AMERICAN ACADEMY OF FAMILY PHYSICIANS

STRONG MEDICINE FOR AMERICA

Statement of the American Academy of Family Physicians

To the

Energy and Commerce

Health Subcommittee

U.S. House of Representatives

By

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Chairman Pitts, Mr. Pallone, and members of the Subcommittee:

Thank you for offering the American Academy of Family Physicians (AAFP) the opportunity to testify this morning on the question of what kind of payment system should replace the Medicare physician fee schedule. On behalf of the 100,300 members and medical students 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. Therefore, reforming the flawed Medicare payment formula is a necessary part of our responsibility to restrain health care costs nationally 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, 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."* The AAFP is the only physician organization whose entire membership has been trained to provide this primary medical care. However, many members of the American Academy of Pediatrics, the American College of Physicians and the American Osteopathic Association are also primary care physicians. All of us are committed to helping Congress find a system that pays for the value of health care provided rather than the volume of those services.

Congress, understandably, is most concerned at this time with controlling federal expenditures for health care, especially, given the rapidly rising bill for Medicare and other federal health care programs. There are many reasons for that increase, some of which are beyond the power of the federal government to control. However, 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.

It is with that in mind that 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:

- Fee-for-service payment
- 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, and for care team members and services that are not eligible for fee-for-service billing

To achieve this payment reform, we recommend that Congress establish a transition period of 5 years with mandated payment updates (with rates 2 percent higher for primary care physicians) for Medicare fee-for-service. 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 health care services at the *individual* physician level by imposing payment penalties *globally* across all physician payments.

The theory is that, when increases in volume 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 (making it infeasible to increase volume to compensate for lower payment rates) and which operate typically on extremely thin margins. At the same time that the payment formula provides a significant disincentive to primary care, we are approaching a shortage of primary care physicians and a need for more because the Baby Boomers are entering 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 – i.e., payment is based solely on what procedure is provided to the patient, not the value of the service provided, 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 the coordination of care in a highly fragmented health care system. It does not value 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 fatigue, a stomach pain 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. It takes sustained, personal relationships to help differentiate the potential causes and tailor diagnosis and treatment. But a fee-for-service payment system undervalues these cognitive skills, preventive health services and care coordination and does not pay for them, apart from a limited, generalized set of office visit codes, labeled "Evaluation and Management."

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 practice provides most of what the patient's needs, including individual and population care management, behavioral health, behavior change coaching, facilitating social services, and making 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 and will not support the full array of services needed to address them.

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.[1]

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.[2] 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, Medicare 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.[3] An evaluation of a primary care-based ACO, funded by the Agency for Healthcare Research and Quality, and conducted by the Robert Graham Center for Policy Studies in Family Medicine and Primary Care (an editorially independent research center and 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, and supports many of the payment changes we recommend. Like MedPAC, 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

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[1] Grumbach K, Grundy P. **Outcomes of Implementing Patient Centered Medical Home Interventions: A Review of the Evidence from Prospective Evaluation Studies in the United States**. 11-16-2010.

[2] Goroll AH, Berenson RA, Schoenbaum SC, Gardner LB. Fundamental reform of payment for adult primary care: comprehensive payment for comprehensive care. J Gen Intern Med. 2007;22(3):410–5.

[3] Phillips RL Jr., Bazemore AW. What is Primary Care and Why It Must Be Central to US Health System Reform. Health Affairs. 2010: 29(5): 806-810.

and the associated technology improves. This leads to an overvalued payment for procedures and undervalued cognitive payments.

While the 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. In a relatively short time, the current PCMH demonstrations show that these investments produce returns that are budget-neutral, at least, and that provide improved quality and patient satisfaction.

Patient Centered Medical Home

Since fee-for-service alone encourages utilization, does not check avoidable duplication of service, misuses 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 increases in health care costs 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
- 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 permanently 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, along with the mandated payment updates that are 2-percent higher for primary care

physicians, help stabilize current practices that have seen so much financial turmoil is the past few years and allow them to begin the often expensive and time-consuming process of redesign to the Patient Centered Medical Home model. Above all, these programs are important statements about the societal value of Family Medicine and primary care.

They also signal to medical students that the largest payer of health care services believes in the value of primary care. The continuation of these programs confirms an emerging national awareness 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 payment incentive 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.

Finally, geographic adjustment of physician payments should ensure equitable payment to providers and access to beneficiaries. Current adjustment policies are neither aligned with one another nor of the magnitude to promote equitable distribution of the primary care workforce, and as a result, frequently penalize physicians in rural and underserved areas. Congress should include targeted geographic practice payment adjustments that offer incentives for better physician workforce distribution, and call upon CMS to monitor the interactions of all current and future payment adjustments. Specifically, CMS should monitor the collective impact of geographic adjustments on total provider reimbursements, workforce distribution, and beneficiary access and quality. Otherwise, maldistribution will continue long after the ratio is balanced between primary care and specialized physician workforce unless the

geographic payment adjustments are focused on providing incentives to lead physician practices to locate where they are most needed.[4]

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 Patient Centered Medical Home, the new Accountable Care Organizations, 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.

When the implementation data ultimately 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.

[4] Xierali I, Bazemore AW, Phillips Jr RL, Petterson SM, Dodoo MS, Teevan B. A perfect storm: changes impacting Medicare threaten primary access in underserved areas. Am Fam Physician. 2008 Jun 15;77(12):1738.

Summary

The AAFP advocates for Medicare payment reforms that ultimately 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 updates (with a rate 2-percent higher for primary care physicians who provide primary care and preventive health services). 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.

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