



AMERICAN OSTEOPATHIC ASSOCIATION

1090 Vermont Ave, Suite 500, Washington, DC 20006-4949 ph (202) 414-0140 | (800) 962-9008 | www.osteopathic.org

May 29, 2013

The Honorable Max Baucus
Chairman
Finance Committee
United States Senate
Washington, DC 20510

The Honorable Orrin Hatch
Ranking Member
Finance Committee
United States Senate
Washington, DC 20510

Dear Chairman Baucus and Ranking Member Hatch:

On behalf of the American Osteopathic Association (AOA) and the more than 100,000 osteopathic physicians and osteopathic medical students we represent, thank you for the opportunity to submit comments on your Committee's work to reform the physician payment system and to permanently repeal the Sustainable Growth Rate (SGR) formula for physicians participating in the Medicare program. In representing physicians practicing in every specialty, the AOA is respectful of the important role each physician plays in the health care delivery system, including over 60 percent of those osteopathic physicians in primary care specialties. Additionally, the osteopathic profession's commitment to primary care and serving those patients in rural and underserved areas must be a high priority as we move to a new system that accommodates various practice settings.

We applaud your recent call for repeal of the SGR and look forward to working with you and your fellow Senators to replace this fatally flawed formula. We believe that steps should be taken to replace the SGR with a reformed system that appropriately values physician services, rewards physicians who strive to provide higher quality care, and promotes the development and expansion of innovative payment models as the path forward. The AOA supports the creation and implementation of a payment system that focuses on Medicare patients and enhances their overall care and experience in the Medicare program. While we firmly believe that all physicians and other health care providers strive each day to provide the highest quality care to Medicare beneficiaries, the current payment model has created an environment that often impedes these efforts. The SGR also contributes to increasing access issues for millions of beneficiaries. As repeated efforts to "patch" the SGR underscore, the system as it currently exists is unsustainable.

Further, we recognize the importance of seizing the day to address this problem and stop perpetuating the pattern of annual patches to a broken system. The most recent \$139.1 billion Congressional Budget Office (CBO) estimate of SGR repeal is an encouraging factor; however, this is not an opportunity that is likely to remain in future years. We hope to collectively take advantage of the lowered cost of repeal along with the renewed bipartisan interest in finding a durable and long-term solution.

The AOA appreciates the Committee's continued work in this regard and willingness to engage the provider community. We applaud your approach to seeking and analyzing proposals from leading physician organizations like the AOA that will move us away from the challenges of the past decade and toward a Medicare payment system that promotes the highest levels of access, quality, and efficiency. As we continue to develop a Medicare physician payment model consistent with the delivery of coordinated, quality, and efficient health care, we must not lose sight of the best elements of those solutions that are currently being discussed, as well as the importance of a timely well thought final product.

We urge you to continue in the spirit of cooperation that your Committee has demonstrated over the years as we transition to a much overdue new physician payment system benefitting physicians and patients alike. The collective voices of physicians and policy makers of all political views and from both sides of the Capitol remain vital.

Physician Fee Schedule

*MedPAC and others have suggested changes they believe would improve the accuracy of fee schedule payment amounts and the validity of resource inputs used to establish payments for services under the fee schedule. What **specific** reforms should be made to the physician fee schedule to ensure that physician services are valued appropriately?*

Provide Annual Updates

The AOA believes that predictability and stability of Medicare payments for physician services should be a guiding principle as we work to reform the physician payment system. We, therefore, recommend stabilizing payments through the physician fee schedule, during which time all providers are protected from reductions in their annual payment rates and, in turn, receive positive updates in line with increased practice costs as defined by the Medicare Economic Index (MEI). Positive updates should continue to be provided for physician services during which time the physician fee schedule is improved and transition to new payment models occurs - likely 3 to 5 years.

We further believe positive updates for all physicians should also include a differential providing a higher update for all primary care, prevention, and care coordination services (as defined by E&M coding). For example, this could mean updates of MEI +0.5% for all physician services, and an additional 1.5% update for all primary care, prevention, and care coordination services. This recommendation is consistent with our goal of providing higher quality care to patients through care coordination and preventive services.

In contrast to the MedPAC proposal, we strongly advocate that budget neutrality within Medicare Part B not be applied for the purposes of providing these higher payments. This approach would serve as a disincentive to innovation and coordination of care within the entire delivery system. The AOA firmly believes silos should instead be broken down across the entire Medicare program to reflect the value of services and savings, with budget neutrality applied in that manner.

Examine Potentially Misvalued Codes

The AOA believes that numerous services are undervalued in the current fee-for-service structure, and further encourage continued consideration of the necessary valuation of non face-to-face encounters. As we stated in our July 22, 2011 CMS comment letter on the Five-Year Review of Work Relative Value Units Under the Physician Fee Schedule, the AOA recognizes the need to examine potentially misvalued codes, particularly those within the categories specified by the Affordable Care Act (ACA). Based on the AOA's experiences, we continue to support the American Medical Association (AMA) Relative Value Update Committee (RUC) as the most efficient body available to provide recommendations on the valuation of physician services.

The RUC has unique and transparent processes in place to address misvalued services defined within the seven categories outlined in ACA as well as the categories that CMS has requested to be reviewed. Additionally, due to the diverse range of specialty representation and Medicare's finite fiscal environment, there is an innate check and balance system preventing gratuitous over-valuation of specific services. The RUC works closely with CMS throughout the process ensuring that Medicare data and the views of CMS are incorporated. This work by the RUC and CMS should be prioritized and substantially accelerated.

Validate RVUs of Potentially Misvalued Codes

The Secretary has the authority to determine what is appropriate to facilitate the validation of RVUs of services. To avoid wasting time and expenses, it would be beneficial for the Secretary to quickly identify what type of surveys, data collection activities, and studies are deemed inappropriate. The physician is the best data source in providing input on the amount of work, time, and intensity involved in performing physician services. Any additional data sources or surveys should incorporate similar processes established and streamlined by the RUC.

We support consolidating the five-year review of work and practice expense (PE) with the annual review of potentially misvalued codes. The process by which the public could submit codes along with supporting documents on an annual basis versus every five years appears to be consistent with the processes currently employed by the RUC and CPT. Consolidating the five-year review with the annual review of potentially misvalued codes will allow for a greater opportunity for physician services to be appropriately valued. We believe preventive services and other non-covered services should be included in the review process.

We believe the evaluation and management (E&M) codes are undervalued and there is no merit in sending the codes back to the RUC process to re-evaluate. The E&M codes need to be restructured to better describe the services performed by primary care physicians, the dominant providers of E&M services. Specifically, E&M codes need to include accounting for those services provided outside of the traditional face-to-face patient encounter. As delivery system reforms such as the Patient-Centered Medical Home (PCMH) become more prevalent in primary care practices, CMS must take the appropriate steps to provide enhanced payment for these advanced services.

Stabilize Incentive Payment Programs

The AOA believes all existing incentive payment programs including the Electronic Health Records Program incentive payments and Physician Quality Reporting System (PQRS) should continue through the period of stability – since they are so closely aligned with the current Medicare payment formula. An immediate transition away from them would undermine the investments that have already been made in these important programs, such as purchase of an EHR system at approximately \$40,000 per practice. Once new comprehensive systems are in place, physicians should no longer be held to penalties under the old model and should be fully transitioned into new improved system(s). The lack of stability and predictability in the current system has been a hindrance to physicians' full investment in these programs and ability to innovate their practices, and should not be further exacerbated.

Thereafter, the AOA supports efforts to minimize the participation burden on physicians by streamlining administrative requirements, facilitating reporting through registries, EHRs, and aligning Medicare payment quality measures with PQRS and private payer initiatives. This will further encourage physicians to view CMS as a partner in the transition to new payment models as efforts are made to ease the transition. Again, it will be necessary for the period of stability to offer truly stable and predictable payment levels in order for physicians to appropriately plan their efforts to participate and fully invest in new models.

In addition, current temporary payment incentives under Medicare for all primary care services must be made permanent - the Primary Care Bonus Incentive Payment Program (PCIP) and the Comprehensive Primary Care Initiative (CPCI). These payment incentives are vital to encouraging a greater focus on prevention and care coordination since current law does not reflect the connections within the respective parts of the Medicare system. The AOA believes this is important as millions of new beneficiaries become eligible to receive coverage of health care services.

Geographic Practice Costs Indices (GPCI)

The AOA opposes the Institute of Medicine (IOM) recommendation of a three-tiered system for defining fee schedule areas, rather than using the current uniform fee schedule areas in adjusting for relative cost differences as compared to the national average. The IOM's recommendations would inequitably redistribute

funds from rural to urban areas. Given the fact that physician services are undervalued and not consistent with practice costs, IOM's recommendation would create more hardship and penalize underserved areas. Additional payment reductions certainly will create nearly insurmountable obstacles to providing services in underserved rural areas, even with bonuses currently in place.

Utilization and Cost

*Physician services are critical to the ongoing health of Medicare beneficiaries. Appropriate utilization of physician services can lessen disease burden and reduce avoidable emergency department visits and hospitalizations. However, inappropriate or excessive utilization of physician-related services can negatively impact beneficiary health and drive up Medicare spending. Volume control mechanisms are not an inherent component of a FFS system. The SGR was intended to address excessive volume, but its mechanism is fatally flawed. What **specific** policies should be implemented that could coexist with the current FFS physician payment system and would identify and reduce unnecessary utilization to improve health and reduce Medicare spending growth?*

Primary Care and Prevention

The AOA believes that the establishment of a strong physician-patient relationship is vital under any delivery system or payment model. We believe that the coordination of care that occurs as a part of the PCMH allows for improved patient education, thus contributing to increased engagement by patients in their health care decisions. While we appreciate and support a beneficiary's ability to seek and receive care based upon their individual needs, we believe that the current lack of shared responsibility between beneficiaries and the Medicare program advances fragmentation in delivery and drives utilization. To address this issue, we propose that all Medicare beneficiaries be required to select a primary care physician. Eligible primary care physicians would be DOs or MDs with a primary practice designation of family medicine, internal medicine, pediatrics, or geriatrics, as currently defined by Medicare.

To support this new policy, we propose that the current cost-sharing arrangements be adjusted to promote care coordination. Consistent with our recommendation that Medicare Parts A & B be blended, we would welcome proposals that would create a combined co-pay and premium. For example, the Bipartisan Policy Center (BPC) has recommended combining the Part A and B deductibles. Such proposals could include aspects of value-based insurance designed to incentivize beneficiary movement toward higher quality and value services and care settings while maintaining availability of all benefits. The BPC also has a proposal that would incentivize beneficiary participation in Medicare Networks through an annual discount on their Medicare premiums.

The AOA is also receptive to provisions that would allow certain beneficiaries to claim two primary care physicians based upon the fact that beneficiaries often reside in two geographic localities over the course of a year. Whether one or two physicians are designated as primary, the bond that is created between a patient and his/her physician through care coordination is of great benefit. Care coordination leads to better management of chronic conditions, prescription drug utilization, and ancillary services. However, we do not believe that physicians should be held responsible for patient behavior that is out of their control, such as medication, routine testing, and care plan adherence.

Appropriate Utilization

The AOA believes that any physician resource utilization reporting should focus primarily on quality and outcomes measurements, not on cost reduction and savings. Efforts to encourage efficient use of resources should complement and enhance the delivery of appropriate, evidence-based, patient-centered health care. Furthermore, the program(s) should not adversely impact the physician-patient relationship or unduly intrude upon the physician's medical judgment. Additionally, increased volume of certain physician services should be viewed in the context of impact on the entire program. Appropriate and responsible physician services focused upon prevention and care coordination, for instance, can drive down costs in other segments of Medicare (i.e. - hospitals, prescription drugs), and should therefore be rewarded accordingly.

We believe that appropriate data adjustments should be made to account for differences in the demographic characteristics and health status of individuals so as not to penalize those physicians who serving less healthy individuals who may require more intensive interventions. The attribution data to physicians for services delivered must be accurate. These risk adjustment and attribution models need to be properly tested and assessed on a condition-specific basis.

Evidence-Based Guidelines

The AOA supports the use of evidence-based guidelines as part of physician decision making, while still allowing the physician to determine the best care plan for her patient. Educating physicians about the appropriate utilization of services and the impact on the Medicare program as a whole is an important first step. The recommendations of the Patient-Centered Outcomes Research Institute (PCORI), United States Preventive Services Task Force (USPSTF), and the Choosing Wisely Initiative are appropriate guidelines in this regard. As physicians adopt these guidelines into their daily decision making, opportunity arises to provide safe-harbors for those physicians employing defined standards of care for their patients. We must reiterate that these guidelines and potential standards of care should not be limiting to a physician's ability to define what is best for a given patient, thus protecting the importance of a strong physician-patient relationship.

Timely Data

The AOA believes access to timely and meaningful data is the foundation of any successful measurement of utilization and value. Physicians find it very difficult to make significant decisions based on old data. One of the most challenging and frustrating aspects of the current set of federal quality programs has been the lack of timely, understandable feedback. We therefore recommend physicians be provided with access to timely and meaningful data from CMS on at minimum a quarterly basis. As we transition to greater reliance on EHR and registry data, Congress may have to invest additional resources and re-evaluate the impact of current regulations related to data privacy and security to ensure they do not impede the collection and distribution of valuable data.

As Congress considers alternative ways to ensure physician accountability for utilization, it is critical that it continue to recognize the value of taking a "crawl-walk-run" approach. Utilization assessment needs to start on a simple basis. Initially, physicians should be recognized for the act of regularly collecting meaningful practice data and analyzing it in a confidential manner (similar to key case collection requirements of some certifying boards). Data collection, alone, has proven to be a valuable exercise that naturally results in improvements in care. This could then evolve into a process whereby physicians are recognized for using the data to attempt to make improvements in practice based on evidence-based metrics (similar to Performance in Practice programs currently used under some Maintenance of Certification programs). Only after physicians are familiar and comfortable with these new processes and only after regulators, specialty societies, and other technical experts have had adequate time to test appropriate attribution methods and account for varying risk should physicians be held accountable for actual utilization.

Value-Based Modifier (VBM)

Overall, the AOA believes the value-based modifier (VBM) can only be useful, if simple to understand for both patients and physicians, easy to incorporate into a busy practice, and straightforward for CMS to administer. Complicated formulas could become an administrative nightmare for physician practices and CMS alike, and will likely be frustrating and unworkable. The AOA supports an evolved VBM that is based upon timely data, episode-based cost measures, alternative attribution methods that accurately assess how a physician affects costs, and physicians receiving credit under Part B for savings they achieve in Part A. Under the VBM's current construct, rewarding or crediting physicians and physician practices for efforts to reduce admissions, readmissions, and hospital lengths of stay are not possible. This concept is consistent with the accountable care organization (ACO) model.

The statute requires the quality of care measures to be risk adjusted as determined appropriate by the Secretary. According to CMS in the CY 2012 Medicare Physician Fee Schedule Rule, “In establishing the quality of care measures for the value modifier, our interest is to move toward a core set of measures so that we can assess and benchmark physician performance.” The AOA is concerned that CMS did not specify details for risk adjustment and attribution models.

Systems, not Silos

The AOA continues to believe that we should view the Medicare program in the context of a comprehensive health care delivery system rather than as individual services provided to a beneficiary. The provision of comprehensive, coordinated, and longitudinal care must be the aim. We offer that the system should first focus on quality before transitioning to a focus on cost and efficiency. Only those who have already proven to be high quality performers should then be held accountable for cost. We believe limiting accountability for efficiency to rewards, and not penalties, is prudent at this time. Penalizing physicians for providing care that is viewed as less than optimally efficient could inadvertently lead to under-treatment. More importantly, in measuring efficiency, we believe that the barriers between Medicare silos should be terminated. The flow of health care dollars should not be limited within individual segments of the program.

The AOA believes there is also value in working to better align payment policies across sites of care while also recognizing that some payment differentiation across care settings is perfectly appropriate and justified based upon the particular service and circumstance. The BPC makes numerous recommendations in this regard that include equalizing payments for evaluation and management services and for some procedures conducted in a physician office versus hospital outpatient department, that should be explored. They estimate substantial opportunity to lower costs for both the Medicare program and beneficiaries.

Alternative Payment Models

*Shifting from a FFS system to an alternative payment model will be a major change for many physicians. Within the context of the current FFS system, how **specifically** can Medicare most effectively incentivize physician practices to undertake the structural, behavioral, and other changes needed to participate in alternative payment models?*

Reward Early Adopters

The AOA believes that health care is provided most effectively in a variety of settings by dedicated physicians. In our opinion, the current philosophy of using a single payment model for all services is not appropriate. Alternative delivery models and correlating payment systems should foster innovation and secure higher quality outcomes for beneficiaries, while being fiscally responsible to the Medicare program as a whole. We propose the use of a variety of payment models that are acutely focused on the various types of care and the settings in which care is delivered. Providing options that enable providers to determine and select the payment model that best fits their respective patient mix and practice setting is key to improving the health care system.

Alternative payment models that are currently based on a fee-for-service foundation already exist, such as the PCMH and ACOs. Physicians who choose to move into these models early in preparation for a full transition should be rewarded for doing so through higher payment updates for the services they are providing. In addition, physicians serving as a medical home should receive a per patient per month care coordination bonus, consistent with the Joint Principles of the Patient-Centered Medical Home developed by the founding organizations of the the Patient-Centered Primary Care Collaborative (PCPCC), including the AOA. The AOA continues to support the National Committee on Quality Assurance (NCQA) PCMH recognition process allowing physician practices to reach advanced levels of recognition. The current Center for Medicare and Medicaid Innovation (CMMI) initiative should be scaled up to allow for national participation by all interested physicians. This will encourage physicians to adopt and embrace new payment models early in the process while still in fee-for-service so they are better prepared for the ultimate transition.

The AOA supports physician-led ACOs that are built upon a patient-centered medical home. ACOs are an innovative approach to providing patient care outside of the traditional fee-for-service structure; however, those fee-for-service patients seeing a physician participating in an ACO will still maintain their "Medicare rights" to choose any physician accepting Medicare. Akin to those PCMH physicians, ACO physicians should also be encouraged and rewarded for their early adoption of care innovations. While issues remain with the ACO model of care, the CMS program should be accelerated and expanded in concert with improving the program. Improvements to beneficiary assignment, physician participation in multiple ACOs, and addressing anti-trust concerns remain key. Additionally, new models of ACOs should be explored.

The Bipartisan Policy Center (BPC) has proposed Medicare Networks in this regard, which are similar to ACOs. Through the networks, BPC suggests an approach of higher payments for those early adopting physicians accepting 2-sided risk, based upon MEI. Those physicians choosing a 1-sided risk model would receive smaller updates equal to one-half of MEI. Beyond the initial period set forth for early adopters, any physician participating in these networks would receive updates equal to MEI, and all other providers would be shielded from payment reductions. We believe this is another viable mechanism for ensuring positive updates to physicians while also encouraging early adoption of new payment models.

Benchmarking

The AOA supports appropriately risk-adjusted and equitable benchmarking of physicians relative to their peers. The data should not be used to penalize physicians; rather, it should be used to encourage improved efficiency and adoption of evidence-based practice guidelines and/or health information technology into a physician's practice. This comparison encourages physicians to look toward innovative ways to improve their practice and the efficiency of services provided to their patients. The introspective look at how a fee-for-service physician is performing relative to a physician in an innovative payment model, can serve as incentive to undertake the structural and behavioral changes that are necessary to effectively move into a new payment model such as the PCMH or ACO.

Summary

In closing, the AOA believes that the Medicare physician payment system of today as tied to the arbitrary SGR target must be repealed. We believe that the Committee's approach to addressing inequities and problems that currently exist in the fee-for-service structure is appropriate. While we agree that cost-containment is important, we suggest the focus remain on appropriate utilization by providing physicians the necessary tools and incentives to manage and coordinate patient care. Further, the one-size fits all payment system of today is stagnant and has not appropriately evolved with the health care needs of the nation. Alternative payment models of today and those yet to be developed should be fluid in this regard, and must provide physicians with options for participation in order to avert repeating the mistake of the SGR.

The flow of health care dollars should not be limited to individual segments of the program. In fact, we believe that the removal of barriers between Parts A and B is one of the most important steps Congress can and should take when establishing new delivery and payment models. The Secretary should establish financial assistance programs and resources should be allocated to aid physicians as they transform their practices to meet federal standards. The role of appropriate and timely data must also be recognized and accounted for as we work to provide value-based health care. In addition, improving the practice environment through reducing practice costs and administrative burden improves patient care and increases the time physicians can spend with their patients as we continue to strengthen the physician-patient relationship.

The AOA supports immediate efforts to set a clear path toward comprehensive payment reform by establishing an equitable payment methodology for physicians participating in the Medicare program. The provisions of any legislation to this end will move us away from the challenges of the past decade and toward a Medicare payment system that promotes the highest levels of access, quality, and efficiency. Embracing the

creation, trial, evaluation, and implementation of innovative new payment and delivery models that focus on enhanced overall patient care and experience in the Medicare program is vital. The permanent repeal of the SGR and stabilization of the current payment system through positive updates for all physicians sets a prudent course toward comprehensive payment reform. The new delivery models, many of which we have mentioned above, foster innovation and secure higher quality outcomes for beneficiaries while being fiscally responsible to the Medicare program as a whole.

The AOA and our members appreciate the opportunity to share these thoughts, views, and recommendations with the Committee, and encourage you to continue seeking physician community input as you progress. Again, we applaud your work toward addressing this critical issue and stand ready to work with you, collectively, to identify and implement new delivery and payment models that promote quality and efficient care for all patients.

Sincerely,

A handwritten signature in black ink, appearing to read 'Ray E. Stowers, DO'. The signature is fluid and cursive, with a large initial 'R' and 'S'.

Ray E. Stowers, DO
President

C: Members, Senate Finance Committee