



American College of Physicians  
Statement to the Senate Finance Committee  
Recommendations for Health Care Delivery System Reform  
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The American College of Physicians (ACP) is the largest medical specialty society in the United States, representing 126,000 internal medicine physicians and medical student members. ACP commends Chairman Max Baucus and Ranking Member Charles Grassley for holding this roundtable discussion on reforming the health care delivery system. We appreciate their leadership in supporting policies to improve payments for primary care services and their recognition of the need for an expansion of the primary care workforce. We look forward to working with you to achieve these goals as the Senate Finance Committee considers health care reform in the weeks ahead.

During the last four years, ACP has consistently warned policymakers of the crisis in primary care. The future of primary care is at great risk at a time when the evidence suggests that the nation needs primary care more than ever before. In a previous white paper, the College documented over 100 studies that confirm the value of primary care.<sup>1</sup> Studies at the state, county, local and international levels confirm that the numbers, proportion and availability of primary care physicians consistently is associated with better health outcomes, better quality and lower costs of care, including lower Medicare per capita expenditures. Despite the availability of such evidence, the United States has done little to ensure that the supply of primary care physicians is sufficient to meet current and future needs.

ACP recommends that Congress pursue a two part strategy to reform the health care delivery system by (1) creating a fast track authority to develop and implement new physician payment models that better align payment with effective, efficient, patient-centered care such as the Patient-Centered Medical Home and simultaneously (2) reforming traditional Medicare fee-for-service payments to make primary care competitive in the market and to improve the accuracy and appropriateness of Medicare payment levels.

### **Reform Medicare Physician Payments**

#### **1. Implement a Fast Track Authority for Payment Reforms to Encourage High Quality, Efficient Care; Including the Patient Centered Medical Home**

There is an urgent need for Medicare and other payers to develop, initiate, pilot, and then expand effective new models of physician payment that re-align incentives from volume of services to effective, efficient, patient-centered, team-based and coordinated care. New

payment models that policymakers are considering include: continued expansion of the Patient-Centered Medical Home Model and testing it in the context of alternative payment models; Accountable Care Organizations, paying for bundles of services for an episode of care based on past treatment patterns; paying for bundles of services associated with care that would be provided according to evidence-based guidelines; making a capitation payment to primary care physicians for the full range of primary care services; and others. Some of these models preserve an element of fee-for-services and others would entirely replace fee-for-service with a bundled payment structure.

Most of these alternatives are in the early stages of testing and some are still conceptual and lack definition. This lack of real-world experience poses a challenge to policymakers. The will to act is as rivaled by the number of reform options.

ACP believes that Congress needs to create a framework that would allow the federal government to select the most promising conceptual models for reforming physician payments, based on clear policy objectives, and to move such models rapidly into real-world implementation and evaluation on a pilot basis, followed by more widespread implementation across Medicare and other programs of the models that prove to be most effective.

Specifically, ACP recommends that the Secretary of HHS be given the funding and fast track authority to identify the most promising models for reform, based on policy criteria to be developed in consultation with outside experts, which should receive priority for pilot testing and subsequent expansion under fast-track authority. ACP recommends that the Secretary specifically consider the following elements in development of such criteria for selecting the most promising payment reforms based on the potential of the model to:

- Create incentives that would lead to improvements in measurable health outcomes;
- Create incentives that would support the delivery of patient-centered care;
- Create incentives to foster the delivery of cost-effective care;
- Create incentives for efficient delivery of care without compromising quality;
- Create incentives to appropriately increase provision of preventive services;
- Support the management of chronic diseases and the coordination of patient-centered care;
- Create incentives to engage patients in shared decision-making on the most effective treatments for their conditions and participation in self-management and prevention plans;
- Support care delivered by primary care physicians;
- Support more effective care by non-primary care physicians;

- Be adaptable to a wide range of physician practices (size, geographic location and patient population served), including smaller practices;
- Be scaled up for broader implementation;
- Support team-based care;
- Support accountability across health care sectors, settings, and providers;
- Reduce inappropriate utilization of high cost and high volume services;
- Present evidence-based metrics for evaluation of the model's effectiveness;
- Impact and feasibility of data collection, reporting and other administrative tasks expected of physician and physician practices participating in the model;
- Be implemented by HHS, CMS, and other payers.

Based on such criteria and other policy objectives, the Secretary should be directed to select payment models, for fast-track funding, implementation and evaluation on a pilot basis, not constrained by the usual requirements for research and development funding, such as the requirement that all pilots be implemented on a budget neutral basis.

In making such selections, the Secretary should also be required to establish a technical advisory panel of health policy experts, consumers, physicians (including primary care physicians), and other stakeholders to provide advice to HHS on design, implementation and evaluation metrics for each pilot selected under such fast track authority. Such technical advisory panel shall also assist HHS in ongoing assessment of each pilot as data become available.

Once alternative physician payment models are selected, the Secretary should be required to create processes to allow for voluntary participation by a wide range of physician practices, primary care and non-primary care practices alike, to participate in the projects selected under the fast track authority, recognizing that different models may be more or less applicable to specific types of physician practices and specialties.

ACP suggests that within two years of initial implementation of each fast track project, the Secretary should submit a report to the Senate Committee on Finance, the House Committees on Ways and Means and Energy and Commerce, and the Medicare Payment Advisory Commission on the initial results of each pilot and which ones hold the most promise for widespread implementation based on the results to date. In making such assessment, the Secretary should consult with the technical advisory panel and the Medicare Payment Advisory Commission.

Within three years of the initial implementation of each pilot, the Secretary should have the authority to make broad changes in Medicare payment policies to scale up the most successful pilots to widespread adoption and implementation across the Medicare system. The Secretary should be required to report to the Senate Committee on Finance, the House

Committees on Ways and Means and Energy and Commerce, and the Medicare Payment Advisory Commission on the projects selected for widespread adoption and implementation across the Medicare program.

The College believes that our proposed framework for prioritizing the design, testing, evaluation and expansion of promising physician payment reform models, based on policy criteria, would strike the right balance between the urgent need to develop new payment models, and assuring that such models are subjected to appropriate testing in a variety of clinical settings before being implemented on a wider basis.

## **2. Expand the Medicare Medical Home Demonstration Project to a National Pilot and Transition to a New Payment Model for Qualified PCMHs**

The Patient-Centered Medical Home (PCMH) is a team-based model of care led by a personal physician who provides continuous and coordinated care throughout a patient's lifetime to maximize health outcomes. The PCMH is responsible for providing all of the patient's health care needs or appropriately arranging for care with other qualified health professionals. This includes the provision of preventive services, treatment of acute and chronic illness, and assistance with end-of-life issues.

The PCMH enjoys the support a wide range of health care stakeholders, including physician organizations, consumer organizations, employers, health plans, and quality-focused organizations. Policymakers view it as a promising reform model, with Congress authorizing the Medicare Medical Home demonstration project through a 2006 law and supplementing it with dedicated funding and increased ability for expansion through a 2008 law. MedPAC recommends a Medicare medical home pilot project to supplement the demonstration currently being developed that focuses on practices that use advanced health information technology. Numerous states are incorporating PCMH tests into reform of their Medicaid and SCHIP programs. There are a myriad of private payers PCMH tests, many involving multiple health plans, underway or being developed across the country.

The current Medicare Medical Home Demonstration, which is limited to eight states, should be expanded to a national pilot. CMS should also set a timeline for expeditiously transitioning to a new payment model for all practices nationwide that have voluntarily sought and received recognition as Patient-Centered Medical Homes following completion of the Medicare demonstration/pilot. Expansion of the current Medical Home demonstration to a national pilot would allow for larger-scale testing of the model in a variety of demographic populations, states, regions, and practices, producing a much larger body of evidence on its effectiveness as a basis for transition to a new payment model for such practices

Specifically, ACP recommends that the Secretary of HHS be required to propose through a rule making process new payment methodology(ies) for qualified PCMHs for implementation no later than January 1, 2013, taking into account the results of the Medicare Medical Home demonstration, as defined in Public Law 109-432, Section 204 and, as expanded to a national pilot of qualifying payment reforms, in developing the alternative PCMH payment structure(s).

We recommend that the Secretary give consideration to different payment models for qualified Patient Centered Medical Homes that align incentives with coordinated, preventive, team-based and patient centered care rather than principally or solely the volume of services. Such model or models should pay PCMH recognized practices, including practices recognized through the National Committee for Quality Assurance (NCQA) Physician Practice Connections-Patient Centered Medical Home (PPC-PCMH) voluntary recognition process or other equivalent process as determined by the Secretary, for the clinical work and practice expenses associated with providing care coordination services. In developing such model or models, the Secretary should give consideration, among other options, to alternative PCMH payment structures that combine risk-adjusted and prospective care coordination fees, performance-based payments, and payments for specific evaluation and management services. Qualified PCMHs could continue to receive fee-for-service payments for evaluation and management services or participate in an alternate approved payment mechanism that meets the above specified payment criteria.

**2. Reform Existing Medicare Fee-for-Service Payments to Recognize the Value of Primary Care and Improve Accuracy of Relative Value Units**

Studies indicate that lower compensation for primary care, compared to other specialties, is one of the most important factors in influencing medical students and young physicians to choose specialties and practice types other than primary care. Such disparities also contribute to decisions by established primary care physicians to leave primary care and pursue other career options. This market competitiveness gap has grown over time. ACP recommends that Congress mandate the following reforms of existing Medicare payment policies, at the same time as new models are being developed and tested, as discussed above.

**A. Congress should direct the Secretary of HHS to conduct an evidence based analysis of total compensation needed to make primary care physicians competitive with other specialties**

Currently, the average primary care physician earns approximately 55 percent of the average earnings for all other non-primary care physician specialties. [ACP analysis based on data from two sources: Medical Group Management Association--2008 and Merritt Hawkins – 2008 Review of Physician and CRNA Recruiting Incentives – Top Twenty Searches]. To eliminate differential income as a critical factor in medical student/resident choice of specialty, the average net income for primary care physicians would need to be raised to be competitive with the average net income for all other specialties. For instance, Medicare and all other payers would need to increase their payments to primary care physicians by 7.5-8 percent per year over a five year period, above the baseline for all other specialties, to bring the average of the median earnings for primary care physicians to 80 percent of those for all other specialties, all other factors being equal.

A market and price sensitivity analysis would model different levels of compensation for primary care, compared to other specialties, to determine the impact they would have on specialty choice. This is similar to what a successful company would do if it was trying to recruit for highly skilled positions in its workforce but was finding that it was failing to do so because competitors were offering a more appealing compensation package.

Based on a market and price sensitivity analysis, Medicare would be able to determine how much its share of total compensation to primary care physicians would need to be increased, over a five year period, to make primary care competitive with all other physician specialty and career options, all other factors being equal. Benchmarks would be created by HHS to determine the impact of the recommended annual Medicare fee schedule increases derived from such sensitivity analysis on increasing the numbers and proportion of primary care physicians.

Because a price and market sensitivity analysis could take some time to complete, the Secretary would begin by implementing a sizeable increase in Medicare fee schedule payment increase for evaluation and management services provided by primary care physicians, starting in 2010, as a down payment on subsequent annual increases to make Medicare payments competitive with other specialties over no longer than a five year period. Non-Medicare payers should also be strongly encouraged and given incentives to increase their payment rates, over the same time period, to make total compensation to primary care competitive in the market.

The Medicare Payment Advisory Commission has recommended a bonus payment in 2010 of up to 10 percent for evaluation and management services provided by primary care physicians, but this increase would apply only to evaluation and management services, not all services provided by primary care physicians. Accordingly, it would yield a far lower net gain in Medicare compensation to primary care physicians than ACP's estimate of 7-8 percent annual increases in *total Medicare compensation* required to achieve market competitiveness (Medicare's share) over five years at 80 percent of the earnings of all other specialties, all other factors being equal. Consequently, there needs to be further discussion of how much Medicare payments would need to be increased in 2010 to be a meaningful and substantial first step toward achieving market competitiveness for primary care physicians within five years.

#### **B. Provide Medicare Payment for Care Coordination Services**

Current Medicare policy fails to pay for many services provided principally by primary care physicians relating to prevention and coordination of care, especially for patients with multiple chronic diseases, because they are considered to be included in the payment for an office visit or other evaluation and management services. This policy has the effect of requiring that patients see their primary care physician in the office in order for the physician to be compensated, even when the patient's condition or question could be managed by email, telephone or remote monitoring. This policy inconveniences patients and results in physicians spending less time with patients who truly need to be seen in the office. Medicare's view that such services are included in the payment for the office visit also does not take into account the physician work and expense associated with such services. Consequently, many primary care physicians are unable to offer patients the convenience of email consultation or other ways of getting medical advice and follow up outside of a face-to-face visit. In addition, studies show that the ability of patients to receive ongoing self-management support from their physicians is critical to achieving better outcomes, especially for patients with multiple chronic diseases, yet current Medicare payment policies will not reimburse for the services needed to provide such support. Separate payment for such services would also help primary care physicians acquire the capabilities to become Patient Centered Medical Homes.

### **C. Revise Medicare Budget Neutrality Rules to Recognize the Value of Primary Care in Reducing Medicare Baseline Spending**

By law, any increases in payments for physician services under the Medicare fee schedule requires offsetting across-the-board “budget neutrality” offsets to all services in the Medicare fee schedule. One argument for making the primary care payment increases “budget neutral” within the Medicare fee schedule is that it not only would increase payments for primary care, but create more parity by lowering payments for higher paid specialties.

This option, however, has several disadvantages. It is opposed by some non-primary care physician specialty societies. Such opposition will make it more difficult to get the political support needed to enact higher payments for primary care. The temptation to reduce offsets to other specialists could result in payment gains for primary care that are too modest to make a difference. It also has the disadvantage of reducing payments for non-primary care services that may not be overvalued, since the budget neutrality adjustment applies to all services, whether over-valued or not. And it even reduces the expected gains for the primary care services the policy is intended to benefit, because primary care services too would be subjected to the budget neutrality offset, taking away on one hand a portion of the gains provided by the other.

A better way to fund primary care would be to re-define budget-neutrality rules to consider the impact of paying more for primary care on total aggregate Medicare spending, Parts A, B, C and D combined. A portion of anticipated savings in other parts of Medicare (such as from fewer preventable hospital or emergency room admissions associated with care coordination by primary care physicians) could then be applied to fund increased payments for primary care.

To illustrate how much can be saved by creating payment incentives for primary care, a recent study in *The American Journal of Medicine* found that “higher proportions of primary care physicians [in each metropolitan statistical area] were associated with significantly decreased utilization, with each 1 percent increase in the proportion of primary care physicians associated with decreased yearly utilization for an average size metropolitan statistical areas of 503 admissions, 2968 emergency department visits, and 512 surgeries.”<sup>ii</sup> Congress should allow for some of the aggregate savings from reduced utilization associated with primary care to be used to fund payment increases targeted to primary care. Congress should also provide such additional funds as may be necessary to fund appropriate increases in primary care services.

### **D. Eliminate the flawed Sustainable Growth Rate Formula**

Over the past several years, ACP has been urging Congress to reform Medicare’s flawed physician payment formula known as the Sustainable Growth Rate (SGR). This formula has led to scheduled annual cuts in physician payments for the past seven consecutive years. On January 1, 2010 physicians face a 21 percent Medicare payment decrease unless Congress intervenes to avert this cut. This uncertainty in concerning Medicare reimbursement rates makes it nearly impossible for physicians to plan their budgets for their practices.

Since 2002, Congress has stepped in just about every year to enact temporary "patches" to stop the SGR cut, but hasn't come up with a permanent replacement. Rather than accounting for the difference between the lower amount mandated by the SGR, and the higher amount paid out under the patch, Congress assumed that the higher spending will be made up with even an even deeper SGR pay cut the following year. This is why the "patch" for an estimated 5% SGR cut in 2008 resulted in a scheduled 10.5% SGR cut in 2009. And why the patch for the 10.5% SGR cut in 2009 balloons to a scheduled 21% cut in 2010.

The accumulated SGR debt has growth dramatically as a result of this viscous cycle.

In December 2008, the Congressional Budget Office estimated that it would cost CBO \$318 billion over ten years to replace the SGR cuts with a freeze in payments at their current level; and \$439 billion over ten years to replace it with an annual update equal to medical inflation.

President Obama's budget is a marked departure from past practices, because it acknowledges what we all know to be true, which is that preventing pay cuts to doctors will require that Medicare baseline spending be increased accordingly. Accounting for funds needed to reform the flawed SGR payment formula, as the President proposes, could remove the greatest single barrier to reaching a consensus on a long-term solution to the SGR payment cuts. Once the true costs of a long-term SGR fix are accounted for in the budget, Congress and the administration should enact a long-term solution that will permanently eliminate the SGR as a factor in updating payments for physicians' services. Instead, payment updates should provide predictable increases based on the costs to practices of providing care to Medicare patients. This is especially important for physicians in smaller practices, where Medicare payments are not keeping pace with their overhead costs.

#### **E. Improve the accuracy and appropriateness of Medicare relative value units.**

Inaccurate and mis-valued relative value units under the Medicare fee schedule contribute to the under-valuation of primary care services and may create incentives for increased and unwarranted volume. ACP recommends several reforms to improve the accuracy and appropriateness of Medicare RVUs including:

- Requiring that the Secretary study the processes it uses to obtain expert advice on relative value units, and specifically, the adequacy of representation of primary care and other physicians who have expertise in the work associated with treating patients with chronic illnesses.
- Establishing an expert process to identify potentially overvalued or mis-valued services for further review.
- Improving the methodologies used to determine practice expense RVUs, including the equipment utilization assumptions for major imaging services.

#### **Improve the Effectiveness of the Medicare Physicians Quality Reporting Initiative**

The relatively low financial reward for successful PQRI reporting is a barrier to participation. For many physicians, especially those who primarily derive their Medicare revenue from relatively low paid evaluation and management services, the cost of participating exceeds the potential PQRI payment. Basing the PQRI bonus payment on a physician's Medicare

allowed charges not only provides the greatest benefit to those with the highest Medicare revenue, it misses an opportunity to provide a financial incentive to improve care in the clinical areas with the largest gap and/or highest impact. Further, stakeholders need assurance that the quality measures used in the PQRI are valid. There continues to be a need for a process for determining the feasibility of implementation of measures and reporting approaches.

The College believes that physicians should have multiple options for reporting on PQRI quality measures so that they can choose the method best for their practice. We are pleased that CMS allows physicians to report quality data to a registry, an entity that service as a repository of information, that can be shared for PQRI purposes and that the agency is testing direct from EHR reporting. These options, which are available to only a small number of physicians, have great potential to reduce reporting administrative burdens and to assist in improving clinical care. While they continue to evolve, CMS can do more to facilitate the development of these options and making them available for broad use. Structural measures provide another opportunity for physicians to report on their quality improvement activities. We commend CMS for including a structural measure reporting options. However, additional structural measure reporting options should be made available. Development and selection of these measures would be greatly aided by establishing a standard structural measure definition.

The College strongly believes, however, that the significant problems physicians have experienced in their attempt to participate—not qualifying for a bonus they thought they earned, receiving a bonus payment amount less than expected, being unable to access their feedback on the CMS secure website—pose serious challenges to future growth of the program. While we appreciate that CMS issued a December 2008 report on the 2007 PQRI experience and identified solutions to a number of the identified problems, a sustained effort to evaluate and improve the program is essential.

### **Implement Other Delivery System Reforms to Improve Quality and Effectiveness**

In addition to reforms proposed above, the College advocates for the following policies to improve the health care delivery system including:

- Investing in research on the comparative effectiveness of different medical treatments for the same or similar conditions to inform decision-making by the physician and patient at the point of care.
- Redesigning benefits under Medicare, Medicaid and private health plans to cover evidence-based preventive, wellness and screening services.
- Creating incentives for physicians and other clinicians to serve in medically underserved areas and specialties facing imminent shortages, including programs to provide scholarships or loan forgiveness for primary care physicians in facilities or areas of the country facing a critical shortage and increased funding for the National Health Services Corps and Title VII primary care training programs.
- Redesigning Medicare graduate medical education funding to support national workforce goals.

- Establishing a permanent national commission to recommend national goals relating to the numbers and distribution of physicians and other health care professionals, including policies to expand primary care workforce capacity in the United States, policies to achieve such goals, and benchmarks to evaluate the impact of such policies.
- Providing assistance to clinicians, financial as well as support to their practices, to encourage adoption and use certified electronic health records that have the functional capabilities needed to support patient-centered, preventive and coordinated care.
- Research into unwarranted regional variations in the quality and cost of care and best practices to reduce such variations.
- Research into the causes of and solutions to racial, gender, and ethnic disparities in health care.

## **Conclusion**

ACP recommends a two-component process to realize the comprehensive payment reform that will result in better value for health care spending in the United States. The first is to develop, test, and evaluate innovative payment models that align incentives with quality, effective, and efficient care instead of paying on the basis of the volume of services. The second component is to improve the current fee-for-service payment system. We believe that such reforms, combined with improvements in the Physicians Quality Reporting Initiative, research on comparative effectiveness, redesign of benefits to promote prevention and wellness, and creation of a national workforce policy to ensure adequate numbers of primary care physicians and other clinicians facing shortages, would result in major gains in improving the quality, effectiveness and efficiency of care at the same time as coverage is expanded, as we hope it will be, to all Americans.

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i American College of Physicians. How Is A Shortage of Primary Care Physicians Affecting the Quality and Cost of Medical Care? A Comprehensive Evidence Review. October 2008.

ii Kravet, et al, Health Care Utilization and the Proportion of Primary Care Physicians, The American Journal of Medicine, February 5, 2008