



AMERICAN ACADEMY OF
FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

February 25, 2013

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

Dear Chairmen Camp and Upton:

The American Academy of Family Physicians (AAFP), representing over 105,900 physicians and medical students nationwide, is pleased to submit these comments in response to your request for information for value-based measures and practice arrangements that can improve health outcomes and efficiency in the Medicare program. The framework developed by the Republican leadership of the House Ways and Means Committee and Energy and Commerce Committee envisions eliminating the SGR and providing a period of stable payment rates at an amount to be determined. Phase two would base fee schedule updates on physician performance as measured by physician-endorsed quality measures. Physicians would be ranked within their own specialties and earn higher updates for better performance. In phase three, physicians who rank high on quality would be given the opportunity to earn additional payments based on efficiency. Though much work remains to be done in developing the details, this is a welcome development.

Specifically, you have solicited comments pertaining to:

- Stabilizing the fee-for-service (FFS) system
- Developing meaningful quality measures
- Rewarding quality and efficiency, including risk-adjustment
- Reducing the administrative burden on providers

The Sustainable Growth Rate (SGR) formula continues to create uncertainty in the Medicare program for health professionals and beneficiaries. Because so many private insurers use the physician fee schedule as a guide for reimbursement decisions, such unpredictable economic activity taken by Medicare casts a pall over the small business environment in which family physicians must function. In addition to the difficulty this causes providers, Medicare beneficiaries are left in a very vulnerable position, unable to depend on the access to the care essential to maintaining a healthy life.

The SGR formula has proven to be flawed policy both from a reimbursement standpoint and a volume-control perspective. The so-called accumulated debt that this formula has produced is an artifact of the architecture of the formula, not a reflection of any economic reality.

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For over a decade, Congress has recognized the uselessness of this formula as evidenced by the multiple times it has chosen to override it. Congress should no longer delay repealing this statute. We commend you for the aggressive initiative you demonstrated in beginning to tackle this important issue so early in the 113th Congress. We believe the guiding principles in determining how to replace this flawed formula should be that it is clinically relevant and patient-centered. Moreover, the payment formula should reflect the actual practice costs physicians experience in running their small businesses.

Stabilizing the fee-for-service system

The uncertainty associated with the yearly and sometimes more frequent exercises of dealing with the dysfunctional SGR is incredibly vexing to AAFP members and disruptive to planning for their business. Thus, we strongly agree with the feature of a period of stability created by annual, positive and adequate fee schedule updates. Future reimbursement can be gradually and increasingly based on meaningful measures of care quality and participation in clinical improvement activities. Rewards should be based on advancements in care quality demonstrated by individual physicians on a per patient basis and on the aggregate of patients under the care of that physician. The measures used should demonstrate broad acceptance by the physicians employing them, regardless of specialty. In no case should measures be developed using a process that does not include physician involvement.

Creating a period of stability and positive annual updates is imperative as a means of transitioning from the SGR. The outline developed by the committees is, in many ways, similar to a bipartisan bill introduced this session: The *Medicare Physician Payment Innovation Act* (HR 574) which fully repeals the SGR, stabilizes current payment rates to ensure beneficiary access in the near-term, and sets out a clear path toward comprehensive payment reform. HR 574 provides modest positive updates of 0.5 percent for all physician services received over five years. The bill also includes a 2-percent positive differential payment for primary care services during the first five years of reimbursement stability. For many reasons, not the least of which being access to primary care, the AAFP strongly supports this minimum differential and believes it would be made permanent. In addition AAFP urges that the Primary Care Incentive Payment and the program that pays for primary care delivered to Medicaid patients at least at Medicare rates be extended permanently.

As we understand your proposal, after the period of stability, updates to the physician fee schedule will be based on performance of meaningful, physician-endorsed measures of care quality and on participation in clinical improvement activities. AAFP believes all specialists, including family physicians, should have meaningful, rigorous, evidence-based performance measures that apply to their scope of practice. These need to be more than just documentation that something was done, or a recording of a clinical measurement result. The payment formula must rapidly go beyond process measures to outcome measures. Patient experience also is an important aspect to measure and improve.

Developing meaningful quality measures

The outline indicates that medical specialty societies will develop meaningful quality measures and clinical improvement activities using a standard process. To ensure appropriate rigor and use of evidence in the measure development process, such measures should always be developed through a multi-disciplinary effort, not by individual specialty societies alone. The Physician

Consortium for Performance Improvement and the National Quality Forum processes are examples of such an effective process that are already in place.

AAFP recognizes that pay for performance is one approach to payment reform. However, there are a multitude of organizational, technical, legal and ethical challenges to designing and implementing pay-for-performance programs. The AAFP also recognizes that there are both advantages (increased payment, improved efficiency and quality) and disadvantages (cost of acquiring information technology, data collection for multiple programs and guidelines) to such programs as they are currently designed and implemented. As we sort out which of these many programs provide the best results, we believe physician measurement processes used to rate/designate family physicians should be transparent. AAFP's relevant policies on incentive programs are appended to this correspondence.

The methodology used to evaluate performance should account for differences in patient populations; thus, accurate risk adjustment is essential. Without it, who will take the non-compliant, complex patients if doing so jeopardizes performance scores, tarnishes a reputation through public reporting and decreases revenues? Additionally, the reduced availability of specialized services in some locations may inhibit ideal performance measurements.

However, AAFP believes there should be no accounting for local variance. The application of quality performance measures and appropriate inclusion and exclusion criteria should be the same for every patient in every geographical area. The performance measures should be developed at the national level to promote consistency and comparison. State and local medical societies can help CMS educate physicians about quality improvement and sharing of best practices.

Once measures are established, there should be an ongoing process for review of performance measures, at predetermined intervals or whenever the guidelines change, so that performance measures can be updated to reflect the latest evidence.

The introduction to quality measurement and improvement should start early in the physician's education, such as medical school and residency. Government grants could be provided to medical specialty societies to help educate practicing physicians about quality improvement.

Rewarding quality and efficiency, including risk-adjustment

The committee outline indicates that performance should be based on both risk-adjusted relative rankings among specialty peer groups and improvement in quality over time. In fact, an accurate risk-adjustment system is the keystone of any payment system that is going to reward desired behavior.

With a reliable risk-adjustment system in place, the number of outliers will be minimized. When outliers do exist, physicians should be allowed to appeal disputed evaluations to a panel that includes a broad cross-section of physicians. It is unfair to penalize those who rank lower, when compared to others, as long as continued improvement is being made.

Physician outliers should be afforded the opportunity to challenge or explain their performance rating, and if appropriate, receive education and assistance locally, from a health department,

quality improvement organization, or private consultant to initiate improvement activities. It also must be acknowledged that improvement on patient outcomes takes longer to achieve than compliance with process measures which can be more immediate; the measure was either done or not.

Reducing the administrative burden on providers

The committee outline correctly insists that the reporting burden on professional practices be reduced under the new method of payment. To achieve this goal, Medicare must harmonize the myriad programs that require reporting. For primary care, this would mean combining and creating consistency between the Physician Quality Reporting System (PQRS), the Electronic Health Record incentive, the Primary Care Incentive Payment and the value-based modifier. In addition, as mentioned above, it is extremely important that the program that pays for primary care delivered to Medicaid patients at least at Medicare rates be included in this initiative.

The ability to pull needed data from an electronic health record should decrease the data collection and reporting burden for physician offices. However, practices must receive timely feedback and payment and should know immediately if they had not submitted data successfully and should have an immediate opportunity to make corrections.

The current programs have long intervals (in the case of PQRS, as much as 18 months) between the practice's reporting of data and receiving incentive payments. The feedback loop on the physician practice's performance has not been efficient or timely. These programs require additional staff time and training for the physician's practice to complete successfully, often making the physician or practice wonder if it is worth the cost to submit the data.

With respect to improvements currently in use in the private payer sector, the federal government has taken the lead by initiating collaboration between public and private payers. An example of this is the Center for Medicare and Medicaid Innovation Comprehensive Primary Care Initiative, in which both types of payers can learn from each other. More importantly, such collaborations are essential because it is cost-prohibitive for primary care practices to undertake the time-consuming and expensive transformation of their practice if only a small portion of their patient population is represented in the innovation.

AAFP notes that many insurers have had quality improvement programs in place for several years, and should have identified barriers and successes that could be shared if not considered proprietary. For this reason, we suggest that CMS consider creating an advisory committee that includes private payers that can analyze and learn from "best practices."

Phase three of the proposal is about efficiency of care, which means controlling costs. In calculating cost-savings it will be important to consider savings in all parts of Medicare such as those resulting from decreased hospitalizations, readmissions and the like. Not all savings from reforms to the physician payment systems will be captured in Medicare Part B. Consequently, physicians and the physician payment system need to be credited with savings regardless of where they appear.

Moreover, if physicians are being asked to be efficient by avoiding unnecessary tests, procedures and referrals, then there must be a commensurate reduction in the risk of experiencing a medical

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liability action. The success of phase three, therefore, depends on the passage and implementation of meaningful medical liability reform. This is still a priority of our members.

At present, more than 1.3 million Medicare beneficiaries have difficulty finding a primary care physician due to a severe shortage. A major factor in the supply of these physicians is the income disparities between primary care and specialty physicians. Nonprocedural services, which constitute the majority of primary care services, are undervalued under the current system, while care coordination is rarely reimbursed at all. During the transition period to more patient-centered, primary care-based delivery models, appropriate measures to attract and retain primary care physicians are needed to ensure beneficiary access to care. We acknowledge that CMS is attempting to address this void by beginning the process of creating and valuing care transition codes. In addition to such efforts as these, we again state the importance of having a primary care differential for any permanent solution to the Medicare Fee Schedule along with permanent extension of the Primary Care Incentive Program and the Medicaid to Medicare parity for primary care payment.

The AAFP commends the leadership of the House Ways and Means and Energy and Commerce Committees for this thoughtful outline that offers a positive path to better and more efficient health care. This endeavor begins the transition to a sustainable payment system that we hope will better recognize the value of primary medical care. We applaud this effort to keep the Medicare program strong for our nation's seniors and we look forward to continued collaboration with the Congress in reforming how physicians are paid for the health care that their patients need.

Sincerely,

A handwritten signature in black ink that reads "Glen Stream MD". The signature is written in a cursive, slightly slanted style.

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

Appendix A

AAFP Policy on Pay-For-Performance

Both public and private health insurers, as well as employers, have come to recognize the importance of experimentation with physician payment methodologies that incentivize medical practices to expand the provision of preventive services, improve clinical outcomes and enhance patient safety and satisfaction with the care they receive. These incentive programs, known collectively as “pay for performance” programs, have the potential to increase physician use of electronic health information technology, evidence-based clinical guidelines, administrative and clinical “best practices” and access to appropriate and timely care.

The American Academy of Family Physicians (AAFP) recognizes the need to reform physician payment, including pay for performance as one approach. However, there are a multitude of organizational, technical, legal and ethical challenges to designing and implementing pay for performance programs. The AAFP also recognizes that there are both advantages (increased payment, improved efficiency and quality) and disadvantages (cost of acquiring information technology, multiple programs and guidelines, data collection) to such programs as they are currently designed and implemented. Payers' physician measurement processes used to rate/designate family physicians should be transparent and adhere to the AAFP policy on Performance Measures Criteria, Physician Profiling, Data Stewardship, and Transparency.

The AAFP supports pay for performance (PEP) programs that adhere to these principles:

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

The AAFP will use its influence to support and encourage experimentation using the following guidelines:

1. PFP programs should provide incentives to physician practices for:
 - a. Adoption and utilization of health information technologies;
 - b. Implementation of systems to improve the quality of patient care and patient safety;
 - c. Adhering to evidence-based clinical guidelines;
 - d. Improving performance and meeting performance targets;
 - e. Improving patient access to appropriate and timely care; and
 - f. Measuring and attempting to improve patient acceptance and satisfaction with their care
2. PFP programs should be consolidated across employers and health plans to make the payment meaningful and the program more manageable for physician practices.
3. PFP incentive programs should utilize new money funded by using a portion of the projected total system savings. There should be no reduction in existing fees for service paid to physicians as a result of implementing a PFP program.
4. The financial rewards to physician practices must both recoup the additional administrative costs to participate in the program (data collection and measurement) and provide significant incentive.
5. The program cannot create incentives that place physicians at odds with their patients, e.g., incentives to fragment care or deselect certain patients. Case-mix evaluation and appropriate adjustments, including known clinical and socioeconomic factors, should be employed to allow fair comparisons of different practices.
6. Programs should minimize administrative, financial and technological barriers to participation.
7. The PFP entity should notify the patients affected, provide related self-care information and reinforce patient responsibilities in achieving the desired health outcomes.
8. When evidence is lacking regarding the value of a particular diagnostic or therapeutic intervention, acknowledge that physicians' judgment, patient's preference, and the costs associated with various options may be the best measures of the appropriateness of a given intervention for PFP purposes.
9. Patient cases should be removed from the performance measure(s) being assessed (“denominator exclusion”) when a physician can demonstrate that attempts have been made to provide patients support to follow recommended care and they have subsequently not followed such recommendations,

the recommendations are inappropriate for this patient due to other clinical or socioeconomic considerations, or the patient is unable to comply.

10. Programs should be designed to include practices of all sizes.

Appendix B

AAFP Policy on Physician Performance Reporting, Guiding Principles

The American Academy of Family Physicians (AAFP) believes the primary purpose of performance measurement and sharing the results should be to identify opportunities to improve patient care. Payers' physician measurement programs should lead to better informed physicians and/or consumers and align with existing 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:

1. Support the physician/patient relationship.
2. Provide physician performance reports/ratings to assessed physician within meaningful time periods and be compared against both peers and performance targets prior to being made public.
3. Be transparent in all facets of physician measurement analysis, including:
 - a. origin and definitions of data sources
 - b. number of cases assessed per measure
 - c. performance measures utilized and their source
 - d. margin of error assumed in calculations
 - e. basis of evaluation - the individual physician or physician group level
 - f. clear communication of the validity, accuracy, reliability and limitations of data utilized, which may include:
 - i. defining the peer group against which individual physician performance is being measured/compared;
 - ii. detailing steps taken to ensure data accuracy and disclose data limitations, e.g., the impact of an "open access" product in which the primary care physician may have little or no control over resource utilization;
 - iii. describing the assignment of patient populations to either individual or physician groupings;
 - iv. including appropriate risk adjustment and case mix measures; and
 - v. using meaningful time periods for data comparisons.
4. Identify physicians that meet quality standards separately from their cost assessment
5. Utilize appropriate and easy to understand designations for physicians who:
 - a. have statistically insufficient data to assess physician performance;
 - b. have data currently under review with pending results;
 - c. have declined to display their designation;
 - d. have insufficient claims data with the payer for evaluation;
 - e. practice in a specialty that is not evaluated under the program;
 - f. practice in a market where the payer's program is not available; or
 - g. have not met payers' criteria for a designation.
6. Provide a minimum of 90 days for physicians to review, validate, and appeal their payer's performance report before public reporting.
7. Immediately adjust physicians' performance rating/designation(s) based upon a successful reconsideration or discovery of errors in the payer's data analysis.
8. Provide consumers adequate guidance about how to use the physician performance information and explicitly describe any limitations in the data.