AMERICAN ACADEMY OF FAMILY PHYSICIANS

STRONG MEDICINE FOR AMERICA

Statement of the American Academy of Family Physicians

TO THE SENATE COMMITTEE ON FINANCE

PRESENTED BY

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Chairman Baucus and Senators, thank you for inviting the American Academy of Family Physicians (AAFP) to provide the Committee with a statement on our views of physician payment policy. The AAFP, with 105,900 members, is the only organization comprised entirely of primary care physicians or those training to become primary care physicians. Approximately, one in four of all office visits are made to family physicians. That is 240 million office visits each year – nearly 87 million more than the next largest medical specialty. We represent the foundation of health delivery in this country. However, health care in the United States is inefficient and delivers lower quality care because it undervalues the delivery of primary care.

The Finance Committee has done an excellent job in examining the causes of this systemic flaw. You well know the source of much of the problem, and that is the fee-for-service payment system. Fee-for-service pays for procedures and encourages volume over value in the delivery of health care. As a nation, we have tried alternatives to pure fee-for-service: managed care with capitated payments was one alternative. But that promoted less service and financially based denials and deferrals of medical care. Other payment methods focus on only part of the health delivery challenges, like efficiency or quality, and end up exacerbating the underlying problems, at least in part because of their claims-based reporting structure.

The AAFP has become convinced that no single alternative payment method will rebuild primary care. Instead, we need a combination of payment methods. AAFP, along with the other three major organizations that include primary care physicians – namely, the American Academy of Pediatrics, the American College of Physicians and the American Osteopathic Association – promote the Patient-Centered Medical Home, which is based on a blended payment system that includes:

- fee-for-service to pay for needed procedures, treatments and services
- care management fee to pay for the necessary and important functions of primary care – continuity and care coordination – over time between visits and when patients need care elsewhere in the health care system
- quality improvement payment to encourage effective review of a physician's patient data and consequent changes in practice.

In turn, the primary care physician has to transform the practice of primary care medicine. The demands of primary care in the Patient-Centered Medical Home (PCMH) are greater and more varied. The physician can no longer be the single source of health care, but rather must be part of a team that provides services, monitors care and advocates for the patient in different settings. Team-based care retains the personal relationship between the physician and the patient that is key to effective and efficient health care delivery, but the care of the patient includes other health care providers. The team uses electronic health records and health information technology to coordinate the care of the patient in different delivery settings and to provide more patient-centered service, like same-day appointments, asynchronous communication by way of e-mail, and educational tools. When the patient sees a non-primary care physician, that practice has access to a current and complete medical history and treatment record. The patient-centered medical home offers a variety of counseling, coaching and health improvement tools for each patient's use, tailored to that patient's need.

We advocate for this reinvigoration of primary care because we know it works to improve health care and restrain costs in the long run. The evidence for this is accumulating rapidly. One example is WellMed, a network of practices in San Antonio, which developed a highly effective Accountable Care Organization to care for Medicare Advantage patients. In a comparison of their patients with a matched sample of Medicare beneficiaries from Texas, the Robert Graham Center found that WellMed patients in a medical home are 35 percent less likely to be hospitalized and 37 percent less likely to visit an emergency department. There were also significant difference in whether patients received preventive screening and chronic care services including age-appropriate colon cancer screening (53 percent vs. 9.8 percent); annual cholesterol screening for patients with diabetes (77 percent vs. 71.7 percent); and annual cholesterol screening for people with ischemic heart disease (76 percent vs. 63.5 percent).

Private sector payers, largely in response to employers demanding it, also have begun several demonstration programs that are producing impressive results. For example, according to Steven Peskin, MD, the Senior Medical Director for Clinical Innovations, Horizon Blue Cross/Blue Shield of New Jersey has a patient-centered medical home demonstration that includes 24,000 members. In its first year, it has already shown notable improvement in the quality of care. Specifically, the plan has demonstrated an 8 percent higher rate in diabetes control, a 6 percent higher rate in breast cancer screening and a 6 percent higher rate in cervical cancer screening. Emergency room visits fell by 26 percent; hospital readmissions fell by 25 percent; and hospital in-patient admissions dropped by 21 percent. Cost indicators also are declining. The per-member, per-month cost of care declined by 10 percent.

Blue Cross/Blue Shield of Michigan reports, from a similar demonstration program, a reduction of 17 percent in in-patient admissions, a 6 percent decline in the 30-day readmission rate and 4.5 percent decrease in ER visits. Advanced imaging declined by 7 percent. Blue Cross/Blue Shield of Texas has noted a 23 percent lower rate of hospital readmissions and savings of approximately $1.2 million in annual health care costs. Idaho Blue Cross/Blue Shield reported $1 million savings in medical claims for its patients in a PCMH.

We have included additional findings from PCMH programs across the nation as an addendum to this statement. The results are compelling. Regardless of geographic location, the PCMH is demonstrating success in improving quality and restraining health care costs – specifically in the areas of emergency room visits and hospital readmission. (These results will be included in a larger report, being prepared by the Patient-Centered Primary Care Collaborative, which will be published later this month.)

Additionally, as members of the Finance Committee are aware from the June 14 roundtable discussion on “Medicare Physician Payment Policy: Lessons from the Private Sector," these are but a few examples of the ROI that can be achieved with an increased investment in primary care. The previous roundtable featured executives from Blue Cross Blue Shield of Massachusetts, Humana, Aetna, CareFirst BlueCross BlueShield, Washington, DC; and Hill Physicians Medical Group, San Francisco, CA. Each member of the roundtable described a variation of the same theme: greater investment in primary care. And each explained how this investment was operationalized and what return was realized.

- **Massachusetts BCBS** – unprecedented improvements in the quality of patient care and a 2-percent slower rate of growth in medical spending.

- **Humana –** the majority of their payment innovations center on engagement with primary care physicians.

- **Aetna** – provider reimbursements, tied to improved population health and reductions in the total cost of care, averaged 45 percent fewer acute hospital admissions, 50 percent fewer acute hospital days, and 56 percent fewer readmissions in 2011 compared to statewide unmanaged, risk-adjusted Medicare populations.

  In a study involving a large-scale commercial population of 200,000 members, ActiveHealth disease management achieved a 2.1 percent decrease in the cost trend in members meeting criteria for disease management interventions and an overall reduction in covered charges of $3.10 per member per month across the entire population.

- **CareFirst BCBS DC** – the Patient-Centered Medical Home (PCMH) was offered as an innovative program designed to give primary care providers new incentives and tools to provide higher quality, lower cost care to plan members.

  Incentives to primary care providers, including an immediate 12-percent increase in their fees as well as additional compensation for the development and monitoring of patient-specific care plans for their sickest patients, reinforce the central role of primary care. Incentive awardees achieved an average 4.2 percent savings against expected 2011 care costs; the cost of care for all CareFirst members attributed to PCMH participants was 1.5 percent lower than had been projected for 2011.

- **Hill Physicians** – primary care physicians are paid using a hybrid model of fee-for-service and performance-based compensation. The (lower-than-Medicare) fee-for-service component is supplemented by a quarterly primary care management fee that results in network physicians being paid at an average rate that is considerably higher than Medicare.

To understand why these programs that depend on greater emphasis on primary are so successful in holding back cost increases and improving health, it is important to understand the difference between primary care, specialty care and surgical care. The definition of primary care encompasses certain core values, including first contact, continuity, comprehensiveness and coordination of care. Specialty care focuses on a limited disease condition or organ system. A surgeon, of course, is trained to treat a specific episode of an acute disease that threatens the health of the whole person. These general medical categories require different skills and different relationships with the patient. It makes sense to pay them differently.

On March 12, 2012, the AAFP sent a series of recommendations to the Acting Administrator of CMS, Marilyn Tavenner. (A copy of that letter is appended to this statement.) These recommendations were the result of an AAFP sponsored Task Force on Primary Care Valuation, which included representatives of family medicine and other primary care organizations (i.e., the American Academy of Pediatrics, the American College of Physicians and the American Osteopathic Association). It also included representatives from employer groups, private payers, and health policy organizations. In the short term, the Task Force urged CMS to create new codes for evaluation and management (E/M) services provided by primary care physicians. These codes would have their relative values pegged to the median values from the 2005 survey of E/M codes done by the primary care and other 'cognitive' specialties at that time. These new codes would be specifically for use by primary care physicians only.

The Task Force also recommended that eligibility for an enhanced payment option for primary care physicians be established following fundamental precepts; namely that the eligibility requirements reward a physician's practice that demonstrates it is carrying out three definitional functions of primary care, namely (1) first contact; (2) continuity; and (3) comprehensiveness.

Additionally, a claims-based measure of coordination of care should be developed since there is currently none ready for use. As pediatric data is not available from Medicare data, further study of state Medicaid for other claims-based data is needed

The key Task Force recommendation is that to build a system of care that will be consistently more efficient and will produce better health, we need to pay primary care differently and better. The AAFP has supported the *Medicare Physician Payment Innovation Act* (HR 5707), which Reps. Allyson Schwartz (D-PA) and Joe Heck, DO (R-NV) introduced. We do so for several reasons, one of which is that it takes a notable step toward recognizing this critical need to pay primary care differently. The legislation would specify a fee-for-service payment rate that is 2-percent higher for primary care services for four years. The bill also includes strong incentives for physicians to commit their efforts to better health care delivery. In later years, for example, the legislation begins reducing fee-for-service payment rates for those practices that have not transitioned to an alternative health delivery model that CMS has certified either reduces costs without reducing quality or improves quality without increasing costs.

The mechanism that CMS will use to determine effective alternatives is the Center for Medicare and Medicaid Innovation. The AAFP commends this committee for your farsightedness in including the Innovation Center in the *Affordable Care Act*. This office provides CMS with a degree of nimbleness and creativity that is unusual in the private sector, much less the federal government. The AAFP is working closely with the Innovation Center, for example, to encourage selected family physicians to participate in the Comprehensive Primary Care Initiative that includes several health plans in various markets that will offer a per-patient, per-month care coordination fee for primary care physicians whose practices are effectively Patient-Centered Medical Homes. We hope this initiative will quickly show the same levels of quality improvement and cost restraints that have become clear in other single-payer tests. The importance of this initiative is that it contains more than just Medicare patients. Since only about 20-25 percent of the patients in an average family physician's practice are in the Medicare

program, it has been difficult for many of these practices that want to transform themselves into a PCMH to find the up-front finances needed to pay for the required investments. By including all payers in a specific market, the chances that the family physician will have access to the necessary capital are greatly increased and practice transformation is much more feasible.

The AAFP commends the Innovation Center for adapting the Accountable Care Organization (ACO) concept to the small primary care practice. The Innovation Center recognized this requirement for up-front investments when it developed the concept of the Advance Payment ACO. This ACO model specifically reduces the risk to the small (and even solo) practice that wants to become an Accountable Care Organization by providing shared savings in advance so that the small practice will have additional access to capital. CMS should be encouraged to continue exploring options for alternative payment that will allow the nation's health care system to escape the hamster-in-the-wheel reality driven by pure fee-for-service.

The *Affordable Care Act* included another provision that will be very helpful to small primary care practices, especially in rural and underserved areas. This is the Primary Care Extension Service, administered by the Agency for Healthcare Research and Quality (AHRQ). Currently without funding, the Primary Care Extension Program is designed to disseminate by local agents the most up-to-date information about evidence-based therapies and techniques to small practices in much the same way as the federal Cooperative Extension Service provides small farms with the most current agricultural information and guidance. One of the crucial values of this extension service is that it would be able to support small family medicine practices that want to become a Patient-Centered Medical Home. We would recommend an extended timeline for the transformation of these practices into a PCMH, but we see the Primary Care Extension Service as a vital tool to help make this transformation possible. The AAFP strongly recommends that Congress fund the Primary Care Extension Service program.

We have an another feature of the ACA that is worth noting and deserves your continued support; namely, the Primary Care Incentive Payment (PCIP), which is the 10-percent bonus payment to primary care physicians and providers for certain primary care services they provide to Medicare patients. According to CMS data, it is an average annual payment to a family physician of about $3500. This modest payment sends an important signal not just to family physicians and other primary care providers, but also to medical students who must decide whether to pursue a career in primary care. The Robert Graham Center for Policy Studies in Family Medicine and Primary Care, in a study for the Macy Foundation, determined that growth in the income gap between primary care and specialty care is the strongest factor in predicting student and resident career choice. Both public and private payers must continue to find mechanisms that will close this gap even further.

The Commonwealth Fund recently published a study that the PCIP, if made permanent, would modestly increase costs of primary care but save much more in other health care costs. James Reschovsky, PhD, and colleagues, in a study published on March 21, 2012, found that making the primary care bonus permanent would boost the number of primary care visits by 8.8 percent, while also raising the overall cost of primary care visits. But these increases would yield more than a six-fold annual return in lower Medicare costs for other services—mostly

reductions in hospitalizations, outpatient services, and post-acute care—once the full impact on treatment patterns is realized. The net result, according to this study, would be a drop in Medicare costs of nearly 2 percent.

Related to the PCIP, there is a similar feature of the health reform law that will be in place only for 2013 and 2014, unless Congress acts to extend it. This is the provision that increases Medicaid payment for primary care and some preventive health services to a rate at least equal to that of Medicare for the same services. Again, this sends a message to medical students that primary care matters for all patients, regardless of their income and health status. The AAFP believes that Congress should extend both payment provisions to assure that they will have the long-lasting effect of encouraging medical students to choose primary care careers.

Senators, we all want the same thing: better health care at less cost. There is a proven way to go a long way toward achieving that outcome – invest in primary care. Our most important recommendation is that we must pay primary care differently and better – and we have ample evidence that doing so will not increase the overall cost of care per individual per year.

Thank you again for your commitment to the health care of this nation and family physicians are eager to assist you in making the difference we need.

Outcomes of Implementing the Patient Centered Medical Home (PCMH)
A Review of the Results - 2012

These findings will be published in July 2012 as part of a larger report prepared by the Patient Centered Primary Care Collaborative (PCPCC).

Results of Patient-Centered Medical Home Initiatives, by State or Agency				
Initiative	**Health Care Cost & Acute Care Service Outcomes**	**Health Outcomes & Quality of Care Results**	**Years of Data Review**	**Report Type**
Air Force (2011)[i]	• 14% fewer emergency department (ED) and urgent care visits • Hill Air Force Base (UT) saved $300,000 annually through improved diabetes care management	• 77% of diabetic patients had improved glycemic control at Hill Air Force Base	2009-2011	Agency Congressional testimony
Alaska: ***Alaska Native Medical Center (2012)***[ii]	• 50% reduction in urgent care and ER utilization • 53% reduction in hospital admissions • 65% reduction in specialist utilization		? - 2012	Industry Report via public presentation
California: **BCBS of California ACO Pilot (2012)** [iii]	• 15% fewer hospital readmissions • 15% fewer inpatient hospital stays • 50% fewer inpatient stays of 20 days or more • Overall health care cost savings of $15.5 million		2010	BCBS Industry Report
Colorado **Colorado Medicaid and SCHIP**[iv]	• $215 lower per member per year for children.	• Increased provider participation in CHIP program from 20% to 96%. • Increased well-care visits for children from 54% in 2007 to 73% in 2009.	2007-2009	Alliance of Community Health Plans: Care Management Handbook
Florida	• 40% lower inpatient hospital	• 250% increase in primary care	2003-?	IHI Report

Capital Health Plan, (Tallahassee, FL) 2012 [v]	days • 37% lower ED visits • 18% lower health care claims costs	visits		
Idaho: **BCBS of Idaho Health Service (2011)**[iii]	• $1 million reduction in single year medical claims • ROI of 4:1 for disease management programs			BCBS Industry Report
Maryland: **CareFirst BlueCross BlueShield (2011)**[vi]	• 4.2% average reduction in expected patient's overall healthcare costs among 60% of practices participating for 6 or more months • Nearly $40 million savings in 2011	•	2011	BCBS Industry Report
Michigan: **BCBS of Michigan (Physician Group Incentive Program) (2011)**	• 13.5% fewer emergency department (ED) visits among children in PCMH (vs 9% non-PCMH) • 10% fewer ED visits among adults in PCMH (vs. 6.5% non-PCMH)[vii] • 7.5% lower use of high-tech radiology.[viii] • 17% lower ambulatory-care sensitive inpatient admissions • 6% lower 30-day readmission rates[iii]	• 60% better access to care for participating practices that provide 24/7 access (as compared to 25% in non-participating sites)[iii]	2008-2011	BCBS Industry Report, Factsheet,
Minnesota **HealthPartners**[ix,xxvi] **(Bloomington, MN)**	• 39% lower ER visits • 24% fewer hospital admissions • 40% lower readmission rates • 30% lower length of stay • 20% lower inpatient costs due to outpatient case management program for behavioral health.	• Reduced appointment wait time by 350% from 26 days to 1 day. Improved quality of services • 129% increase in optimal diabetes care • 48% increase in optimal heart disease care. Changed provider	2004-2009	Industry Report

	• Overall costs decreased to 92% of state average in 2008. • Reduced outpatient costs of $1282 for patients using 11 or more medications.	behavior • 13% increase in generic prescribing • 10% decrease in diagnostic imaging scans		
Nebraska: **BCBS of Nebraska 2012)**[x]	• 10% fewer hospitalizations • 27% fewer emergency visits		2011	BCBS Industry Report
New Jersey: **BCBS of New Jersey (Horizon BCBSNJ) 2012**[xi,xii]	• 10% lower per member per month (PMPM) costs • 26% fewer ED visits • 25% fewer hospital readmissions • 21% fewer inpatient admissions • 5% increase in use of generic prescriptions	Better diabetes care • 8% improvement in HbA1c levels • 31% increase in ability to effectively self-manage blood sugar Better prevention • 24% increase in LDL screening • 6% increase in breast and cervical cancer screening	2011	BCBS Industry Report, Press release
New York **Capital District Physicians' Health Plan (Albany, NY)**[xiii]	• 24% lower hospital admissions • 9% lower overall medical cost increases resulting in savings of $32 PMPM.		20082010	Industry Report - Press Release
New York **Independent Health**[xiv] **(Buffalo, NY)**	• Reduced ER visits from 198 to 124 per 1,000 patients. • Cost savings of $2.9 million due to a 0.02 decrease in the total cost index.	• Increased preventive care from 70% to 78% • increased usage of generic statins from 52% to 74%. • Improved satisfaction with 2% increase in satisfaction among patients and 19% among staff.	2009	Alliance of Community Health Plans
New York **Priority Community Healthcare Center Medicaid Program**[xv] **(Chemung County, NY)**	• Cost savings of 11% overall in first 9 months of approximately $150,000 • Reduced hospital		2010	

	spending by 27% and ER spending by 35%			
North Carolina **Blue Quality Physician's Program (BCBSNC) 2011**[xvi]	• 52% fewer visits to specialists • 70% fewer visits to the ER		2011	BCBS Industry Report, Press release
North Carolina **Community Care of North Carolina (Medicaid)**[xvii]	• 23% lower ED utilization and costs • 25% lower outpatient care costs • 11% lower pharmacy costs • Estimated cost savings of $60 million in 2003 • $161 million in 2006 • $103 million in 2007 • $204 million in 2008 • $295 million in 2009 • $382 million 2010.[xviii]	Improvements in asthma care • 21% increase in asthma staging • 112% increase in influenza inoculations	2003-2010	Peer reviewed journals: Health Affairs, Annals of Family Medicine; Agency report
North Dakota **BlueCross BlueShield of North Dakota – MediQHome Quality Program 2012**[xii]	• 6% lower hospital admissions • 24% fewer ED visits • 30% lower ED use among patients with chronic disease • 18% lower inpatient hospital admission rates compared to general North Dakota population	Better diabetes care: • 6.7% improvement in BP control • 10.3% improvement in cholesterol control • 64.3% improvement in optimal diabetes care. Better coronary artery disease management • 8.6% improvement in BP control • 9.4% improvement in cholesterol control • 53.8% improvement in optimal diabetes control. Better care for hypertension • 8% improvement in	2005-2006	BCBS Industry Report

		blood pressure control		
Ohio: **Humana Queen City Physicians (2012)**[xix]	• 34% decrease in ER visits	• 22% decrease in patients with uncontrolled blood pressure	2008-2010	Industry Report
Oklahoma **Oklahoma Medicaid (Year)**[xx]	• Reduced per capita member costs by $29 PPPY.	Improved access over one year period • Reduction from 1,670 to 13 patient inquiries related to same-day/next-day appointment availability • 8% increase in patients "always getting treatment quickly."	2008-2010	
Oregon **Bend Memorial Clinic & Clear One Medicare Advantage (PacificSource Medicare Advantage) 2012**[xxi]	Lower hospital admission rates • 231.5 per 1000 beneficiaries (compared to state/national averages of 257 and 351 per 1000, respectively). Lower ER visit rates • 242 per 1000 beneficiaries (compared to state/national averages of 490 and 530 per 1000, respectively).		2010	Press Release
Oregon **CareOregon Medicaid and Dual Eligibles (Portland, OR)**	• 9% lower PMPM costs[xxii] • Reduced PMPM costs by $100.[xxii]	Better disease management among diabetics in one clinic • 65% had controlled HbA1c levels vs. 45% pre-PCMH.[xxiii] • 10% increase HbA1c testing over a six-month period[xxiv]	2007-2009	Common-wealth Foundation, Journal article
Pennsylvania **Geisinger Health System ProvenHealth Navigator PCMH**	• 23% reduced hospital length of stay • 25% lower hospital admissions • 53% lower	Improved quality of care • 74% for preventive care • 22% for coronary artery care	2005-2010	Congressional testimony, PCPCC Outcomes Report, Peer

model (Danville, PA) 2010, 2012	readmissions following discharge[xxv] • Estimated net savings of $3.7 million equaling an ROI of 2:1.[xxvi] • 18% reduced inpatient admissions • 36% lower readmissions • 7% lower cumulative total spending (from 2005 to 2008.)[xxvii] Longer exposure to medical homes resulted in lower health care costs. • 7.1% lower cumulative cost savings (from 2006 to 2010) with an ROI of 1.7.[xxviii]	• 34.5% for diabetes care.[xxix]		Reviewed Journal: American Journal of Managed Care
Pennsylvania **UPMC[xxx] (Pittsburgh, PA) YEAR**	• 13% fewer hospitalizations by 2009. • Medical costs nearly 4% lower.	Improved patient outcomes for diabetics • Increases in eye exams from 50% to 90% • 20% long-term improvement in control of blood sugar • 37% long-term improvement of cholesterol control	2009	Press interview
Pennsylvania: **BCBS of South-eastern Pennsyl-vania (Independence Blue Cross - Pennsyl-vania Chronic Care Initiative) 2012[xii]**		Better diabetes care • Increased diabetic screenings from 40% to 92% • 49% improvement in HbA1c levels • 25% increase in blood pressure control • 27% increase in cholesterol control • 56% increase in patients with self-management goals	2008-2011	BCBS Industry Report
Pennsylvania	• 0% 30-day hospital readmission rate		2011	Industry Report Press

PinnacleHealth (2012)[xxxi]	for PCMH patients vs. 10-20% for non-PCMH patients			Release
Rhode Island **BCBS of Rhode Island (2012)[xii]**	• 17-33% lower health care costs among PCMH patients.	Improved quality of care measures • 44% for family & children's health • 35% for women's care • 24% for internal medicine	2008-2011	BCBS Industry Report
South Carolina **BCBS of South Carolina (Palmetto Primary Care Physicians) 2012[xii]**	• 14.7% lower inpatient hospital days • 25.9% fewer ED visits • 6.5% lower total per member per month (PMPM) medical and pharmacy costs		2008-2011	BCBS Industry Report
Tennessee **BCBS of Tennessee (2012)[xii]**		Increased screening rates • 3% for diabetes exams • 7% for diabetes retinal exams • 14% for diabetes nephropathy exams • 4% for lipid exams. Increased prescription rates • 6% for coronary artery disease medications.	2009-2012	BCBS Industry Report
Texas **BCBS of Texas (2012)[iii]**	• 23% lower readmission rates • $1.2 million estimated health care cost savings		2009	BCBS Industry Report
Texas **WellMed Inc.[xxxii] (San Antonio, Texas)**		Improved disease management • Increased control of HbA1C levels from 81% to 93% of diabetic patients • LDL levels under control from 51% to 95% from heart disease patients • Increased control of BP levels from 67% to 90%.	2000-2008	Peer Review Journal: Journal of Ambulatory Care Management

		Improved preventive care: • Increased screening rates for Mammography from 19 to 40% • Colon cancer from 11 to 50% • HbA1c from 55 to 71% • LDL screenings for all patients increased from 47 to 70% • LDL screenings for diabetic patients increased from 53 to 78% • LDL screenings for ischemic heart disease patients increased from 53 to 76%. • BP screening rates for all patients increased from 38 to 76% • BP screenings for high BP patients increased from 46 to 88%.		
Vermont **Vermont Blueprint for Health (2012)[xxxiii]**	• 27% reduction in projected cost avoidance across its commercial insurer population		2010-2012	Industry Report as part of public presentation
Vermont **Vermont Medicaid[iv]**	• 21% decreased inpatient use • 22% lower PMPM inpatient costs • 31% lower ED use • 36% lower PMPM ED costs		2008-2010	
Veterans Health Administration and VA Midwest Healthcare Network, (VISN 23) **2012**	• 8% lower urgent care visits • 4% lower acute admission rates by 4% [xxxiv] • 27% lower hospitalizations and ED visits among chronic disease patients • $593 per chronic		2011 2007-2009	Press Interview

	disease patient cost savings.[xxxv]			
Washington **Regence Blue Shield (Intensive Outpatient Care Program with Boeing) 2012[iii]**	• 20% lower health care costs	• 14.8% improved patient-reported physical function and mental function • 65% reduced patient reported missed workdays	2007-2009	BCBS Industry Report
Washington **Group Health of Washington (Seattle, WA) 2009, 2010**	• 29% fewer ED visits[xxxvi] • 11% fewer hospitalizations for ambulatory care-sensitive conditions[xxxvi] • Cost savings of $17 PMPM • $4 million in transcriptions cost savings through the use of EHRs • $2.5 million in cost savings through medical records management • $3.4 million in cost savings through medication use management program • 40% cost reduction through use of generic statin drug[xxxvii]	Improved medication management • 18% reduction in use of high-risk medications among elderly • 36% increase in use of cholesterol lowering drugs • 65% increase in use of generic statin drug.[xxxviii] Improved quality of care • Composite measures by 3.7% to 4.4%.[xxxvi] Improved provider satisfaction • Less emotional exhaustion reported by staff (10% PCMH vs. 30% controls).[xxxvi] Improved patient experiences in one clinic • 83% of patient calls resolved on the first call compared to 0% pre-PCMH.[xxxix]	2006-2007[xxxvi] 2008[xxxvii-57] •	Common-wealth Fund, Peer Reviewed Journal: Health Affairs

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AMERICAN ACADEMY OF
FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

March 12, 2012

Ms. Marilyn Tavenner
Acting Administrator and Chief Operating Officer
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Ms. Tavenner:

I am writing on behalf of the American Academy of Family Physicians (AAFP), which represents 100,300 family physicians and medical students nationwide. We are recommending that the Centers for Medicare and Medicaid Services (CMS) adopt a series of short term strategies for improving primary care payment as part of the proposed rule on the 2013 Medicare physician fee schedule that is currently under development by CMS.

The inadequate and dysfunctional payment system for primary care services remains one of the major barriers to the revitalization and transformation of primary care in the United States today. While many examples of payment reform are beginning to occur, most payment for primary care remains fee-for-service, with rates based on Medicare's physician fee schedule. Faced with increasing demands and inadequate financial resources, primary care practices are in an increasingly tenuous position, unable to redesign themselves into the model of the Patient Centered Medical Home using the teams and technology necessary to improve the quality and cost efficiency of care. As a result there are serious implications for access to care by patients throughout the country, and for the future physician workforce in the US. It is important to note that the strategies recommended below will not "save" primary care. However, if adopted by CMS, they will provide some desperately needed short-term help that family medicine and primary care needs until payment reform efforts are complete and long-term strategies can be identified and implemented.

In June 2011, the AAFP Board of Directors created a Task Force on Primary Care Valuation whose charge was to review and make recommendations to the AAFP Board of Directors for an alternative methodology(s) to value primary care services (evaluation and management services) provided by family physicians and other primary care physicians. The task force included representatives from other primary care organizations (i.e. American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association). It also included representatives from employer groups, private payers, and health policy organizations, such as the Urban Institute. Finally, we included observers from other organizations, including the Medicare Payment Advisory Commission and CMS. We have enclosed a complete list of the task force members for your information.

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Over the last seven months, the task force developed a series of recommendations that would improve payment for primary care services by primary care physicians in the near term and support principles for longer term payment reform developed by the Patient Centered Primary Care Collaborative. The AAFP Board of Directors approved those recommendations last week. Among them were the following recommendations, which we urge CMS to adopt as part of the proposed rule on the 2013 Medicare physician fee schedule:

RECOMMENDATION: That CMS create new codes for evaluation and management (E/M) services provided by primary care physicians with relative values that, at a minimum, would equal or exceed the median survey values from the 2005 survey of E/M codes (done by the primary care and other 'cognitive' specialties at that time). These new codes would be specifically for use only by primary care physicians who meet the definition as defined in the next recommendation.

Given that the bulk of primary care payment is derived from a fee-for-service payment model based on current E/M codes, the AAFP believes that it is important to ensure that the E/M codes used by primary care physicians accurately reflect the work required and be appropriately valued. The current E/M paradigm is based on "problem" identification and management. Primary care today is much more proactive, complex and strategic, including treatment of illness even before symptomatic presentation, extensive screening and prevention, and counseling -- comprehensive, coordinated, and continuous care. Codes for these E/M services provided in primary care today must accurately capture and value the physician work. Additionally, the practice expenses for these codes also need to be revalued to account for the significant infrastructure staffing and material expenses associated with care coordination and the continuity work of primary care. If CMS believes that new vignettes are necessary in further determining the physician work and practice expense values for such new codes, the AAFP would be very interested in working with CMS in this regard.

Additionally, new codes would avoid the difficulty of paying different specialties different amounts for the same codes, which is currently prohibited under the Medicare physician fee schedule. While the creation of new E/M codes for primary care services would ideally occur through the Current Procedural Terminology (CPT) process, the CPT schedule does not permit that in time for the 2013 Medicare physician fee schedule. Instead, we recognize that CMS has the ability to create new Healthcare Common Procedure Coding System codes at its discretion and can do so in time for the 2013 Medicare physician fee schedule.

Regarding the suggestion that CMS use the relative values recommended by the survey data in 2005, the AAFP believes that intensity of primary care work would be more appropriately acknowledged in the 2005 values. The AAFP accepts the notion that complexity and intensity of evaluation and management services provided by primary care physicians differ from similar services done by other specialties and believes the median survey values identified in 2005 best reflect, at a minimum, work values commensurate with new codes which can be created by CMS.

In sum, the AAFP believes that this recommendation has the advantage of appropriately highlighting the complexity of the work of primary care in a manner that may be readily utilized by both CMS and private payers. It should be noted that the recommendation is to use the new codes only for primary care physicians as defined below and that these new codes would replace the current E/M codes and values for such services provided by primary care physicians. Other ways of coding may be important to pursue in the long term, and we encourage CMS to consider this for further development.

In the meantime, these new codes are comprehensive for the acute, preventive, and chronic care provided in family medicine and primary care often in the same visit. Importantly, this is not just about patients with multiple co-morbidities. Further, CMS should make any necessary budget neutrality adjustments through an adjustment to the RVUs of all of the other codes in the Medicare physician fee schedule, rather than an adjustment to the conversion factor. An adjustment to the conversion factor will only serve to dilute the impact of these codes for primary care, whereas an adjustment to the RVUs of all other services will reinforce its impact.

RECOMMENDATION: The AAFP recommends that eligibility for enhanced payment options for primary care physicians be based on the following fundamental precepts. That the eligibility requirements reward demonstration of carrying out three definitional functions of primary care, namely 1) first contact, 2) continuity, and 3) comprehensiveness using claims to characterize every physician and replace the current claims-based process created by the Affordable Care Act (ACA) and revised by CMS.

1) **Additionally, a claims-based measure of coordination of care should be studied and considered for implementation (there currently is not one ready for use).**
2) **As Pediatric data is not available using Medicare data, further study on state Medicaid or other claims based data is needed.**

The definition of primary care in this country varies in different contexts but it consistently encompasses certain core values, including first contact of care, continuity of care, comprehensiveness, and coordination of care. The AAFP believes that to appropriately identify primary care physicians, CMS must use a working definition that reflects the core definitional elements. The following table provides a summary of the measurement of each element. We could not find a claims-based way to measure community/family functions of primary care.

Table 1: Core Definitional Elements of Primary Care

Primary Care Definitional Elements	How to measure and use for payment
first contact care	Family medicine, general internal medicine, general pediatrics and geriatrics (claims-based or NPI)
continuity of care	Patients who see this physician/clinic get the plurality of their care there (claims-based)
comprehensive care	Breadth and depth of ICD-9 codes used by physicians in Medicare claims
coordinated care	Patients who see more than 3 physicians are seen by a PCP or PC practice at least every 6 months
Bridges personal, family, and community	Undetermined

Physician specialty by itself does not necessarily define a primary care physician, as many internal medicine and family physicians work as hospitalists or in emergency rooms or have limited scope of care. The ACA defines primary care physicians by specialty combined with use of certain CPT codes that reflect common primary care services.

The measures above incorporate first contact, comprehensiveness, and continuity using Medicare claims data to identify primary care physicians as an alternative to the definition provided in the ACA. Since pediatric data is not available, the current model would serve as a proxy until other data is available. We have analyzed coordination of care, but this measure was so low using claims that it may not be sufficient to measure this function of primary care at this time. Utilizing key definitional elements of primary care will result in rewarding the appropriate physicians with additional payments for providing primary care.

Applying the filters as described in Appendix A of the enclosed task force report and using Medicare claims data allows identification of physicians who are providing care consistent with core elemental components of primary care with the exclusion of pediatrics. This approach is the first to attempt to define and identify primary care physicians in this way. Moving forward, we believe that it is essential to be able to appropriately identify those physicians providing primary care consistent with its most basic tenets. This approach is as complex as the nuances of the definition of primary care and as simple as recognizing core values we should expect from primary care. It is offered as an alternative to the definition set out in the ACA, and we have demonstrated that it captures a more functional definition of primary care.

We recognize that this definition may appear more complicated than the one that CMS currently uses in conjunction with the Primary Care Incentive Program (PCIP), and we would be happy to work with CMS to help you better understand how this new definition might be implemented. If this new definition is too complicated for CMS to implement immediately, we are open to the agency using the PCIP definition in the interim.

RECOMMENDATION: That CMS pay for the following services under the Medicare physician fee schedule using established relative value units (RVUs) when provided by primary care physicians as an interim strategy until this work is recognized under a care management fee:

- Telephone evaluation and management services (CPT codes 99441-99443)
- Collection and interpretation of physiologic data (CPT code 99091)
- Domiciliary, rest home, or home care plan oversight services (CPT codes 99339-99340)
- Anticoagulant management (CPT codes 99363-99364)
- Medical team conferences (CPT codes 99366-99367)
- Care plan oversight services (CPT codes 99374-99380)

All of the services covered by this recommendation have established RVUs. However, CMS does not pay for them separately under the Medicare physician fee schedule. CMS considers most of them "bundled" with other services paid under the fee schedule. While some of these services and corresponding codes ultimately would be part of a care management fee (as planned for example in the Comprehensive Primary Care Initiative), the AAFP believes that paying for them now on a fee-for-service basis is a sound and interim short-term strategy. All are integral to primary care, and we note that the Relative Value Scale Update Committee (RUC) has made a similar recommendation to CMS.

To be sure, primary care is moving toward a blended system of payment, and these codes ultimately may be covered in a care management fee rather than on a fee-for-service basis. In the meantime, the services described above are not part of face-to-face care and validly fall outside the current bundled payments for E/M services.

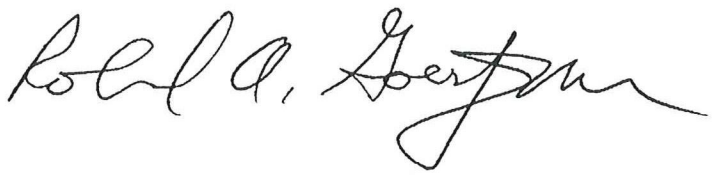
RECOMMENDATION: That CMS value and pay for the online evaluation and management service (i.e., CPT code 99444) provided by primary care physicians.

CPT code 99444 (Online evaluation and management service provided by a physician to an established patient . . .) does not have established RVUs and is not covered under the Medicare physician fee schedule. The RUC attempted to value this code in 2007 and was not successful. The RUC discussed code 99444 and concluded that the definition of work and physician time and complexity involved in this service were unclear, therefore making it difficult to recommend a specific work relative value.

The AAFP believes that the service represented by this code is as integral to primary care as the other non-face-to-face services described in the recommendation above. Since CMS has the ability to value services independent of the RUC, the AAFP recommends that CMS proceed to work directly with AAFP and other organizations that represent primary care physicians to establish a value for this service and implement payment for it under the Medicare physician fee schedule in 2013.

We appreciate your consideration of these recommendations and welcome the opportunity to discuss them with you and your staff. To pursue such conversations, please contact Mr. Robert Bennett, Federal Regulatory Manager at the AAFP at rbennett@aafp.org or at 1-800-274-2237, extension 2522.

Sincerely,



Roland A. Goertz, MD, MBA, FAAFP
Board Chair

Enclosures

RAG:kjm