



AMERICAN ACADEMY OF
FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

Statement of the American Academy of Family Physicians

House Energy and Commerce Committee's Subcommittee on Health Hearing on,

“A Permanent Solution to the SGR: The Time Is Now”

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AAFP Headquarters

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

AAFP Washington Office

1133 Connecticut Avenue, NW, Ste. 1100
Washington, DC 20036-1011
202.232.9033
Fax: 202.232.9044
capitol@aafp.org

Introduction

This statement is submitted to the House Energy and Commerce's Subcommittee on Health on behalf of the 115,900 members of the American Academy of Family Physicians (AAFP) for the January 21 hearing titled, *A Permanent Solution to the SGR: The Time is Now*.

Since 2003, Congress has enacted 17 short-term fixes to address the flawed Medicare Sustainable Growth Rate (SGR) formula. The temporary patches, or "doc fixes," have cost more than \$160 billion during that time. While the AAFP is pleased Congress approved these short-term patches, it is unfortunate that the 113th and previous Congresses failed to enact a long-term SGR repeal-and-replace bill.

The AAFP appreciates the Subcommittee's robust health care agenda and current efforts to address SGR reform. We view this goal as a top legislative priority and stand prepared to work with Members of the Subcommittee to enact legislation this session that builds on the bipartisan, bicameral agreement. As the Subcommittee moves forward, the AAFP offers you our key health care principles and legislative priorities within the context of Medicare payment reform.

Health Care Principles

A Strong Primary-Care System

Primary care is the foundation of an efficient health care system. Efforts to enact federal health program reforms should increase access to primary care and ensure that the nation's system for providing these services is strong. Primary care is comprehensive, first contact, whole person, continuing care. It is not limited to a single disease or condition, and can be accessed in a variety of settings.¹ Primary care (family medicine, general internal medicine and general pediatrics) is provided and managed by a personal physician, based on a strong physician-patient relationship, and requires communication and coordination with other health professionals and medical specialists.²

Research shows that preventive care, care coordination for the chronically ill, and continuity of care – all hallmarks of primary care medicine – can achieve better health outcomes and cost savings.³ The benefits also translate into healthier communities.⁴ Published studies have demonstrated the positive impact of primary care on a variety of health outcomes, including decreased mortality from cancer, heart disease, stroke, and all causes combined.⁵ Primary care clinician capacity is also associated with fewer low birth weight infants, increased life expectancy, and improved self-rated health. An increase of one primary care physician per 10,000 people was associated with an average mortality reduction of 5.3 percent, or 49 per 100,000 per year.⁶ In addition, high quality care is necessary to achieve the triple aim of improving population health, enhancing the patient experience and lowering costs.⁷

Therefore, it is in the national interest to support a strong and efficient primary care system. This is especially true for the treatment of America's aging population, which represent a large majority of the Medicare population. According to a recent Kaiser Family Foundation report, by the year 2050, the number of people 65 years of age and older will nearly double.⁸ This population trend is associated with higher forecasted per capita spending for beneficiaries between 65 and 85 years of age.⁹ In 2020, Medicare costs are projected to consume 17 percent of the federal budget, a significant level, but, to date, increased spending has not produced a proportionate improvement in the nation's health.¹⁰ In fact, America ranks 37th in health status compared to other nations.¹¹

The factors driving Medicare costs are chronic care management and costly fee-for-service care. Currently, 82 percent of the Medicare population has at least one chronic condition and two-thirds have more than one.¹² The high utilization of specialty care combined with its reliance on expensive technology results in higher priced medicine – even when treating the exact same conditions.¹³ Successful management of these conditions within primary care means patients are healthier; make fewer trips to the hospital and doctors' offices *and* utilize less expensive medical care. According to a 2004 study commissioned by the Medicare Quality Improvement Organization, states with more primary care supply have lower cost per Medicare beneficiary. Essentially, primary care access contributes to a stronger and more fiscally sound Medicare program.

Appropriate Physician Payments for Quality and Complex Care Delivery

The nation's primary care physicians are committed to the health and well-being of their patients, but increasingly they practice medicine under challenging conditions.¹⁴ For example, the current payment system is unpredictable and does not reflect the value primary care provides to the health of Medicare beneficiaries. Instead, it rewards procedures, tests, technology and acute care rather than preventive health care, the coordination of care and chronic disease management. Payment methodologies need to be re-balanced to establish a predictable and equitable payment formula that appropriately compensates physicians for care provided. A new payment formula should invest more in primary care as a percent of overall total cost of care and is essential to improving the health and health care of Medicare beneficiaries and controlling costs. Such an increased investment in primary care payment would be significant to reduce the current disparity in payments compared to subspecialty care, which contributes to the growing primary physician workforce shortage and the escalation of health care costs.¹⁵

Family physicians, in comparison to other medical specialties, offer a broader range of care, inclusive of the care of patients with complex conditions. Primary care physicians provide care for a larger number of diagnoses than non-primary care specialists and correspondingly provide three times as many distinct physician services. A 2014 report by the Robert Graham Center found that on average, primary care physicians report 23 diagnosis codes, while cardiologists, for example, report six.¹⁶ Payers and policy makers should recognize this complexity of care.

AAFP Legislative Priorities

Based on the important framework of the bipartisan, bicameral legislation, which proposed strengthening primary and more appropriately paying for physicians' services, the following represents the AAFP's policy priorities.

Repeal of the Medicare Sustainable Growth Rate (SGR)

The AAFP strongly supports the immediate repeal of the Medicare sustainable growth rate (SGR) formula. Under the SGR, physicians face unpredictable payments into the foreseeable future even while their practice costs continue to increase. According to the government's own calculations, the Medicare payment rate for physician services has for several years not kept pace with the cost of operating a small business that delivers medical care. This system of non-aligned incentives, especially fee-for-service alone, rewards individual physicians for ordering more tests and performing more procedures – for volume over value. The system lacks incentives for physicians to coordinate those tests and procedures, or patient health care generally, or to offer preventive and health-maintenance services. This payment method has produced expensive, fragmented health care delivery.

Congress is well aware of the troublesome history of this payment formula, since policy makers have had to override the reductions in the physician payment rate mandated by the SGR. These perennial reductions threaten the stability of the Medicare program and the access of seniors to Medicare benefits. The looming threat of frequent reductions also stifles innovation in care delivery and hinders the transformation of primary care practices. Investments in process and quality improvement have proven difficult for most physicians under the current unpredictable payment structure. The AAFP has long advocated for repeal of the SGR – so the primary care delivery system can flourish through innovation unencumbered by a flawed payment structure and can provide quality care to patients.

Stable Payments and Performance Measures

Stable payment rates and performance measures are important and welcome reforms. The changes in the previous legislation would provide physicians with much-needed efficiency and predictability. The 2014 legislation would stabilize payment rates permanently by specifying an annual update increase of 0.5 percent through 2018 and then freeze the rate until 2023 followed by further positive updates in 2024 and thereafter. Under the bipartisan agreement, physicians would receive additional payment adjustments in the 2018-2023 period through the Merit-based Incentive Payment System (MIPS), a reform of the current fee-for-service system. MIPS is based on consolidation of three current performance-based programs: (1) The Physician Quality Reporting System (PQRS) that incentivizes physicians to report on quality of care measures; (2) The Value-Based Modifier (VBM) that adjusts payment based on quality and resource use; and (3) Meaningful Use of Electronic Health Records (EHR MU) that calls for meeting certain requirements in the use of certified EHR systems. In short, the real value of the SGR repeal legislation from the 113th Congress is that it not only eliminates the current SGR formula but

most importantly it creates the pathway for moving away from a total reliance on fee-for-service payment to alternative payment models which can be supportive of primary care and the achievement of the Triple Aim of better care, better health, and lower cost.

In addition, the AAFP supports the elimination of penalties associated with the PQRS, VBM and EHR MU programs after 2017. Instead, MIPS would assess the performance of those physicians billing Medicare who are not in Alternative Payment Models (APM). The assessment would be made in four categories: quality; resource use; EHR meaningful use; and clinical practice improvement activities. A composite performance score is created from these assessments and payments would be adjusted in the subsequent year based on the composite score. If approved, reducing the administrative duplications and paperwork burdens within these three programs will be an improvement in the health care delivery system.

Quality-Based Health Care Delivery Reforms

Care coordination is a key element of primary care. Within the framework plan, physicians who have a significant share of their Medicare revenues in an Alternative Payment Model (APM) that involves two-sided financial risk and a quality measurement component would receive a 5 percent bonus each year from 2018 and thereafter. Physicians participating in a qualifying APM would be exempt from the reporting and performance thresholds established by the Merit-based Incentive Payment System (MIPS). Physicians, who have a significant share of their Medicare revenue in a patient-centered medical home model that has been certified as maintaining or improving quality, and without increasing costs, are also eligible for the 5 percent bonus in 2018 and in subsequent years. Most often, these will be family physicians.

The AAFP strongly recommends that Medicare incorporate the patient-centered medical home (PCMH) concept into the program because it has shown to improve not only the quality but also the delivery of health care. Currently, 26 percent of AAFP members operate as part of a federally-recognized PCMH. An efficient payment system should place greater value on cognitive and clinical decision-making skills that result in more effective use of resources and that result in better health outcomes.

Patients, particularly the elderly, who have a usual source of care, like a medical home, are healthier and the cost of their care is lower because they use fewer medical resources than those who do not. An abundance of evidence shows that even the uninsured benefit from having a usual source of care.¹⁷ Individuals with a usual source of care receive more appropriate preventive services and more appropriate prescription drugs than those without a usual source of care, and do not get their basic primary health care in a costly emergency room, for example. In contrast, those without this usual source have more problems getting health care and neglect to seek appropriate medical help when it is necessary.¹⁸ A more efficient payment system would encourage physicians to provide patients with a medical home in which a patient's care is coordinated and expensive duplication of services is prevented.

Care Coordination Payments

The AAFP supports provisions within the bipartisan, bicameral agreement that would create a Medicare payment within the fee-for-service system complex chronic care services. The AAFP has long urged CMS to pay for care coordination and other cognitive services that play a pivotal role in enhancing health care access, improving quality and controlling costs. A care coordination payment would compensate eligible physicians for those services generally provided outside a traditional face-to-face encounter. The AAFP would support efforts to permanently codify the care coordination payment into law with a provision that these services not be subject to co-payments or deductibles when they are provided by primary care physicians.

Accurate Valuation of Services

The AAFP supports redistribution of relative value units (RVU) within the fee schedule to achieve accuracy. Under current law, CMS has the authority to adjust the fee schedule. Congress has added new authority to adjust misvalued codes, in order to reduce overvalued services and increase undervalued services. Congress has since accelerated that process. The AAFP supports this process, but only if the savings are retained within the fee schedule.

Primary Care Incentive Payment

Currently, the Centers for Medicare and Medicaid Services (CMS) pays primary care physicians (defined as those with a specialty designation of family medicine, internal medicine, geriatric medicine or pediatric medicine) an additional 10 percent for primary care services, defined essentially as evaluation and management services. This incentive payment program expires on December 31, 2015. The goal is to recognize, to some degree, the value of primary care and to improve compensation for these services. Family Medicine appreciates the underlying message of the provision, but is asking Congress to increase the payment and make it permanent for all federal health care payment programs, including Medicaid. Otherwise, the incentive is too limited to achieve its important goals.

Conclusion

As Congress moves forward to repeal the SGR and reform Medicare payments, the AAFP urges policy makers to do so in a way that supports primary care and appropriately pays physicians for the care that they provide. A strong primary system benefits the Medicare program and is fiscally sound policy. Again, the AAFP is pleased to work with the Subcommittee to advance SGR repeal-and-replace legislation based on the bipartisan, bicameral framework approved in 2014, and looks forward to working with you to enact this important policy into law.

For more information, please contact Sonya Clay, Government Relations Representative, at 202-232-9033 or sclay@aafp.org

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²Ibid.

³Donald M Berwick, Thomas W Nolan, and John Whittington, "The triple aim: care, health, and cost," *Health Affairs* (Project Hope) 27, no. 3 (June 2008): 759- 769

⁴Bruce Steinwald, US Governmental Accountability Office, Testimony before the Committee on Health, Education, Labor, and Pensions, U.S. Senate. Primary Care Professionals: Recent Supply Trends, Projections and Valuation of Services.(February 12, 2008) GAO-08-472T

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⁸Tricia Neuman, Juliette Cubanski, Jennifer Huang, Anthony Dominco, Kaiser Family Foundation, Report, Rising Cost of Living Longer (January 2015), accessed online at: <http://kff.org/medicare/report/the-rising-cost-of-living-longer-analysis-of-medicare-spending-by-age-for-beneficiaries-in-traditional-medicare/>

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¹⁰National Commission on Physician Payment Reform (March 2013), accessed online at: http://physicianpaymentcommission.org/wp-content/uploads/2013/03/physician_payment_report.pdf

¹¹Ibid.

¹²Reid B. Blackwelder, MD, Leaders Voices Blog, (October 2014), We're Doing Our Part to Keep SGR Issue On Congress' Radar, http://blogs.aafp.org/cfr/leadervoices/entry/we_re_doing_our_part

¹³Ibid.

¹⁴Blackwelder (October 2014)

¹⁵National Commission on Physician Payment Reform (March 2013), p. 8

¹⁶Graham Center, December 2014, <http://www.graham-center.org/online/graham/home/publications/onepaggers/2014/accounting-for-complexity-12-01-14.html>

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¹⁸Ibid.