

STATEMENT
of the
**American Academy
of Family Physicians**

Submitted

Before The

Regulations, Healthcare and Trade Subcommittee
of the House Small Business Committee

Concerning

Medicare Reimbursement Cuts: The Potential Impact on Solo and Small
Group Medical Practices

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November 8, 2007

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Introduction

On behalf of the 93,800 members of the American Academy of Family Physicians and, more importantly, for the 50 million of your constituents who give us the privilege of taking care of their health every day, thank you for your invitation to participate in this hearing. The Academy commends the committee for your persistent and successful efforts to ease the burdens of small businesses in this country.

A large percentage of family physicians work in small and medium sized practices of four physicians or fewer. Our practices are typical of small businesses that operate with very tight financial margins. As family physicians, nearly half of our patients are Medicare beneficiaries, on Medicaid, or have no insurance at all.

The average gross revenue for family medicine practices in 2003 was \$360,000. From this total, family physicians pay staff salaries, rent, utilities, medical equipment costs and medical liability insurance premiums. Most of these costs have risen rather steadily and predictably with the single, significant exception of medical liability premiums. When these premiums increase at the rate of which we have seen for the last several years, our practices have no way to absorb them.

The AAFP appreciates the work this Committee has undertaken to examine how Medicare pays for the services that physicians deliver to Medicare beneficiaries and how Medicare reimbursement affects the operation of these small businesses. Family physicians also share the Committee's concerns that the current system is inefficient, inaccurate and outdated. For this reason, the AAFP supports the restructuring of Medicare payments to reward quality and care coordination. This should be done with the needs of Medicare patients foremost in mind. Since most of these patients have two or more chronic conditions that call for continuous management and that depend on differing pharmaceutical treatments, Medicare should focus on how beneficiaries can coordinate their care and prevent expensive and duplicative tests and procedures.

Most people in this country receive the majority of their health care in ambulatory care settings from physicians in small or medium size practices. Specifically, about a quarter of all office visits in the U.S are to family physicians, and Medicare beneficiaries comprise about a quarter of the typical family physician's practice. Finding a more efficient and effective method of paying for physicians' services delivered in diverse settings to Medicare beneficiaries with a large variety of health conditions is a difficult but necessary endeavor, and one that has tremendous implications for millions of patients. Likewise, the implications are enormous for the specialty of family medicine. The Academy, therefore, is committed to involvement in the design of a new payment system that meets the needs of patients and physicians.

While the AAFP appreciates the Committee's action that avoided a 5-percent payment reduction in the Medicare Physician Fee Schedule for this year, the fact that current Medicare reimbursement rates for physician services is less than it was in 2001 underscores the urgency of correcting this problem for this all-important health program for our nation's seniors.

Current Payment Environment

The environment in which U.S. physicians practice and are paid is challenging at best. Medicare, in particular, has a history of making disproportionately low payments to family physicians and other primary care physicians, largely because its payment formula rewards procedural volume and fails to foster the comprehensive, coordinated management of patients that is the hallmark of primary care. More broadly, the prospect of steep annual cuts in payment resulting from the flawed payment formula is, at best, discouraging. In the current environment, physicians know that, without Congressional action now, they face Medicare payment cuts of 10-percent and subsequent annual cuts in the range of 5-8 percent for the foreseeable future (nearly 40 percent over the next nine years) while their practice costs continue to increase. Clearly, the Sustainable Growth Rate (SGR) formula belies its name and simply is not sustainable.

Primary Care Physicians in the U.S.

While other developed countries have a better balance of primary care doctors and subspecialists, primary care physicians make up less than one-third of the U.S. physician workforce. Compared to those in other developed countries, Americans spend the highest amount per capita on healthcare but have some of the worst healthcare outcomes. More than 20 years of evidence shows that having a primary care-based health system has both health and economic benefits. Two years ago, a study comparing the health and economic outcomes of the physician workforce in the U.S. reached the same conclusion (*Health Affairs*, April 2004). By not having health care predicated on the coordination of patients' care by primary care physicians, we waste resources and forego significant quality improvement to the system of health care.

The Patient-Centered Medical Home

From the outset, the Medicare program has based physician payment on a fee-for-service system. This system of non-aligned incentives rewards individual physicians for ordering more tests and performing more procedures. The system lacks incentives for physicians to coordinate the tests, procedures, or patient health care generally, including preventive services and care to maintain health. This payment method has resulted in an expensive, fragmented Medicare program.

The outdated payment scheme does not adequately compensate physicians who do manage and organize their patients' health care. Currently, there is no compensation to physicians in recognition of the considerable time and effort associated with coordinating health care in a way that is understandable to patients and cost-effective for the Medicare program.

To correct these inverted incentives, the American Academy of Family Physicians recommends that beginning in 2008, Medicare compensate physicians for care coordination services. Such payment should go to the personal physician or practice chosen by the patient to perform this role. Any physician practice prepared to provide care coordination could be eligible to serve as a patient's "personal medical home."

The AAFP, the American College of Physicians (ACP), the American Osteopathic Association (AOA) and the American Academy of Pediatrics (AAP), who combined represent all of U.S. primary care physicians, have been working with the National Committee on Quality Assurance (NCQA) to develop a certification program for those physician practices that want to be recognized as a "patient-centered medical home." We would recommend that once this process is completed, the Congress might want to consider requiring third party certification by NCQA or another non-profit third party before a patient can designate a practice as his or her medical home. By requiring this certification, the federal government can be assured that the physician practice will have met rigorous standards of service.

The Institute of Medicine (IOM) has repeatedly praised the value of, and cited the need for, care coordination. And while there are a number of possible methods to build this into the Medicare program, AAFP recommends a blended model that combines fee-for-service with a per-beneficiary, per-month stipend for care coordination in a beneficiary's medical home. Patients should be given incentives to select a personal medical home by reduced out-of-pocket expenses such as co-pays and deductibles.

The more efficient payment system should place greater value on cognitive and clinical decision-making skills that result in more efficient use of resources and that result in better health outcomes. For example, the work of Barbara Starfield, Ed Wagner and others has shown that patients, particularly the elderly, who have a usual source of care, are healthier and the cost of their care is lower because they use fewer medical resources than those who do not. The evidence shows that even the uninsured benefit from having a usual source of care (or medical home). These individuals receive more appropriate preventive care 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 they need it. 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 eliminated.

One model that the Committee could well consider is the Medicaid program in North Carolina, headed by a family physician, Dr. Allen Dobson. Gov. Mike Easley announced recently that Community Care of North Carolina, based on this primary care "medical home" model saved North Carolina taxpayers more than \$231 million dollars in state fiscal years 2005 and 2006.

Community Care is a good example of a good business model that enables us to work smarter, raise the quality of health care for the patient while at the same time making it cheaper for the purchaser.

The model has been the subject of discussions between the primary care physician organizations and IBM in Austin, Texas, to create a demonstration project for their employees that will examine the characteristics of a successful patient-centered medical

home. And AAFP, ACP, AOA and the National Association of Community Health Centers have joined with the ERISA Industry Committee, the National Business Group on Health and several major employers to form the Patient Centered Primary Care Collaborative to advance the medical home as a way to improve the health care system generally.

The patient-centered, physician-guided medical home being advanced jointly by the American Academy of Family Physicians, the American College of Physicians, the American Osteopathic Association, and the American Academy of Pediatrics would include the following elements:

- **Personal physician** - each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.
- **Physician directed medical practice** – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.
- **Whole person orientation** – the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.
- **Care is coordinated and/or integrated** across all domains of the health care system (hospitals, home health agencies, nursing homes, consultants and other components of the complex health care system), facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it.
- **Quality and safety** are hallmarks of the patient-centered medical home: Evidence-based medicine and clinical decision-support tools guide decision making. Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement. Patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met.

Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication.

Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model.

- **Enhanced access** to care through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and office staff.

Payment of the care management fee for the medical home would reflect the value of physician and non-physician staff work that falls outside of the face-to-face visit associated with patient-centered care management, and it would pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources. In order to capitalize on the effectiveness of primary care and the capabilities of family physicians who function in small business environments, it is this type of innovation to the Medicare program that must be implemented and emphasized and when accomplished it will pay dividends to the beneficiary and the Medicare program alike.

Aligning Incentives

Beyond replacing the outdated and dysfunctional SGR formula, a workable, predictable method of determining physician reimbursement - one that is sensitive to the costs of providing care - should align the incentives to encourage evidence-based practice and foster the delivery of services that are known to be more effective and result in better health outcomes for patients. Moreover, the reformed system must facilitate efficient use of Medicare resources by paying for appropriate utilization of effective services and not paying for services that are unnecessary, redundant or known to be ineffective. Such an approach is endorsed by the Institute of Medicine (IOM) in its 2001 publication *Crossing the Quality Chasm*.

Another IOM report released in autumn of 2006, entitled *Rewarding Provider Performance: Aligning Incentives in Medicare* states that aligning payment incentives with quality improvement goals represents a promising opportunity to encourage higher levels of quality and provide better value for all Americans. The objective of aligning incentives through pay for performance is to create payment incentives that will: (1) encourage the most rapidly feasible performance improvement by all providers; (2) support innovation and constructive change throughout the health care system; and (3) promote better outcomes of care, especially through coordination of care across provider settings and time. The AAFP concurs with the IOM recommendations:

- Measures should allow for shared accountability and more coordinated care across provider settings.
- P4P programs should reward care that is patient-centered and efficient and reward providers who improve performance as well as those who achieve high performance.
- Providers should be offered (adequate) incentives to report performance measures.
- Because electronic health information technology will increase the probability of a successful pay-for-performance program, the Secretary should explore ways to assist providers in implementing electronic data collection and reporting to strengthen the use of consistent performance measures.

Aligning the incentives requires collecting and reporting data through the use of meaningful quality measures. AAFP supports collecting and reporting quality measures and has demonstrated leadership in the physician community in the development of

such measures. It is the Academy's belief that measures of quality and efficiency should include a mix of outcome, process and structural measures. Clinical care measures must be evidence-based and physicians should be directly involved in determining the measures used for assessing their performance.

A Chronic Care Model in Medicare

If we do not change the Medicare payment system, the aging population and the rising incidence of chronic disease will overwhelm Medicare's ability to provide health care. Currently, 82 percent of the Medicare population has at least one chronic condition and two-thirds have more than one illness. However, the 20 percent of beneficiaries with five or more chronic conditions account for two-thirds of all Medicare spending.

There is strong evidence that the *Chronic Care Model* (Ed Wagner, Robert Wood Johnson Foundation) would improve health care quality and cost-effectiveness, integrate patient care, and increase patient satisfaction. This well-known model is based on the fact that most health care for the chronically ill takes place in primary care settings, such as the offices of family physicians. The model focuses on six components:

- self-management by patients of their disease
- an organized and sophisticated delivery system
- strong support by the sponsoring organization
- evidence-based support for clinical decisions
- information systems; and
- links to community organizations.

This model, with its emphasis on care-coordination, has been tested in some 39 studies and has repeatedly shown its value. While we believe payment should be provided to any physician who agrees to coordinate a patient's care (and serve as a medical home), generally this will be provided by a primary care doctor, such as a family physician.

The AAFP advocates for a new Medicare physician payment system that embraces the following:

- Adoption of the Medical Home model which would provide a per month care management fee for physicians whom beneficiaries designate as their Patient-centered Medical Home;
- Continued use of the resource-based relative value scale (RBRVS) using a conversion factor(s) updated annually by the Medicare Economic Index (MEI) and providing no geographic adjustment in Medicare allowances except as it relates to identified shortage areas.

Information Technology in the Family Medicine Office Setting

An effective system emphasizing coordinated care is predicated on the presence of health information technology, i.e., the electronic health record (EHR) in the physician's office. Using advances in health information technology (HIT) also aids in reducing errors and allows for ongoing care assessment and quality improvement in the practice

setting – two additional goals of recent IOM reports. We have learned from the experience of the Integrated Healthcare Association (IHA) in California that when physicians and practices invested in EHRs and other electronic tools to automate data reporting, they were both more efficient and more effective, achieving improved quality results at a more rapid pace than those that lacked advanced HIT capacity.

Family physicians are leading the transition to EHR systems in large part due to the efforts of AAFP's Center for Health Information Technology (CHiT). The AAFP created the CHiT in 2003 to increase the availability and use of low-cost, standards-based information technology among family physicians with the goal of improving the quality and safety of medical care and increasing the efficiency of medical practice. Since 2003, the rate of EHR adoption among AAFP members has more than doubled, with over 30 percent of our family physician members now utilizing these systems in their practices.

In an HHS-supported EHR Pilot Project conducted by the AAFP, we learned that practices with a well-defined implementation plan and analysis of workflow and processes had greater success in implementing an EHR. CHiT used this information to develop a practice assessment tool on its Web site, allowing physicians to assess their readiness for EHRs.

In any discussion of increasing utilization of an EHR system, there are a number of barriers, and cost is a top concern for family physicians. The AAFP has worked aggressively with the vendor community through our Partners for Patients Program to lower the prices of appropriate information technology. The AAFP's Executive Vice President serves on the American Health Information Community (AHIC), which is working to increase confidence in these systems by developing recommendations on interoperability. The AAFP sponsored the development of the Continuity of Care Record (CCR) standard, now successfully balloted through the American Society for Testing and Materials (ASTM). We initiated the Physician EHR Coalition, now jointly chaired by ACP and AAFP, to engage a broad base of medical specialties to advance EHR adoption in small and medium size ambulatory care practices. In preparation for greater adoption of EHR systems, every family medicine residency will implement EHRs by the end of this year.

To accelerate care coordination, the AAFP joins the IOM in encouraging federal funding for health care providers to purchase HIT systems. According to the US Department of Health & Human Services, billions of dollars will be saved each year with the widespread adoption of HIT systems. While the federal government has already made a financial commitment to this technology, the funding, unfortunately, is not directed to the systems that will truly have the most impact and where ultimately all health care is practiced - at the individual patient level. We encourage you to include funding in the form of grants, low interest loans or tax credits for those physicians committed to integrating an HIT system in their practice.

Conclusion

It is time to modernize Medicare by recognizing the importance of, and appropriately valuing, primary care and by embracing the Patient-centered Medical Home model as an integral part of the Medicare program.

Specifically, the AAFP encourages Congressional action to reform the Medicare physician payment system in the following manner:

- Repeal the Sustainable Growth Rate formula at a date certain and replace it with a stable and predictable annual update based on changes in the costs of providing care as calculated by the Medicare Economic Index.
- Adopt the patient-centered medical home by giving patients incentives to use this model and compensate physicians who provide this function. The physician designated by the beneficiary as the patient-centered medical home shall receive a per-member, per-month stipend in addition to payment under the fee schedule for services delivered.
- When appropriate, phase in value-based purchasing by starting with the Physician Quality Reporting Initiative. Analyze compensation for reporting and ensure that it is sufficient to cover costs associated with the program and provide a sufficient incentive to report the required data.
- Ultimately, payment should be linked to health care quality and efficiency and should reward the most effective patient and physician behavior.

The Academy commends the Committee for its commitment to identify a more accurate and contemporary Medicare payment methodology for physician services. Moreover, the AAFP is eager to work with Congress toward the needed system changes that will improve not only the efficiency of the program but also the effectiveness of the services delivered to our nation's elderly.