



AMERICAN ACADEMY OF
FAMILY PHYSICIANS

STRONG MEDICINE FOR AMERICA

Statement of the American Academy of Family Physicians

Submitted To The
U.S. Senate
Health, Education, Labor and Pensions
Committee

November 10, 2011

Attributable to
Glen Stream, MD, FAAFP, President

AAFP Headquarters

11400 Tomahawk Creek Pkwy.
Leawood, Kansas 66211-2680
800.274.2237
913.906.6000
fp@aafp.org

AAFP Washington Office

2021 Massachusetts Avenue, NW
Washington, DC 20036-1011
202.232.9033
Fax: 202.232.9044
capitol@aafp.org

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The American Academy of Family Physicians (AAFP), which represents 100,300 family physicians and medical students, is pleased to submit the following statement for the record of the Health, Education, Labor and Pensions Committee's hearing entitled, "Improving Quality, Lowering Costs: The Role of Healthcare Delivery Reform."

AAFP Recommendation for Healthcare Delivery Reform

Family Medicine urges Congress to:

- Repeal the Sustainable Growth Rate Formula (SGR): Prevent Medicare payment cuts from occurring and end the practice of enacting short-term retroactive patches to the SGR.
- Enact permanent payment reform that includes a positive payment differential of at least 3 percent for primary care physicians who are providing primary care services.

Specifically, family medicine supports a clearly defined path to permanent payment reform. Whether this includes a multi-year extension of the current payment formula with a higher conversion factor for primary care, or a permanent fix to the fee-for-service system that includes higher payment rate for primary care services, our recommendation is that the current flawed approach does not serve Medicare patients well and must be changed to reflect the value of primary care and family physicians.

Following is our rationale for these recommendations.

Background

AAFP congratulates the Committee for examining the issue of health delivery reforms and commends the Centers for Medicare and Medicaid Innovation (CMMI) ably led by Richard Gilfillan, MD, a family physician, for its vigorous and varied efforts to examine how the health system in this nation can deliver health care better and more efficiently to patients in the US.

The AAFP is deeply interested in this topic because approximately one in four of all office visits are made to family physicians. That is 228 million office visits each year — nearly 84 million more than the next largest medical specialty. Today, family physicians provide more care for America's underserved and rural populations than any other medical specialty. Family medicine's cornerstone is an ongoing, personal patient-physician relationship focused on integrated care.

While the AAFP is the only physician organization whose entire membership has been trained to provide primary medical care, many members of the American Academy of Pediatrics, the American College of Physicians and the American Osteopathic Association also are primary care physicians. All of us are committed to helping Congress find a system that pays for the *value* of health care services rather than the

volume of those services. Thus, we believe that primary care must be the foundation of any healthcare delivery reform.

Definition and Importance of Primary Care

According to the Institute of Medicine, primary care is defined as:

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.

Unfortunately, our current health care system is not consistent with this definition. Instead, the system is fragmented, uncoordinated, wasteful and expensive.

Every day, family physicians and other primary care doctors see the results of our poorly-functioning system of care. Duplicative and unnecessary tests are ordered. Diseases remain undiagnosed and untreated until they result in acute conditions. Patients with multiple chronic illnesses are shunted from one specialist to another -- each one of whom treats only one of the diseases.

That is why AAFP consistently has supported efforts to increase the role of primary care physicians in the delivery of health care. Primary care provides high-quality, coordinated, cost-effective care to patients.

As such, the primary care physician must be the usual source of care for people. Family physicians and other primary care physicians can help patients prevent disease by improving their healthy behavior. They can aid them in managing their chronic diseases, especially when the patient has more than one chronic illness, and refer to a subspecialist, when necessary. And family physicians and other primary care physicians can help patients navigate the complex world of hospitals and other health institutions.

Health delivery reform requires considering how our dysfunctional health care system can become one that serves the patient by coordinating care over time to prevent disease, managing chronic conditions and providing immediate and targeted care for an acute condition when it arises.

The Flawed Sustainable Growth Rate Formula

Much of the current dysfunctional health care system, and disincentives for primary care, is reflected in the current Medicare physician schedule. 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 initial goal of the formula was the following: when increases in volume exceeded established targets, payment rates would decline, thus signaling to medical practices that they should reduce services. The theory was that medical costs would be controlled by this formula.

However, over time, the incentive has been shown to be perverse. Specifically, a medical practice must meet certain fixed costs. Thus, as payment rates decline, physicians have made the logical, economic decision to increase the number of services provided. However, non-procedure-based providers, like primary care physicians, cannot physically increase the volume of services. Their alternative is to stop providing services because payments simply are not covering the fixed costs.

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 procedures that physicians do*. For example, the doctor performs an EKG, removes a cyst from the patient's eye lid, provides a session of therapy or guides parents through childbirth. The physician provides 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.

However, what this formula *cannot* do is pay for the *value* of the thought, analysis, deduction, discussion and persuasion by primary care physicians managing the care of the whole person. It cannot determine the value that comes from avoiding unnecessary care. It also cannot adequately value the coordination of care in a highly fragmented health care system. More specifically, the formula cannot 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 an 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.

A patient also sees a primary care physician to understand his or her current health condition, 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.

However, a fee-for-service payment system undervalues these cognitive skills, preventive health services and care coordination. Consequently, fee-for-service alone 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.

Fee-for-service also does not measure 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. It cannot determine the value of helping a patient successfully manage his or her health in such a way as to avoid costly hospitalizations and procedural services.

The fee-for-service system does not pay for these cognitive actions, apart from a limited, generalized set of office visit codes, labeled "Evaluation and Management." While

comprehensive primary care does include some procedural activities for which a fee-for-service payment is appropriate, such procedures are not the core of primary care.

Unfortunately, at the same time the Medicare payment formula is providing a significant disincentive to primary care, we are approaching a shortage of primary care physicians. Not only is there a need for more because the Baby Boomers are entering the Medicare system, but the *Affordable Care Act* extends coverage to millions of otherwise uninsured individuals.

The unintended consequences of the payment formula are why AAFP and all major physician organizations long have recommended that Congress repeal the SGR. Most recently, we have asked the Joint Select Committee on Deficit Reduction to repeal this unworkable payment system that creates a fragmented and inefficient delivery of health care.

In addition, AAFP has asked that the Joint Select Committee recommend a payment level for the next 3-5 years as transition period to study alternative payment methods. During that transition, we have urged the Joint Select Committee to specify a payment rate for primary care physicians that is at least 3 percent higher than that for non-primary care physicians.

MedPAC's Recommendations

Outside groups also have recognized the need to jettison the SGR. In October of this year, the Medicare Payment Advisory Commission (MedPAC) once again recommended elimination of the SGR formula stating:

- The link between cumulative fee-schedule expenditures and annual updates is unworkable.
- Beneficiary access to care must be protected.
- Proposals to replace the SGR must be fiscally responsible.
- It will never be less expensive to repeal the SGR than it is right now.

MedPAC has for years consistently recommended eliminating the SGR. In its most recent recommendations, the Commission proposed a series of updates that would no longer be based on an expenditure- or volume-control formula. However, at the same time, MedPAC said it was crucial to protect primary care from fee reductions.

Specifically, recent research suggests that the greatest threat to access over the next decade is concentrated in primary care services. In both patient and physician surveys, access to primary care providers is more problematic than access to specialists. These findings hold for both Medicare and privately insured patients, magnifying the vulnerability of access to primary care services.

Fee-for-Service Program: Changes that Could be Made Now

As the search for an alternative to the SGR continues, and as efforts to achieve true payment reform for primary care progress, we note that fee-for-service will remain the "coin of the realm" for several more years. Given this, a "fix" to fee-for-service, especially as it relates to evaluation and management (E/M) and other primary care services, is needed as well. We believe that these services remain undervalued.

In 2006, an effort was made to properly value these codes during the third five-year review of the Medicare physician fee schedule. That effort resulted in an increase in the work RVUs of E/M codes in 2007. However, the recommended RVUs for these services reflected a significant compromise on the part of primary care, and the accepted values were substantially less than what primary care physicians thought those services were worth relative to other services in the fee schedule.

Due to the statutory requirement for budget neutrality, which CMS chose to apply using a “work adjuster” in that instance, the accepted increase was effectively reduced further in a drastic manner. We believe that CMS could go a long way toward “fixing” the fee-for-service payments for E/M services by reconsidering and adopting the specialty society recommendations for these codes made in 2006. Revaluing the E/M codes in this way would provide an opportunity to recognize and reward high-value primary care services and to encourage integrated models of care such as the patient centered medical home.

Alternatives to the SGR

AAFP, along with the American Academy of Pediatrics, the American College of Physicians, and the American Osteopathic Association, have worked together to recommend the Joint Principles for a Patient Centered Medical Home (PCMH). This is a health delivery model based on blended payments to a primary care team, led by a physician that includes fee-for-service and a monthly per-patient fee to cover the coordination of health care that focuses on preventing illness and managing chronic diseases like diabetes or asthma; and a component that recognizes quality improvement.

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 also is growing evidence that experiments with PCMH and Accountable Care Organizations—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 -- Medicare should increase primary care payments so that they are 10-12 percent of total health care spending, particularly if done in ways that improve access to a broader array of services.

The Centers for Medicare and Medicaid Services (CMS) recently announced the Comprehensive Primary Care Initiative (CPCI), which anticipates using a blended payment that is consistent with the PCMH model. We commend CMMI for developing this initiative, which is designed to help primary care practices deliver higher quality, better coordinated and more patient-centered care.

Under the CPCI, Medicare, commercial and state insurance plans will offer additional per-patient payments to primary care teams who better coordinate care for their patients. The CPCI will recognize primary care practices that invest in electronic medical records, redesign their medical practices and commit time for communications with subspecialists, pharmacists, hospitals, home care agencies and therapists. The CPCI will demonstrate that patient outcomes improve and costs are saved when the health care system values primary care by paying for all of the services family physicians and other primary care physicians provide to their patients.

In addition, the AAFP believes that Accountable Care Organizations (ACO) may be structured to deliver health care more effectively and efficiently if they have primary care and the PCMH at their core. We appreciate that CMS has revised its proposed regulations for the ACO to allow more primary care practices to participate. To the extent that the ACO is built on the primary care physician, it may be a health delivery model that could improve health and restrain costs.

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.

Additional Research on the Value of Primary Care

Whatever the alternative health delivery model, AAFP believes that it will succeed only if it is built on providing health care that is patient-centered and incorporates an advanced primary care practice that is team-based and technologically capable.

Specifically, multiple investigators from various disciplines have assessed the effects of primary care and find that when people have access to primary care, treatment occurs before evolution to more severe problems. They also have fewer preventable emergency department visits and hospital admissions. Primary care clinicians use fewer tests, spend less money, and protect people from over treatment than those who use subspecialists for routine care. Particularly for the poor, access to primary care is associated with improved outcomes, more complete immunization, better blood pressure control, enhanced dental status, reduced mortality, and improved quality of life.

Finally, people with a regular source of primary care also receive more preventive services. Higher levels of primary care in a geographic area are associated with lower mortality rates, after controlling for important effects of urban-rural difference, poverty rates, education, and lifestyle factors. In addition, having a primary care physician is associated with increased trust and treatment compliance. Primary care enhances the performance of health care systems. It is not the solution to every health-related problem, but few, if any, health-related problems can be adequately addressed absent excellent primary care.

CONCLUSION

AAFP appreciates the opportunity to provide family medicine's views on how to reform the US health delivery system. In particular, we believe that health system reform only will be successful if built on a base of primary care physicians. To this end, we recommend elimination of the flawed sustainable growth formula and support for alternative delivery systems. These systems can include blended payment models, such as the patient centered medical home, which emphasize the currently undervalued component of primary care services.

Thank you for the opportunity to provide recommendations on this critical topic.