AMERICAN OSTEOPATHIC ASSOCIATION

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April 28, 2011

The Honorable Fred Upton
Chairman
Energy & Commerce Committee
U.S. House of Representatives
Washington, DC 20515

The Honorable Henry Waxman
Ranking Member
Energy & Commerce Committee
U.S. House of Representatives
Washington, DC 20515

The Honorable Joseph Pitts
Chairman, Subcommittee on Health
Energy & Commerce Committee
U.S. House of Representatives
Washington, DC 20515

The Honorable Frank Pallone, Jr.
Ranking Member, Subcommittee on Health
Energy & Commerce Committee
U.S. House of Representatives
Washington, DC 20515

Dear Chairmen Upton and Pitts and Ranking Members Waxman and Pallone:

On behalf of the American Osteopathic Association (AOA) and the more than 70,000 osteopathic physicians we represent, thank you for the opportunity to submit comments on policies that would establish an equitable payment methodology for physicians participating in the Medicare program. The AOA appreciates the Committee's recognition that current Medicare physician payment models are inconsistent with the delivery of coordinated, quality, and efficient health care. In fact, the current payment models advance fragmentation in delivery and is prohibitive to the establishment of coordinated delivery models.

We applaud your bipartisan and thoughtful approach to seeking and analyzing proposals 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. Most importantly, the AOA supports the creation and implementation of a payment system that focuses on Medicare patients and promotes delivery models that enhance 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 is unsustainable and inequitable. Additionally, it contributes to increasing access issues for millions of beneficiaries.

The AOA recognizes that health care is provided 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. We approached your request from the point-of-view that we first should determine what are the most appropriate delivery models that can be used in the Medicare program and then develop payment models that promote selected delivery models. These delivery models should foster innovation and secure higher quality outcomes for beneficiaries, while being fiscally responsible to the Medicare program as a whole. We do not believe every physician should be

subject to the same payment model. Instead, 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 provided.

Additionally, we believe that Medicare must be evaluated as a comprehensive health care program, not a collection of four distinct programs. As designed, Medicare is a fragmented program with four individual benefits. This fragmentation ignores the impact each individual component has on the others and limits our ability to analyze how changes or improvements in one area of the program impact others. Specifically, we believe that it is important that the barriers between Parts A and B be terminated. 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 & B is one of the most important steps Congress can and should take when establishing new delivery and payment models.

The AOA does not believe we should pursue legislation that "fixes" or extends the use of the sustainable growth rate (SGR) in the Medicare program on a permanent basis. It is our opinion that this policy is severely flawed and inequitable. Furthermore, we believe it further advances fragmentation in our health care system. The AOA believes that we should transition to new payment models that advance and support proven delivery models and provide a more consistent and equitable payment structure for physicians. However, a rapid transition away from the current payment methodology potentially creates confusion for physicians and patients, thus compounding growing access to care issues in the program. Since a number of existing policies are closely aligned with the current Medicare payment formula, an immediate transition to a new payment model would undermine the investment made in these important programs. These programs include the Physician Quality Reporting System, the Electronic Health Records Incentive program, the Electronic Prescribing program, and the primary care and general surgery bonus payment programs, among others. Immediate implementation of a new payment formula would jeopardize the success of these programs and the financial incentives they provide for participating physicians. Based upon these concerns we are proposing a three-phase approach that is built around a period of stability and innovation, transitioning to new payment models within the next decade.

Phase I – Stability

The sustainable growth rate (SGR) should be terminated as a factor in establishing annual payment updates and the annual conversion factor (CF), in statute effective December 31, 2015. We believe it is imperative that Congress establish a clear termination date for the SGR. Failure to define a termination date of the SGR will impede the identification and adoption of new delivery and payment models, further promulgating our current challenges for years to come.

During the time period between January 1, 2012 and December 31, 2015, all physicians participating in the Medicare program should be protected against reductions in their annual payment rates and ideally receive annual payment updates equal to increases in practice costs. We suggest that the annual payment update for evaluation and management (E&M) services be set at 2% per year for the time period 2012-2015. The payment update for all non-E&M services should be set at 1% during the same time period.

To further accelerate growth in primary care specialties, we recommend that any increases in the Relative Value Units (RVUs) for E&M services not be subject to budget neutrality requirements. In addition, we urge the Centers for Medicare and Medicaid Services (CMS) to work closely with the American Medical Association's (AMA) Relative Value Update Committee (RUC) to identify potentially misvalued and overvalued codes, with an emphasis on increasing payment rates for E&M services. While recommendations have been made by MedPAC and others that CMS establish an independent panel of experts to assist in this effort, we believe that the current expertise of the RUC is better positioned to make these necessary changes. If the RUC, in the opinion of Congress and CMS, fails to accept and meet this recommendation over the next 4 years, then the AOA would support the establishment of an independent expert panel.

Additionally, all existing incentive payment programs such as the primary care and general surgery bonus, electronic health records, physician quality reporting system, and others should continue through December 31, 2015. We also recommend that the "work GPCI" be made 1.0 for all localities during this transition period.

Phase II – Innovation and New Payment Models

The AOA encourages Congress to work with multiple entities, including physician organizations and practices, to identify, develop, and test new payment models during the 2012-2015 time period. The AOA is a strong supporter of the Center for Medicare and Medicaid Innovation (CMMI), which was established as part of the Patient Protection and Affordable Care Act (Public Law 111-148). The CMMI is authorized to develop and test innovative delivery and payment models in the Medicare program. More importantly, the CMMI is unencumbered by the historic budget neutrality provisions that have hampered past Medicare demonstrations and pilots. Instead, the CMMI has new resources at its disposal that can be used to test and evaluate new models of care and supporting payment models in a manner that allows for a thorough evaluation of their impact on the Medicare program – not just Part B services. The CMMI is a key component to identifying new delivery and payment models that will allow the Medicare program to move away from its current fragmented models towards a more integrated and coordinated health care system. We urge the Committee and Congress to support the CMMI and work with them to identify and test new delivery and payment models.

Additionally, we recommend that Congress seek the expert opinions of the Medicare Payment Advisory Commission (MedPAC). Over the past decade, MedPAC has put forth numerous recommendations on how the Medicare program could improve care delivery, payment of services, and quality. The AOA appreciates the expertise offered by MedPAC and believes that they should be a vital part of our efforts moving forward.

Finally, we believe that the input and recommendations of physicians and their professional organizations are essential to our collective efforts. Physician organizations have enormous resources and expertise available and are a key component in the collection of information from practicing physicians on the impact of various proposed and implemented policies.

Our recommendations on new delivery payment models that should be studied include the following:

Patient-Centered Medical Home

The AOA believes that a health care delivery system with a sound foundation in primary care is best positioned to meet our joint goals of increasing the quality of care provided to beneficiaries and better aligning resources. Numerous studies have demonstrated that continuous and comprehensive primary care increases the quality of care and reduces Medicare costs through reductions in hospitalizations and readmissions to hospitals. Based upon these findings, the AOA proposes the broad and immediate implementation of the patient-centered medical home in the Medicare program.

To further promote continuous and comprehensive primary care services, the AOA believes that the current primary care incentive program should be made permanent and, beginning January 1, 2016, be allocated in a manner that promotes the wide-spread adoption of the patient-centered medical home. To accomplish this, we propose that all primary care practices recognized at the top level by current patient-centered medical home recognition programs be eligible for a PCMH care management payment equal to 20 percent of the physician's allowable primary care Medicare charges. Practices recognized as patient-centered medical homes at any level should be eligible for a payment equal to 10 percent of their allowable primary care Medicare charges. We believe that the definition of "allowable primary care Medicare charges" for the PCMH payment be based upon criteria established in the Affordable Care Act for the purposes of the primary care bonus.

To support this, we recommend two payment models, either of which in our opinion will provide the foundation for its implementation.

PCMH Payment Option 1 – Blended Payments

The AOA proposes the establishment of a blended payment model for primary care practices. This payment model would be based on a new methodology that incorporates all Medicare Part B historical spending on a per beneficiary basis, with the appropriate annual risk-adjustments that incorporates beneficiary characteristics that contribute to increases in annual spending. Primary care practices would be eligible for the PCMH care management payments as outlined above.

PCMH Payment Option 2 – Global Payments

The AOA proposes the establishment of a global payment model for primary care practices. This payment model would be based on a new methodology that incorporates all Medicare Parts A and B historical spending on a per beneficiary basis, with appropriate annual risk-adjustments that incorporate beneficiary characteristics that contribute to increases in annual spending. To protect against any suggestions that there are incentives to withhold care as a means of meeting the benchmark, only practices that are recognized as patient-centered medical homes would be eligible to participate in the global payment model and would receive the 20% PCMH care management payment.

Beneficiary Assignment to Primary Care Practices

While we appreciate and support a beneficiary's ability to seek and receive care based upon their individual needs, we believe that the 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, beginning in 2016, be required to identify 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. To support this new policy, we propose that the current cost-sharing arrangements be adjusted to promote this policy recommendation. Consistent with our previous recommendation that Medicare Parts A & B be blended, we would welcome proposals that would create a combined premium and co-pay. The AOA is receptive to provisions that would allow certain beneficiaries to claim two primary care physicians based upon the fact that beneficiaries often reside in two primary localities over the course of a year.

Accountable Care Organizations

The AOA believes that Congress should support the continued evolution of accountable care organizations (ACOs). While we have significant concerns with the rules and regulations under development, we strongly support the concept of integrated delivery models as a means of improving the quality and efficiency of health care. We recommend that ACOs be better designed to allow for the virtual versus contractual alignment of physician practices as a means of achieving integration.

Bundled Payments for Non-Primary Care Ambulatory Services

The AOA recognizes that a large percentage of health care services provided to Medicare beneficiaries are provided by non-primary care physicians in an ambulatory setting. We also recognize that many of these services are episodic in nature and are not conducive to a global payment. In fact, these services are more conducive to the current fee-for-service payment structure. However, we do believe that a bundled payment for such services is achievable. To this end we propose that a bundled payment model for all non-primary care ambulatory services be established and studied. We further recommend that this payment be "all-inclusive" so that fragmentation of services and payments are eliminated.

Bundled Payments for Physician Services Provided in Hospital or Institutional Settings

The AOA proposes the establishment of a bundled payment model for acute-care physician services provided in hospital or other institutional settings. This payment would reflect both the costs

associated with physician and institutional services. We recommend that the payment flow through the physician.

Private Contracting for Beneficiaries and Physicians

The AOA recognizes that all physicians are not willing to accept new payment models, but may wish to retain their ability to provide services to Medicare beneficiaries. We support the creation of policies that allow all physicians to privately contract with Medicare beneficiaries for health care services.

Imaging Services

The value of imaging services to beneficiaries and the Medicare program are well documented. However, the payment structure for such services has been a source of continuous policy debates over the past decade. We urge the development of clear and sustainable coverage and payment policies that promote access to imaging services. Any future coverage and payment policies should promote quality and be based on appropriateness criteria established by physician organizations, but not restrict access to imaging services. Specifically, we do not support coverage and payment policies for imaging services that would limit the ability of all physicians, as appropriate and justified by clinical guidelines, to provide such services to their patients in a timely manner.

Laboratory Benefit

Currently, the laboratory fee schedule is the only Medicare benefit that has a payment structure independent of a beneficiary cost-sharing arrangement. For this reason we propose the establishment of a defined laboratory benefit that includes a beneficiary cost-sharing arrangement as suggested by the Congressional Budget Office (CBO) and others.

Education and Training

One of the keys to fostering the adoption of new delivery and payment models is ensuring that future generations of physicians have the appropriate training experiences. We urge Congress and CMS to use their inherent ability as the primary financer of graduate medical education to promote new delivery models, specifically those focused on primary care, through the GME system. All too often, the experiences garnered during the training years will influence the practice style of a physician throughout their career. To better prepare the next generation of physicians, we believe modifications in the GME system are warranted.

Phase III – Implementation of New Payment Models

Starting January 1, 2016, physicians and physician practices would be eligible to select from a list of payment models based on the needs of their patients and practice setting. Physicians participating in innovative delivery and payment models during the years 2012-2015 would retain their ability to opt-out of one model for another, free of penalty. Beginning in 2016, all physicians would be required to select a new payment model suitable for their practice specialty and location.

The AOA recognizes that not all physicians are positioned to participate in new payment models, or may simply oppose doing so based upon specific factors for their practice or career. Regardless of reason, we do not believe that prohibiting physicians from participating in the Medicare program based upon their reluctance to participate in new payment models is justified. In fact, we feel that this would be counterproductive and further exacerbate access to care issues for beneficiaries. We propose that the current fee-for-service (FFS) system be maintained for 10 years – 2016 to 2026 – and that payments be gradually reduced by 1% per year as a means of encouraging transitions to new delivery and payment models. After 2026, physicians would no longer have the option of participating in the FFS payment system and would be required to enter into a new payment model as a means of participating in the Medicare program.

The AOA and our members appreciate the opportunity to share these thoughts, views, and recommendations with the Committee. Again, we applaud your thoughtful and bipartisan approach to 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.

Respectfully,

Karen J. Nichols, DO
President

C: The Honorable John Boehner, Speaker
The Honorable Eric Cantor, Majority Leader
The Honorable Nancy Pelosi, Minority Leader
The Honorable Kevin McCarthy, Majority Whip
The Honorable Steny Hoyer, Minority Whip
Members, Energy & Commerce Committee
Members, Ways & Means Committee