



AMERICAN COLLEGE OF PHYSICIANS
INTERNAL MEDICINE | *Doctors for Adults*[®]

July 9, 2013

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

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

Dear Chairman Upton and Ranking Member Waxman:

On behalf of the American College of Physicians (ACP), I appreciate the opportunity to respond to draft legislative language released on June 28, 2013 by the Energy and Commerce Committee to repeal the current Sustainable Growth Rate (SGR) system and replace it with a fair and stable system of physician payment in the Medicare program. We continue to appreciate your leadership in addressing the flawed SGR and for your initiative in working to advance a solution with input from physicians, physician organizations, and other stakeholders. Overall, the College supports the intent of your legislative proposal to move toward a more stable, effective and efficient physician payment system, something we agree is absolutely necessary. However, this letter offers some feedback on several of the specific questions you have raised and recommendations for the Committee to consider as you further develop this legislation.

ACP is the largest medical specialty organization and second-largest physician group in the United States, representing 137,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum, from health to complex illness.

As explained in more detail below and in our previous comments to earlier drafts, including the detailed section-by-section recommendations we sent you on June 20, 2013¹, the College strongly believes that the final bill should advance the following four overarching policy objectives:

- 1. Create a clear transition timetable for physicians to participate in new payment and delivery models, with a graduated and positive quality incentive program during this transition, including higher transitional payments for physician practices organized as Patient-Centered Medical Homes.**
- 2. Positive and stable baseline updates for all physicians during this transition phase, with higher baseline updates for undervalued evaluation and management services.**
- 3. Create a process for the Department of Health & Human Services (HHS) to “deem” alternative payment models and quality improvement programs that meet criteria to ensure that the programs have the key elements associated with better outcomes and more effective care.**

¹Section-By-Section Crosswalk: May 28 Energy & Commerce Discussion Draft and ACP Proposal. Accessible at: http://www.acponline.org/acp_policy/policies/crosswalk_ec_sgr_draft_acp_proposal_2013.pdf.

4. Accelerate adoption of new payment and delivery models that the evidence shows are effective in improving outcomes and effectiveness of care, including but not limited to Patient-Centered Medical Homes (PCMHs).

Although the current draft includes many elements that are consistent with these four policy objectives, the College believes that the bill should be strengthened, especially as it relates to accelerating broader adoption of new payment and delivery models including PCMHs.

Energy & Commerce Committee Questions

1. *Can you provide feedback on how the draft addresses tying measurement to payment? Do you prefer one type of payment model over another? Are there other ways to link quality to payment than those provided in the draft?*

As was discussed in our previous feedback to the Committee², physicians at all points along the spectrum of readiness need to have models available to them that are appropriate and realistic for their particular stage of development, but with the opportunity for them to *earn additional value-based payment (VBP) updates* (above the baselines to be set in the statute) on a graduated VBP scale that *provides greater rewards for those who are doing more to improve outcomes and effectiveness of care*. Such a graduated VBP scale should be based on how much a particular deemed/approved program has demonstrated core capabilities/competencies to achieve better clinical outcomes, with more effective use of resources. Studies demonstrate that the most effective programs have some or all of the following components associated with better outcomes and more effective care:

- Reporting on *validated* clinical performance measures appropriate for the specialty of the physician patient population being served, with particular emphasis on measures that improve clinical outcomes and patient experience at an organizational/system level, rather than process measures at the individual physician level.
- Coordinated, interdisciplinary and team-based care “best practices” to overcome fragmentation of medicine into distinct silos of care.
- Tracking of patient outcomes through patient-registry systems.
- Patient engagement and shared decision-making.
- Commitment to evidence-based practice guidelines, such as ACP’s High Value Care Initiative³, and the *Choosing Wisely* effort⁴ organized by the American Board of Internal Medicine, to reduce ordering of marginal, ineffective, low value or even harmful care.
- Informed and pro-active clinical care management teams and empowered patients, as described in the Chronic Care Model (CCM),⁵ within a practice or across a group of practices. The CCM has proven itself over the past decade as a meaningful framework for practice redesign that leads to improved patient care and better health outcomes.⁶
- A strong emphasis on primary care and appropriate valuation of primary care services as being critical to delivering high value, coordinated care for the whole person, including programs that

² This feedback was provided via a [formal letter to the Energy and Commerce Committee on June 10, 2013](#) and via an [informal section-by-section crosswalk](#) of the Energy and Commerce May 28, 2013 discussion draft with ACP’s proposal.

³ Additional information on ACP’s High Value Care Initiative can be accessed at: <http://hvc.acponline.org/>.

⁴ Additional information on the Choosing Wisely effort can be accessed at: <http://www.choosingwisely.org/>.

⁵ Additional information on the Chronic Care Model can be accessed at: http://www.improvingchroniccare.org/index.php?p=The_Chronic_Care_Model&s=2.

⁶ Katie Coleman, Brian T. Austin, Cindy Brach and Edward H. Wagner. Jan/Feb 2009. “Evidence On The Chronic Care Model In The New Millennium” Accessed at: <http://content.healthaffairs.org/content/28/1/75.short>.

incorporate the elements of the Patient-Centered Medical Home (PCMH/ primary care model) and PCMH-N practices (specialty practice model).

ACP appreciates that the Committee has included “clinical improvement activities,” in addition to reporting on quality measures, in the latest legislative draft as an option to be tied to payment—however, we recommend that the Committee take this a step further and consider specifying the components outlined above as additional approaches that could be used for linking quality to payment.

Additionally, ACP would like to recommend that the Committee be less prescriptive in its proposed payment scenarios for the Update Incentive Program. The scoring thresholds could be more effectively established via the regulatory rule-making process, which would allow greater time for meaningful input from physicians, consumers, and other key stakeholders. Keeping that level of specificity out of the statute also ensures a greater level of flexibility, which will likely be needed, for the initial establishment of the payment approaches and for any necessary modification to those approaches over time.

2. *Are there any other safeguards, besides the IG, that could be implemented to ensure integrity in the reporting process?*

In addition to having an independent audit by the Inspector General (IG), as proposed in the legislation, **clinicians should have a timely, fair, and accurate appeals process available to examine potential inaccuracies in their data—particularly before measurement data are tied to payment incentives.**

3. *If providers decide not to participate in the Update Incentive Program, should they be held to the same standard? How should their payment updates be applied if they do not report on quality measures?*

In the short term, the College specifically recommends that the Committee establish a period of stable and positive payments for all physicians, during which new models of payment and delivery would be evaluated and the Update Incentive Program could be implemented. We also urge the Committee to establish positive baseline updates for all physicians, plus an additional baseline update for undervalued evaluation and management services, during this period of stability. The following language to that effect was included in the Medicare Physician Payment Innovation Act, H.R. 574, which ACP has endorsed:

Section 2, (a) through (c), establishing baseline updates for primary care and non-primary care services defining the service codes to be included in the primary care update and qualifying primary care practitioners, and the period of stability.

2014—baseline update for all services is equal to 2013 Conversion factor (zero update)

2015-18: Annual primary care baseline update shall be 2.5%. Annual non-primary care update shall be 0.5%.

The necessity of providing higher updates for undervalued evaluation and management services has broad support within the medical community and from independent experts, including the [National Commission on Physician Payment Reform](#), [National Coalition on Health Care](#), and [The Commonwealth Fund](#).

Additionally, ACP strongly believes that the Patient-Centered Medical Home (PCMH) and Patient-Centered Medical Home Neighborhood models are ready now to be a part of a new, value-based health care payment and delivery system, given all of the federal, state, and private sector activity

to design, implement and evaluate these models. *As explained below, we are concerned that the current draft of the bill backs off on including PCMHs as one of the approved Alternative Payment Models (APMs), instead only calling for a study by MedPAC.* (PCMHs are more than an alternative payment model—they represent a highly sophisticated, evidence-based redesign of delivery systems to achieve patient-centered care, *supported by* new payment models that align incentives with achieving the best possible outcomes for patients. ACP believes that Congress should put the greatest emphasis on supporting the development of models, including PCMHs, that combine delivery system reform with new payment approaches.) Our complete approach to providing graduated incentives for value-based programs over the course of a 5-year transition period was laid out in our previous responses, cited above, to the Committee’s earlier iterations of this draft legislation.

Over the longer term, ACP believes that it is appropriate to establish a clear but realistic timeline for physicians to transition to new payment and delivery models, with positive incentives during the transition, as described earlier. We also believe that it may be appropriate to provide reduced FFS updates for physicians who *choose* to remain in a pure FFS system at the end of such a transition period, if alternative payment and delivery models are available that are suitable for their specialty, patient population, and type of practice. However, we believe that hardship exemptions need to be available for physicians who cannot make such a transition through no fault of their own. **We strongly encourage the committee to consider incorporating language from H.R. 574 to establish such a timeline and hardship exemption process.**

4. *Do you think the policy, as outlined in the discussion draft, can accommodate early adopters and those with minimal quality standards by the time Phase II goes into effect?*

Early Adopters

It is not clear if the policy outlined in the discussion draft will be able to accommodate early adopters. It appears to be best equipped to accommodate those physicians who want to stay within the fee-for-service system and who have a robust set of measures already available. However, for those who wish to opt out into an alternative model prior to Phase II, the latest discussion draft seems to put a fairly complex process into place for approving proposed models that may take several years to implement. **ACP recommends that the Committee consider establishing a deeming process building on HHS’ long history with that approach.** HHS has a tradition of deeming non-profit private sector accreditation organizations to satisfy compliance with federal regulations in a way that relies on the accreditation organization’s expertise, while still ensuring that the process meets federal standards relating to transparency.

We believe that CMS can learn from those relationships and work with the accreditation organizations and national specialty societies, including ACP, to design a deeming program for PCMH and PCMH-N recognition—as well as for programs developed by national specialty societies (e.g., registries), state medical societies, county medical societies, community-based physician groups, or other entities—that appropriately balances the interests of the non-profit, private sector accreditation organizations with CMS’ responsibility to establish and maintain transparency in its decision-making processes.

Additionally, as stated previously, ACP strongly believes that the PCMH and PCMH-N models are ready to be a part of a new, value-based health care payment and delivery system, given all of the federal, state, and private sector activity to design, implement and evaluate these models and the growing amount of data on its effectiveness in improving care and lowering costs.⁷ Therefore we were appreciative that the

⁷ A sampling of recent data on the effectiveness of PCMH programs can be accessed at: <http://www.pcpc.net/guide/benefits-implementing-primary-care-medical-home>, <http://content.healthaffairs.org/content/29/5/819.full>,

Committee had included the PCMH concept in the May 28, 2013 version of the draft legislation as an option for the Secretary to consider—but we recommended that the bill *require* the Secretary to create a process to recognize PCMH and PCMH-N practices for higher Medicare payments as early as 2014. However, it appears that the Committee has now moved toward calling for a MedPAC study of the PCMH, along with Accountable Care Organizations (ACOs), bundled payments, and gainsharing arrangements, before they could be approved as alternative payment models. *It is not clear why the Committee chose to step back from its earlier approach.* **We are strongly concerned about this change, and urge the committee to reinstate language from the earlier draft directing the Secretary to include PCMHs as an approved payment model. The language should make this a “shall” requirement, rather than specifying that the Secretary “may” consider including PCMHs as an APM. The bill should also include language directing the Secretary to include PCMHs that have achieved accreditation or recognition through private sector accreditation as an approved APM.**

ACP also reiterates the significant and growing amount of data on the PCMH that was previously cited, the large number of private health plans that have decided to roll out the PCMH model across their markets, and the current CMS Innovation Center projects (particularly the Comprehensive Primary Care Initiative) focused on the PCMH model. All of these sources should be considered before the Committee calls for an additional study. Also, with regard to the other models that the draft legislation is now calling on to be reviewed by MedPAC, it should be noted that they are all either part of the Medicare program already (as is the case with ACOs), or currently being studied by the CMS Innovation Center, as well as by the private sector health plans.

Accordingly, we firmly believe that now is the time for Congress to accelerate the process of making PCMHs, bundled payments and ACOs broadly available to Medicare beneficiaries, rather than calling for more study by MedPAC.

Those with minimal quality standards

It is also not clear if the draft legislation will effectively accommodate physicians that have minimal quality standards available for their use. While there is language included that would “establish a process for the development of quality measures,” it is not clear in the discussion draft exactly how that would be facilitated or funded. **ACP strongly recommends that all measures, whether developed by a specialty society or other experts, accordingly should go through a multi-stakeholder evaluation process, a role that is performed by the National Quality Forum (NQF) as a trusted evaluator of measures. Therefore, ACP encourages the Committee to ensure that there is stable and sustainable financing for the NQF, as well as for the measure development and maintenance processes that feed into NQF’s endorsement process.**

We also support the recommendation from the paper published by the Robert Wood Johnson Foundation (RWJF) by Berenson, Pronovost, and Krumholz⁸ on the need to “invest in the ‘basic science’ of measurement development.” The authors observe that: “there is no body of expertise with responsibility for addressing the science of performance measurement. NQF comes closest, and while it addresses some scientific issues when deciding whether to endorse a proposed measure, NQF is not mandated to explore broader issues to advance the science of measure development.”

http://www.bcbsm.com/content/dam/public/Providers/Documents/help/R007532_2012PartnersReport_01WEB.pdf, <http://content.healthaffairs.org/content/31/9/2002.full.html>, and <http://content.healthaffairs.org/content/31/9/2010.full.html>.

⁸ Berenson, Pronovost, and Krumholz. “Achieving the Potential of Health Care Performance Measures: Timely Analysis of Immediate Health Policy Issues.” May 2013. Published by The Robert Wood Johnson Foundation and the Urban Institute. Accessed at: <http://www.urban.org/publications/412823.html>.

The authors of the RWJF report further state that an infrastructure is needed to gain national consensus on: what to measure, how to collect the data needed to calculate measures, the accuracy of EHR data for use in performance measurement, how to determine the cost-effectiveness of particular measures, how to reduce the costs of data collection, what thresholds to use to ensure measure accuracy, and how to prioritize which measures to collect. Establishing general standards for performance measures could help move the policy discussion from whether measures are good enough to use despite their flaws to a more fundamental discussion of how to design good measures, how to assess current measures, and whether the costs of producing better measures are worth the benefits.

5. *The draft policy endeavors to ensure public and provider feedback. Do you feel that the policy succeeds in achieving this goal?*

The draft legislation does seem to achieve this goal in part. As discussed earlier, the College recommends that all measures, whether developed by a specialty society or other experts, accordingly should go through a multi-stakeholder evaluation process, a role that is performed by NQF as a trusted evaluator of measures. The NQF multi-stakeholder process does involve input from consumers. We also support the concept of allowing for a public comment period on measures and clinical practice improvement activities that will be linked to Medicare incentive payments—an approach that was included in the draft legislation—but caution that such a comment period should not result in measures being altered, adopted, or rejected in response to public comments that are not supported by evidence.

Additionally, ACP believes that the legislation should more clearly specify that physicians should have a key role in determining methods used to:

- **Develop and select measures (including the measurement evidence and any evidence grading methods used),**
- **Collect data from physicians,**
- **Aggregate and score performance,**
- **Report performance data internally and publicly, and**
- **Tie payment updates to performance data.**

There should also be a timely, fair, and accurate appeals process available to clinicians that enables them to examine potential inaccuracies in their data—particularly before measurement data are tied to payment incentives.

6. *Should the new quality system align and coordinate with PQRS in the manner in which it provides feedback at the group level?*

ACP supports greater alignment across all of the existing QI programs such as Medicare PQRS, e-RX, EHR Incentive/Meaningful Use, and Value-Based Payment Modifier (VBPM) programs—and with any new programs that may be put into place. However, ACP also believes that it would be appropriate to consider sunsetting the existing PQRS and e-RX programs, and potentially the VBPM and EHR Incentive programs, if a new quality incentive program is created that achieves the same objectives but in a more consistent way with consistent and harmonized measures, and fewer administrative burdens on physicians and practices. In this event, the infrastructure that has been built for these programs—including the infrastructure for providing feedback—should be leveraged to the extent possible and not recreated from scratch. Additionally, the new program should ensure that it can provide feedback to physicians in a much timelier manner than the current programs, which often have a 2 year data lag.

7. *The draft envisions a repertoire of quality measures and clinical practice improvement activities. Some have suggested also including efficiency measures. Should we explore efficiency measures and other improvement activities?*

Other Improvement Activities

As discussed earlier, the College strongly recommends that the Committee consider a number of additional clinical improvement activities, such as:

- **Coordinated, interdisciplinary and team-based care “best practices” to overcome fragmentation of medicine into distinct silos of care.**
- **Tracking of patient outcomes through patient-registry systems.**
- **Patient engagement and shared decision-making (via the use of certified patient decision aids).**
- **Commitment to and use of evidence-based practice guidelines to reduce ordering of marginal, ineffective, low value or even harmful care, such as ACP’s High Value Care Initiative ,and the *Choosing Wisely* effort organized by the American Board of Internal Medicine.**
- **Informed and pro-active clinical care management team and empowered patients, as described in the Chronic Care Model (CCM), within a practice or across a group of practices.**

Measures

The report cited earlier from Berenson, Pronovost, and Krumholz includes an in depth discussion of structure, process, and outcomes measures, outlining the pros and cons of each type. The researchers conclude that the best approach is to “decisively move from measuring processes to outcomes.” ACP agrees with this conclusion and therefore, in our recommendation to implement a graduated VBP approach, the College calls for a higher percentage update above the baseline for physicians and practices that are reporting on a more robust set of performance measures, either within a PCMH program or independently, that includes composite, population, outcomes, and cost measures, particularly for those participants that are showing improvement and/or consistently high quality in those measures over time.

ACP recognizes that measures of efficiency should be part of the performance measurement system, but at the current time the development of such metrics lags behind clinical process and outcomes measures. Overall, measure sets must primarily focus on improving patient outcomes, gauging the patient-centeredness of a practice, and improving the coordination of care across all providers. The College maintains that efficiency—or “value-of-care” measures—must be based on an objective assessment of evidence on the effectiveness of particular treatments, with both cost and quality taken into consideration. Value-of-care measures must appreciate the nuances of physician care and must not compromise the patient–physician relationship. And, as noted earlier, stakeholders must also work to develop population health measures designed for specific populations.⁹

8. *Do you believe the draft policy adequately addresses the issue (of non-compliant patients) and protects providers who are reporting on quality outcome measures in the setting of non-compliant patients (i.e., one of many aspects of risk adjustment)?*

⁹See ACP’s policy paper titled, “The Role of Performance Assessment in a Reformed Health Care System” (2012) for additional background on this position:

http://www.acponline.org/acp_policy/policies/role_of_performance_assessment_in_reformed_healthcaresystems_2012.pdf.

ACP agrees that any program that ties payment to measurement data should have a robust risk-adjustment approach that takes into account differing patient populations, specialties, geography, as well as factors, such as sample size, age/sex distribution, severity of illness, number of comorbid conditions, patient compliance, patient health insurance status, panel size/patient load, and other features of a physician’s practice that may influence the results. However, risk adjustment methodologies may not fully account for cultural and socioeconomic barriers that may make some patients, with a similar disease risk profile as another patient, less able to follow their physician’s recommended prevention and treatment plans. Therefore, programs that link payment to assessment of performance must monitor participants to identify and address unintended consequences, such as exacerbation of racial and ethnic health disparities. This may be achieved by including incentives to care for underserved or complex-needs patients in such programs. Additionally, measuring, scoring, and incentivizing physician and system performance should result in better patient care and must not compromise patient access to care through such mechanisms as “deselection” or lead to increased attention to or manipulation of documentation.¹⁰

As was noted in our June 10, 2013 letter to the Committee, allowing physicians to spend appropriate clinical time with their patients—time spent learning about them and their families and home life, listening to them, uncovering the reasons for their symptoms, explaining the clinical issues, developing an appropriate treatment plan, and engaging their patients in shared decision-making—is at the very essence of the patient-physician relationship, and is critical to ensuring that a patient is able to follow his/her care plan.

Patient decision aids are educational tools that can help patients and caregivers better understand and communicate their preferences about reasonable treatment options. Randomized trials consistently demonstrate the effectiveness of patient decision aids. In January 2013, Lee and Emanuel¹¹ investigated the potential of shared decision-making approaches, such as the use of patient decision aids, on improving care and reducing cost—and found that these aids are indeed successful (a subset of their findings was included in our June 10, 2013 letter). **Therefore, ACP recommends that the Committee consider including in this legislation the authorization of a program to encourage broad adoption of patient decision aids to improve care as well as reduce costs and overutilization.** Such a program could include:

- The development of and funding for implementation of decision aids focused on high cost or high frequency elective or preference-sensitive procedures/tests via a certification approach (discussed further below).
- Positive incentive payments for physicians who use guidelines to encourage high value care, such as those from ACP’s High Value Care Initiative and the *Choosing Wisely* Campaign, and engage their patients in shared decision-making using certified decision support tools in a patient visit.
- Measurement of utilization of such elective procedures in practices that use and document the decision tools compared to physicians and practices that do not.

Specifically, ACP recommends that CMS rapidly certify patient decision aids that have been rigorously evaluated by independent researchers for a prioritized list of the top 20 most expensive and/or most frequent performed procedures, particularly those that are considered preference-sensitive or are

¹⁰ See ACP’s policy paper titled, “The Role of Performance Assessment in a Reformed Health Care System” (2012) for additional background on this position:
http://www.acponline.org/acp_policy/policies/role_of_performance_assessment_in_reformed_healthcaresystems_2012.pdf.

¹¹ Lee and Emanuel (2013). “Shared Decision Making to Improve Care and Reduce Costs”NEJM. Accessed at:
<http://www.nejm.org/doi/full/10.1056/NEJMp1209500>.

elective—and then require that the use of those aids be documented. In addition, Medicare should create a methodology for physicians to document that they are using high value care guidelines and associated decision support tools in their practices. For instance, Medicare could allow physicians to indicate via a modifier to an E/M visit code (backed up with the appropriate documentation, which should ideally be facilitated by the electronic health record) that they have engaged their patients in shared decision-making, using a specialty society’s evidence-based clinical guidelines to reduce utilization of marginal and ineffective care, supported by certified patient decision aids as available and appropriate. Physicians who provide such documentation would receive a higher payment for that E/M visit.

9. *Should core competency categories be defined as those set forth under the National Quality Strategy?*

ACP is supportive of the priorities outlined by the National Quality Strategy. Additionally, ACP recommends that:

- Cohorts that include competencies and related measures to *achieving better patient outcomes and experience with the care provided*, as opposed to process measures, should have more weight (and qualify physicians who are participating in such cohorts for higher competency-based incentive payments) than physicians who are participating in cohorts that involve reporting only on individual *physician-level process measures*.
- Cohorts that evaluate performance *at the level of the organization or system* in which the physician is delivering care and are focused on achieving better outcomes and patient experience with the care provided, should carry more weight than cohorts that evaluate the performance of the individual physician acting on his or her own.

Also, ACP notes that the ABMS maintenance of certification (MOC) is a multi-source assessment program that addresses competencies for good medical practice and provides a program of continuous professional development and a platform for quality improvement. Therefore, ACP recommends that the Committee’s SGR repeal proposal include participation in ABMS MOC as a quality metric, include ABMS MOC as a reporting pathway, and allow physicians choice in reporting so that they can align their quality improvement activities in ways that are relevant to their practices.

10. *Do you think the draft policy method provides ample opportunity for formulating and submitting alternative payment models?*

11. *Comments on the process to obtain input on modifying and retiring alternative payment models that are on the public list.*

The draft legislation would create a new process of contracting with an APM contracting entity to carry out the identification, evaluation, and selection of APMs for inclusion as opt-out options for physicians. As noted earlier, ACP recommends that the Committee consider establishing a deeming process building on HHS’ long history with that approach. Using a deeming approach may be more efficient and facile than establishing an entirely new, seemingly complex process. However, ACP does agree that any new APM should be required to meet a robust set of criteria, built on the latest evidence—and that there should be an ongoing process to modify or retire APMs as appropriate. The details of these selection and modification processes could be worked through during the rule-making process.

We also urge the Committee to include language from the Medicare Physician Payment Innovation Act of 2013, H.R. 574, on promoting, testing and evaluation of new payment models.

Additionally, we would again like to reiterate our concern that this legislative draft seems to have moved backward with regard to inclusion of the PCMH model. We strongly urge the Committee to

direct the Secretary to include Patient-Centered Medical Homes as an approved payment model, as explained in detail earlier in this letter.

The College appreciates this opportunity to share its recommendations with the House Energy & Commerce Committee on your second round legislative draft to repeal the SGR, improve the Medicare physician fee schedule and the FFS system overall to provide stability for physician reimbursement, and lay the necessary foundation for performance-based and alternative payment systems. Please contact Jonni McCrann at jmccrann@acponline.org or 202-261-4541 if you have any questions or would like additional information.

Sincerely,

A handwritten signature in blue ink, appearing to read "Molly Cooke", is displayed within a light gray rectangular box.

Molly Cooke, MD, FACP
President, American College of Physicians