakewood, Washington

Robert Pallay, MD
Hillsborough, New Jersey

David W. Avery, MD
Vienna, West Virginia

James Dearing, DO
Phoenix, Arizona

Roland A. Goertz, MD
Waco, Texas

Marin Granholm, MD
(New Physician Member)
Bethel, Alaska

Daniel Lewis, MD
(Resident Member)
Greenwood, South Carolina

Jennifer Hyer
(Student Member)
Portland, Oregon

July 6, 2007

The Honorable John Dingell
Chair, Energy & Commerce Committee
U.S. House of Representatives
Washington, DC 20515

The Honorable Fortney Pete Stark
Chair, Health Subcommittee
Ways & Means Committee
U. S. House of Representatives
Washington, DC 20515

Dear Representatives Dingell and Stark:

Thank you for the opportunity to review a draft of your legislative proposal to address the pending 9.9 percent reduction in Medicare payment to physicians. We greatly appreciate your willingness to engage in a discussion of the problems that have been created by the Sustainable Growth Rate (SGR) formula for physicians and their patients. Your staff members have been very helpful in their discussions with us on this subject and we would like to acknowledge their assistance.

We appreciate your response to our request for a positive update for at least the next two years, and we commend the committees for proposing to actually pay for this increase in the current budget. We understand the great fiscal pressure that the Congress is working with and the expense involved in resolving the problems created by the SGR, but we would urge the committees to increase the stipulated minimum rate in light of the several years of frozen payments that physicians have experienced.

We have noted many other positive features of the draft legislation that are clearly in response to suggestions made by the AAFP and the rest of the physician community. For example, removing the costs of biologics and clinical lab services form the calculation of the expenditure targets makes a great deal of sense, and we'll continue to urge the administration to do the same retroactively. The draft legislation also stipulates that future national coverage determinations will be considered changes in law and regulation for purposes of the expenditure targets. The AAFP has long objected to the practice of CMS of adding a new service to the benefits covered by Medicare without making appropriate allowances for increased utilization of the newly covered service.

We also support the effort of a new advisory committee to determine which services are overvalued and to make recommendations to the Secretary to bring payment in line with their appropriate values. And we agree with the committees' requirement that the physician payment increase should not increase beneficiaries' premiums.

The draft legislation also included a provision to provide physicians with feedback about their utilization and practice patterns with regional comparative data. This mechanism will be invaluable in promoting practice improvement only if the data is confidential and protected from disclosure.

We would like to comment about two other features of the draft bill. First, while we have always called for a single payment rate formula for physician services, we deeply appreciate the committees' desire to support primary care physician services in a meaningful manner. We can support the use of these six categories and conversion factors given that they are

2021 Massachusetts Avenue, N.W.
Washington, DC 20036-1011
(888) 794-7481
(202) 232-9033
Fax: (202) 232-9044
E-mail: capitol@aafp.org
http://www.aafp.org

not specialty specific but rather CPT code specific. However, mixing preventive procedural services with office visit codes may make it more likely that this category will reach or exceed the expenditure target – thus potentially having a negative impact on primary care payment. Our concern here is that primary care physicians generally are not able to increase the number of office visits that they conduct; consequently, if the use of preventive procedural services grows significantly (as it should) and the expenditure target is exceeded as a result of this factor, family physicians and other primary care providers will potentially be paid less for the same (maximum) number of office visits. We would suggest that the committees consider moving these non-evaluation and management preventive services to the other E&M category, which might be a more logical grouping of such procedures.

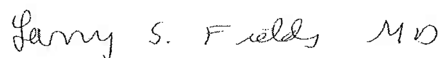
Another concern is the use of the Gross Domestic Product (GDP) as the basis of calculating the expenditure targets. The annual fluctuations of the GDP would undermine the ability of physician practices to have confidence in their future costs. There is some evidence that the decline in the GDP would actually tend to increase practice costs. In any case, using the Medicare Economic Index (MEI) rather than the GDP would bring expenditure targets more in line with actual practice costs.

The second major provision of the draft bill that we would comment on involves recapturing the so-called "Excess Overhang" or the accumulated deficit created by the way Congress has decided to pay physicians in the past several years. By our calculations, it will be impossible to establish a positive update in any category for the next 5 years after 2009. In fact, this single feature of the proposed legislation may reduce physician payments in all categories by nearly 40 percent at the end of the budget period. We understand the need to account for the debt that has accumulated because of the way Congress has addressed the SGR payment issue in the past, but we believe that the mechanism created by the draft legislation would be counter-productive, especially to the primary care services that you are attempting to address in a meaningful manner. We would like to work with the committees in the two years before it would become effective to find a better approach.

As we have discussed with you and others in Congress, you should consider an accelerated use of the patient-centered medical home as a payment mechanism to control costs and improve quality. This would include the use of a care management (per patient per month) fee to the patient's qualified medical home in addition to fee for service. Important data and experience demonstrate that this care management fee will not require "new money" but rather would be covered by savings elsewhere in the system over time.

The draft legislation is a major step forward in many ways. We are eager to assist you and your staff in making it better and in seeking Congressional support.

Sincerely,



Larry S. Fields, MD, FAAFP
Board Chair