NATIONAL PHYSICIANS ALLIANCE

Max Baucus
Chairman, U.S. Senate Committee on Finance

Orrin Hatch
Ranking Member, U.S. Senate Committee on Finance

May 30, 2013

Dear Senators Baucus and Hatch,

We at the National Physicians Alliance appreciate the opportunity to provide input to the Senate Finance Committee in response to your letter of May 10, 2013 relating to repeal of the sustainable growth rate (SGR). The SGR was an attempt to control the rate of growth in spending in the Medicare program, specifically for physician services. It has failed to accomplish that goal, and we strongly support its repeal. The imperative to constrain costs in the Medicare program and health care in general remains – spiraling health care costs constrain the ability to address important social determinants of health such as employment, education, poverty, race, and equity.

Your letter asks for specific recommendations for reform of physician payment within the context of the fee for service (FFS) framework. We recognize the need for a transitional period from the FFS model to a more sustainable system focused on outcomes and value. There is broad agreement that FFS encourages overuse of unnecessary and sometimes harmful care. Modifications to this system cannot be seen as an alternative to real reform, to the needed transformation of the health care system in the U.S. We urge acceleration of migration to a new system of incentives aligned with the triple aim – better health, better health care, lower cost.

We appreciate the work of the National Commission on Physician Payment Reform, and are very much aligned with its analysis and recommendations. We also appreciate the efforts of Representative Schwartz and her bill focused on this issue, and endorse that bill's approach to a phased migration from FFS.

There are two overarching issues with the current FFS system. First, as noted above, it encourages overuse of care. Second, it has consistently undervalued primary care relative to procedures and interventions. Medical students too often choose highly compensated specialties, aggravating the misdistribution of resources. Primary care specialties are perceived – by society and too often within the profession - as of lesser value than specialties focused on procedures. Salary disparities are a proxy for how society values the two careers. In fact, there is good evidence that a strong primary care base improves outcomes and reduces overall cost – that is, it can improve the *value* provided by our health care system. Our compensation system drives distribution in the wrong direction. Recent reforms directed at this inequity are promising, but inadequate, and without assurance of a long-term solution, real transformation seems unlikely. In addition, it should be acknowledged that there is a significant

disconnect between resource requirements and value. The current system reimburses based on an (often flawed) estimate of resources required to provide a service, without regard to benefit. Ultimately, our system must provide a way to assess and reward value.

In response to the questions in your letter, we offer the following:

1. What specific reforms should be made to the physician fee schedule to ensure that physician services are valued appropriately?
    - First, the fundamental difference between cognitive services and procedural services must be acknowledged and addressed. For cognitive services, predominantly primary care, there needs to be recognition of non-visit care: telephone and email care, population management, care coordination, team leadership, etc. We need to recognize and pay for effective teams providing these services. For instance, work by important team members including physicians, PAs, NPs, dieticians, pharmacists, nurse care managers, behavioral health specialists, and health coaches should be recognized and compensated. Early efforts in this area offer promise, and should be accelerated. Ultimately, capitation for primary care services, with appropriate safeguards against underuse (such as clear outcome and process measures and improved risk adjustment), is our recommendation and we would be happy to provide further detail on that model.
    - For procedural services, there should be closer examination of actual resource requirements, adjusted on a timely basis, particularly for new procedures (often resource intensive when first introduced, with a rapid improvement in efficiency not matched by a reduction in payment).
    - The RUC should be replaced, or at least supplemented by alternative sources of input to CMS as they make decisions on relative values. For instance, a separate 'RUC' focused on valuing team based primary care could be supported. In spite of recent reforms, the RUC remains dominated by procedural specialties, and its sponsoring body, the AMA, represents a shrinking minority of US physicians.

2. What specific policies should be implemented that could co-exist with the current FFS physician payment system and would identify and reduce unnecessary utilization to improve health and reduce Medicare spending growth?
    - Movement to new models of care, such as accountable care organizations, that focus on population health and rational distribution and use of resources, including some risk sharing, would slow over-utilization. Internally, such systems could use FFS or some other method for provider compensation.
    - Outcome measurement is a critical piece of a move toward value and incentives should be built into the FFS system to accelerate development and adoption of valid outcome measures. Payment should, in part, be based upon consensus-based and well validated quality outcome measures that are transparent and do not put undue burdens on providers for reporting.
    - Shared decision making, with detailed unbiased information for patients about alternative treatment options, has been shown to result in improved outcomes (including satisfaction)

and in many cases reduced cost. Its use should be strongly encouraged and incentivized in areas where there are multiple reasonable diagnostic or therapeutic options.

- Thoughtful use of evidence-based protocols and guidelines should provide a 'safe harbor' in litigation, and can help prevent overuse.

3. 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 methods?
    - As mentioned above, carefully designed incentives for development and implementation of outcome measures, registries, shared decision making, and team development can move practices. In addition, measures of patient complexity will be essential to an increased focus on population management. Incentives for their development and deployment will be important. Development of effective primary care medical homes can be accelerated in this way, but ultimately new payment paradigms (e.g. primary care capitation) will be needed. In the interim, payment for things like care coordinators, population health managers, RN nurse specialists, can facilitate a team approach.
    - Encouragement of development of networks of care for effective co-management should be incentivized. Compacts between primary care and specialties, effective information sharing, and shared care coordination will help build new models of care.

Thank you for the opportunity to comment on these important issues. Repeal of the SGR offers an opportunity to take an incremental step to the transformation needed in US health care.

Sincerely,

Cheryl Bettigole, MD, MPH
President
National Physicians Alliance