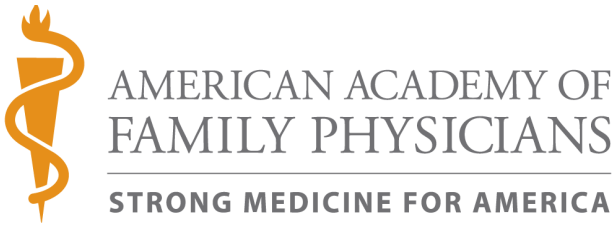

July 16, 2013

The Honorable Fred Upton, Chairman
Committee on Energy and Commerce -
U.S. House of Representatives
Washington, DC 20515

Via: SGRComments@mail.house.gov

Re: Advanced Discussion Draft Bill to Repeal and Reform SGR

Dear Chairman Upton:

On behalf of the American Academy of Family Physicians (AAFP) and its 110,600 members, I write in response to your request for feedback on the June 28 draft bill to repeal the sustainable growth rate (SGR) formula and redesign the Medicare physician payment schedule. The AAFP appreciates that the committee seeks input regarding specific ways in which this dysfunctional SGR formula can be replaced. The Energy and Commerce Committee is working deliberately and openly to develop this badly needed legislation and the AAFP commends your leadership in making this such an inclusive process.

As we have emphasized in our responses to the previous iterations of this discussion draft, the AAFP agrees that payment should promote the improvement of quality as better patient care is the ultimate goal of effective health care delivery. We will continue to work with Congress to achieve that goal. The AAFP appreciates your investigation into performance measures and your solicitation of our views on how such a performance-based system might work. And we would again like to stress that a reformed payment schedule should not rely solely on performance measurement. It is imperative that payment for the coordination of care across delivery settings and for complex conditions be included to achieve meaningful and cost-effective reform. The reformed system should reflect an emphasis on primary care by adopting a blended payment for these services. We continue to propose a blended payment that includes fee-for-service, care coordination and performance improvement.

Such a balance is supported by evidence. For example, as we detailed in our letter to the Centers for Medicare & Medicaid Services (CMS) on March 27, 2013, 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. In addition, the AAFP recommends that Congress adopt policy that encourages primary care physician practices to become Patient Centered Medical Homes (PCMH). Those practices that function as PCMHs should receive a per-patient, per-month care coordination fee that supports the management 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. And physicians who lead a PCMH health care team should be responsible for demonstrating

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quality improvement in their delivery of health care. Commercial payers have been using PCMH models for several years and have consistently shown measurable improvement in health care quality and cost savings. Clearly, the PCMH is no longer a theoretical proposal, but rather a tested and proven transformation that delivers quality and efficiency.

Finally, even in the fee-for-service model, there is a step that the committee should take to improve quality and achieve some system savings. The evidence clearly supports permanently increasing payment for primary care services by adoption of separate primary care E/M codes with higher values that reflect the complexity and intensity of the services provided by primary care physicians and the patients served, as the AAFP has asked CMS to do in the 2014 payment rule.[1,2,3]

QUESTIONS FOR COMMENT

As you requested in your June 28 materials, we would respond as follows to your 13 questions on the advanced draft of the reform legislation.

1. *Can you provide feedback on how the draft addresses tying measurement to payment? Do you prefer one type of payment model over the other? Are there other ways to link quality to payment than those provided in the draft?*

AAFP Comment:
As we have said in our previous letters on earlier drafts of this proposal, paying for performance is perhaps necessary but it is not sufficient to achieve quality improvement. Paying for specific performance measures means that physicians and patients will focus on those activities needed to meet those benchmarks. The concern is that there are many other activities that a physician, especially a primary care physician, must take into account in providing appropriate health care. This is why we believe that the best way to achieve improved health care and reduce costs is to use a payment system that blends fee-for-service with a chronic care management fee and pay for performance incentives.

The AAFP has numerous existing policies that provide informative guidance on tying payment to quality. For example, the AAFP supports pay-for-performance programs that:

- Focus on improved quality of care
- Support the physician/patient relationship
- Utilize performance measures based on evidence-based clinical guidelines
- Involve practicing physicians in program design
- Use reliable, accurate, and scientifically valid data
- Provide positive physician incentives
- Offer voluntary physician participation.

The AAFP's entire policy on "Pay-for-Performance" is at: http://www.aafp.org/about/policies/all/pay-performance.html

The AAFP also believes that any payment system must address the following principles:

- Quality care, access to care and positive health outcomes must be the primary goals of any payment system;
- The unique partnership embodied in the doctor-patient relationship must be preserved;
- A payment system must be based on continuing, comprehensive care rather than fragmented care and should encourage treatment on an ambulatory basis with coordinated team-based care rather than in a costly institutional setting;
- There must be recognition of the value of prevention, early diagnosis and early treatment with appropriate incentives to the patient and to the physician to participate;

- Increased emphasis must be placed on payment for the cognitive portion of physician services, recognizing that this will likely result in lower payment for other services.
- The comprehensive AAFP policy on Physician Payment can be found at: http://www.aafp.org/about/policies/all/payment-physician.html

The AAFP has extensive policy on quality measurement that encourages the utilization of performance measures that are consistent with specific criteria for evaluating and improving patient care. The AAFP supports health care quality improvement endeavors, including the development and application of performance measures (whether single or in aggregate) which have the following attributes:

- Are focused on improving important processes and outcomes of care in terms that matter to patients
- Are responsive to informed patients' cultures, values and preferences
- Are based on best evidence and reflect variations in care consistent with appropriate professional judgment
- Are practical given variations of systems and resources available across practice settings
- Do not separately evaluate cost of care from quality and appropriateness
- Take into account the burden of data collection, particularly in the aggregation of multiple measures
- Provide transparency for methodology used
- Assess patient well-being, satisfaction, access to care, disparities and health status
- Are updated regularly or when new evidence is developed.

The AAFP believes the spirit in which performance measures are developed and applied should be one of continuous improvement. The primary purpose of performance measurement should be to identify opportunities to improve patient care. Some measures will have usefulness for accountability, public reporting or pay for performance programs. Efficiency-of-care measures, associated with a specified level of quality of care, are increasingly being incorporated into performance measurement sets. The Physician Consortium for Performance Improvement Position Statement, *The Linkage of Quality of Care Assessment to Cost of Care Assessment*, describes "efficiency of care" as the relationship of the cost of care associated with a specific level of performance measured with respect to the other five Institute of Medicine (IOM) aims of quality.

Only the most evidence-based, widely accepted, and important measures should be used for accountability, pay for performance or other significant decisions. When comparisons are made, they should be risk-adjusted, consider differences in denominator populations and account for variations in patient preferences, values, access, and availability of services. The value of the application of performance measures should also be assessed in the context of physician, practice and health system burden, economic costs and savings, and impact on patient-oriented outcomes that matter.

The specific criteria used and the comprehensive AAFP policy on quality measurement can be found at: http://www.aafp.org/about/policies/all/performance-measures.html

Tying payment to measurement could involve physician profiling upon which the AAFP has considerable policy. The AAFP defines physician profiling as an analytic tool that uses epidemiological methods to compare physician practice patterns across various quality-of-care dimensions (process and clinical outcomes). Cost, service and resource utilization data are dimensions of measuring quality, but should not be used as independent measures of quality care. The ultimate goal is to deliver high quality, evidence-based care to improve clinical outcomes.

It is important to recognize that physician profiling is not intended to be used to address issues of physician competency, including the evaluation of medical knowledge, education and skills. Such issues should be addressed by the appropriate public and private credentialing bodies that exist for these purposes.

Family physicians must have an opportunity to review payer performance profiles prior to their being publicly reported. Payers must establish and communicate a reasonable, formalized reconsideration process in which physicians can appeal their performance rating and designation(s). More extensive policy and specific guidelines on physician profiling is at: http://www.aafp.org/about/policies/all/physician-profiling.html

The AAFP believes the primary purpose of performance measurement and sharing the results should be to identify opportunities to improve patient care. Payers' programs for physician measurement should lead to better informed physicians and consumers and align with relevant AAFP policies on Physician Profiling Principles and Performance Measures. The benefit of measurement is reporting the results so the improvement process can begin and be measured over time. Ideally, any Physician Performance Reporting should:

- Support the physician-patient relationship
- Provide physician performance reports and ratings to assessed physician within meaningful time periods and be compared against both peers and performance targets prior to being made public
- Be transparent in all facets of physician measurement analysis
- Identify physicians that meet quality standards separately from their cost assessment
- Utilize appropriate designations that are easy to understand.

The AAFP's policy Physician Performance Reporting, Guiding Principles, can be accessed at: http://www.aafp.org/about/policies/all/physician-performance.html

2. *Do you think the IG report will bring integrity to the reporting process? Does this process meet the required level of oversight? Are there any other safeguards, besides the IG, that could be implemented to ensure integrity in the reporting process?*

AAFP Comment:
The AAFP believes this process does meet the required level of oversight and recommends no additional safeguards beyond the Inspector General of HHS.

3. *If providers decide not to participate in the Update Incentive Program, should they be held to the same standard? How should their payment updates be applied if they do not report on quality measures?*

AAFP Comment:
AAFP encourages the Committee to embrace a five-year period of payment stability. During this phase, while new models of payment and delivery are evaluated and the Update Incentive Program is prepared for implementation, the updates for all physicians should be positive. AAFP is concerned about the effects of care delivered by providers who choose not to participate in the Update Incentive Program if reimbursement for this population is reduced, but we understand the value of signaling by eventual and gradual disincentives the importance of achieving quality improvement goals. We would recommend that if a physician practice achieves applicable quality measures whether or not the practice participates in the Update Incentive Program, payment should be the same. If a practice chooses not to participate, then payment should reflect that.

In addition, AAFP recommends a positive differential for primary care evaluation and management services during the period of stability. AAFP supports the bipartisan *Medicare Physician Payment Innovation Act* (H.R. 574), because it embraces this approach. Providing higher updates for primary care evaluation and management services has broad support within the medical community and from independent experts, including the National Commission on Physician Payment Reform, National Coalition on Health Care, and The Commonwealth Fund.

4. What do we do with physicians who do not bill Medicare?

AAFP Comment:
Physicians who bill the patient directly are either Medicare non-participating physicians who have chosen not to accept assignment on a given claim or they are "opt out" physicians. Medicare non-participating physicians who do not accept assignment collect directly from the beneficiary, up to the limiting charge. The physician must still file a claim with Medicare on the beneficiary's behalf, but the Medicare payment in that scenario goes to the beneficiary.

"Opt-out" physicians also collect directly from their Medicare patients. However, under the terms of the private contract such physicians must have with their Medicare patients, neither the physician nor the patient is permitted to seek reimbursement from Medicare for the opt-out physician's services.

If a physician does not have a sufficient number of Medicare patients, the physician may choose to opt out of Medicare because the investment of money, time and staff required to comply with the new payment system would exceed the reimbursement provided. In addition, many office-based physicians, including family physicians, have entered into an employee relationship with a larger health care provider institution. Whether these physicians participate in the reformed payment may well be determined by the employer.

There is a large variation in physician practices and settings, which mainly reflect the variation in their patient population, their environment, their socio-economic status, their culture and background and, of course, the medical conditions that they experience. Accounting for this variation in the payment schedule is probably not feasible. Therefore, the AAFP recommends that the Congress avoid mandating which practices can adopt this reformed fee schedule and instead concentrate on providing sufficient incentives that will account for the significant costs that are incurred in practice transformation.

5. Do you think the policy, as outlined in the discussion draft, can accommodate early adopters and those with minimal quality standards by the time Phase II goes into effect?

AAFP Comment:
The period of stability in physician payment should be at least 5 years, since it takes a physician’s office at least that amount of time to understand, evaluate, adopt, invest in, test and train for the reporting mechanisms and procedures. The range of experience and sophistication with quality improvement efforts is quite varied. Clinics and providers who have had quality improvement efforts in place for years may be experienced with robust measures, while others are in early stages of learning about these particular processes for quality improvement and population health. For this reason, there should be incentive for continuous improvement. Incentive payments must take into consideration the degree of “improvement change” in a practice’s performance as well as the health risk status of the patient population.

6. *The draft policy endeavors to ensure public and provider feedback. Do you feel that the policy succeeds in achieving this goal?*

AAFP Comment:
AAFP appreciates the multiple opportunities for public and provider input and notes that this is consistent with AAFP policy. The AAFP does support a requirement that all performance measures should be reviewed and evaluated by an objective and independent third party, like the National Quality Forum (NQF). The AAFP also encourages the Committee to require physician input in all of the stage of collecting, evaluating and reporting performance data.

7. *Should the new quality system align and coordinate with PQRS in the manner in which it provides feedback at the group level?*

AAFP Comment:
In general, multiple CMS quality reporting systems should align as much as possible to minimize the burden on the reporting physicians. Indeed the Physician Quality Reporting System (PQRS) may be superfluous if the Energy and Commerce Committee's performance system is effective. In any event, AAFP would not encourage Congress or CMS to hold the PQRS model as the standard to be achieved, especially in terms of providing feedback which is far from timely.

8. *The draft envisions a repertoire of quality measures and clinical practice improvement activities. Some have suggested also including efficiency measures. Should we also explore efficiency measures and other improvement activities?*

AAFP Comment:
The AAFP is aware that an effort has been made to include an efficiency measure for most new sets of quality performance measures developed over the past few years with the intent of gradual inclusion. But the reliability, validity, and evidence-basis have not yet been established.

Moreover, most efficiency measures achieve short-term savings that accrue to the payer and the health care system broadly, but not often to the individual practice. Efficiency measures without gain-sharing across the health care system are likely to be ineffective. The AAFP believes that the evidence is clear that the way to achieve savings is to firmly base the health care delivery on primary care.

We would emphasize that payment for efficiency requires review of all of the components of health care delivery, not just a physician practice. Appropriate efficiency also requires sufficient time-horizons. Investment in preventive care and the management of chronic diseases will lead to reductions in hospitalizations and in hospital readmissions, which are often the most expensive care. So long-term efficiency for the health care system overall will require up-front investments. But if efficiency is measured year-to-year, these improvements will be impossible to achieve.

Lastly, if efficiency is the sole or predominant measure, the result could be the unintended and adverse consequence of reviving the era of managed care and HMOs and its associated problems.

9. *People have expressed concerns about the effect of non-compliant patients on outcomes and thus outcome measures. Do you believe the draft policy adequately addresses the issue and protects providers who are reporting on quality outcome measures in the setting of non-compliant patients (i.e., one of many aspects of risk-adjustment)?*

AAFP Comment:
The AAFP acknowledges that there are limitations to what any physician can do with respect to providing the patient with the necessary self-care advice and instructions and patients do have a responsibility to be an important participant of the health care team. However, determining the criteria for identifying a patient as non-compliant will be a complex task. The AAFP is not aware that the extensive algorithms, degrees of responsibility, relative weighting and other considerations necessary for incorporating this element into payment methodology currently exist. Non-compliance is not always equivalent to high risk, thus risk adjustment cannot serve as a proxy for it.

10. *Should core competency categories be defined as those set forth under the National Quality Strategy?*

AAFP Comment:
The AAFP strongly supports the principles that embrace placing a greater focus on primary care, care coordination and integration of care delivery, person-centeredness and family engagement, eliminating disparities, promoting national standards while maintaining support for local, community, and State-level activities.

The AAFP believes efforts to improve health and health care delivery should be anchored in a core set of principles shared by stakeholders, including federal and state agencies, local communities, provider organizations, consumers, clinicians, businesses, employers, and payers. To that end, the National Quality Strategy (NQS) principles provide a practical roadmap for achieving the triple aim of better care, better health, and better health care affordability.

The NQS principles are:
1. Person-centeredness and family engagement
2. Specific health considerations
3. Eliminating disparities in care
4. Aligning the efforts of public and private sectors
5. Quality improvement
6. Consistent national standards
7. Primary care will become a bigger focus
8. Coordination will be enhanced
9. Integration of care delivery
10. Providing clear information

11. *The draft policy envisions an updated and streamlined process to submit and test alternative payment models outside the traditional pathway. Do you think the draft policy method provides ample opportunity for formulating and submitting alternative payment models?*

AAFP Comment:
In general, yes. But perhaps more importantly, the discussion draft should allow for immediate verification of alternative payment models that have been sufficiently tested and evaluated. The AAFP believes that the Patient-Centered Medical Home (PCMH) has shown in varied settings that it is a model that improves care and patient satisfaction while exerting considerable downward pressure on health care costs. We believe that the PCMH should be specified in the legislation as an alternative payment model, since this approach has already received considerable examination from the research and provider communities. For example, the Patient Centered Primary Care Collaborative has assembled an impressive collection of research and experience in the application of the PCMH. The authors of the report identified three broad conclusions about PCMH outcomes:

- As medical home implementation increases, better health, better care and lower costs are being achieved.

- Medical home expansion has reached the tipping point with broad private and public sector support.
- Investment in the medical home offers both short- and long-term savings for patients, employers, health plans and policymakers.

12. *The draft policy provides a process to obtain input on modifying and retiring alternative payment models that are on the public list. Please provide comments on this process.*

AAFP Comment:
The draft legislation would create a new process of contracting with an entity to carry out the identification, evaluation, and selection of alternative payment models (APM) for inclusion as options for physicians who choose not to participate in the Committee's revised performance-based payment model. The AAFP agrees that any new APM should be required to meet a robust set of criteria, based on the strong evidence and that there should be an ongoing process to modify or retire APMs as appropriate. The intended process for modification or retirement of APMs warrants further description and discussion.

13. *Should the replacement payment model to SGR move further toward episodic care? Is this a direction that should be more fully explored, and if so how?*

AAFP Comment:
Payment for episodic care lends itself well to surgical procedures and acute care with a well-circumscribed, defined course of care. By comparison, primary care, which is often dealing with chronic care and comprehensive care over time, is less well-suited to payment for an episode of care. For this reason, and in order to provide the appropriate emphasis on primary care, the AAFP urges the adoption of a blended payment model of enhanced fee-for-service, a per-patient, per-month care management fee, and rewards for demonstrated quality or quality improvement. The AAFP believes this blended payment model is ready for implementation now. Sufficient demonstrations and studies, along with an abundance of literature published in peer-reviewed journals, justify immediate implementation.[4,5,6]

Additional Considerations and Questions for the Committee:

- Measure consistency:
  If the measure sets are determined by specialty, will the measures that cross between specialties be consistent? For example, the goal for the blood pressure or LDL cholesterol level of a patient with diabetes is the same whether the patient is seen by a primary care physician as an endocrinologist.

- Attribution:
  This is a long-standing problem, but attribution and designating who is credited for health outcomes will be challenging when patients are seen by multiple physicians and providers. This is more important than ever when the entire payment model relies on the accuracy of the data reported. For example, if a patient is seen by both a primary care physician and an endocrinologist, and both list diabetes as a diagnosis on their claims (because it is relevant for both), to which physician is the patient's care attributed?

- Composite score:
  How many measures will be involved in creating a physician score and what will the required denominator be for each measure in order to have statistical relevance? This is a particularly important consideration due to family medicine's broad scope of practice and the prevalence of small and solo practices.

- Ongoing feedback:
  It is stated that the feedback will be provided timely, at least quarterly. Timeliness is important but of equal concern is the age of the data that are provided quarterly.

- Data portal:
  The draft legislation contains a reference to the portal being developed in consultation with private payers and health insurance issuers as appropriate. This prompts questions related to access to these data. Will the payers and health insurance issuers see all the data, not just information on the patients they are covering? Is the ultimate goal to have a repository of *all* patient data? If so, will insurers use the composite scores and measures for determining physician participation?

AAFP appreciates the opportunity to provide these comments and make ourselves available for any questions you might have or clarifications you might need. Please contact Kevin Burke, Director of Government Relations, at 202-232-9033 or kburke@aafp.org.

Sincerely,

Glen R. Stream, MD, MBI, FAAFP
Board Chair

Notes:

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