

**Comments on the
Senate Finance Committee:
Policy Options for the Health Care Delivery System**

May 15, 2009

The American College of Physicians (ACP), representing 128,000 internists and medical students, appreciates the opportunity to provide comments concerning the Senate Finance Committee's Policy Options for Transforming the Health Care Delivery System. We appreciate your consideration of these policy recommendations and look forward to working with you to improve patient care and reduce health care costs as Congress considers health reform legislation this year. ACP has conducted a review of the following policy options included in the Senate Finance Committee's proposals to transform the health care delivery system. We may have additional comments to share with you early next week following meetings of ACP's two principal public policy committees this weekend.

Primary Care Bonus Payment

Senate Finance Committee Proposal

Certain Medicare providers would be eligible for a primary care services bonus payment. Providers who furnish at least 60 percent of their services in specified ambulatory settings would receive a bonus of at least 5 percent over the fee schedule amount for providing certain evaluation and management services defined as follows: office visits (codes 99201-99215) nursing home visits (codes 99341-99350). The bonus would apply to services furnished to both established and new patients. The provision would be in effect for five years, from January 1, 2010, through December 31, 2014.

ACP Reaction and Recommendations

We very much appreciate that the options paper calls for improved payments for primary care, but our review of the evidence on the impact of earning differentials on specialty choice, and our discussions with our own physician and medical student members, had led us to conclude that a 5 percent increase in payments for evaluation and management codes provided by primary care physicians, although well-intended, will not be effective in influencing more physicians to choose primary care or to sustain those currently in practice. The number of primary care physicians must increase to adequately support the health care reform goal of expanding insurance coverage to most, if not all, Americans. **We recommend the following changes to this proposal:**

1. Establish in law a goal of making annual increases in Medicare payments to primary care physicians competitive in the market, compared to other specialty choices, within five years.

2. Mandate a 10 percent increase in total Medicare payments to primary care physicians in 2010 as the first step toward market competitiveness. (A much larger percentage increase would be required if applied only to evaluation and management codes provided by primary care physicians.)
3. Mandate additional payment increases of at least 5 percent per year in total Medicare payments to primary care physicians in 2011, 12, 13 and 14.
4. Concurrently, require that the Secretary conduct a market analysis of the impact of compensation on specialty choice, and based on such analysis, give the Secretary authority to adjust such annual increases, as described above, to ensure that primary care will be competitive.
5. Such primary care increases should be applied to a positive Medicare baseline over five years that leads to repeal of the SGR as described below.
6. Criteria for determining who should qualify for the increases in 2010, and subsequent years as described above, should be designed to be inclusive of physicians who truly are providing primary care, as evidenced by their specialty (family medicine, general internal medicine, pediatrics) types of services and/or other factors.
7. The above primary care increases should be cumulative and permanent.
8. The Secretary should be required to report to the congressional committees of jurisdiction on an annual basis on the impact of the above payment adjustments, combined with other federal policies to support primary care, in increasing the numbers and proportions of physicians going into and remaining in primary care specialties, and any changes in the payment policies needed should the policies be shown to be ineffective in influencing specialty choice. The Medicare Payment Advisory Commission should be consulted in developing such reports and recommendations.

ACP also believes that other improvements need to be made in the Medicare physician fee schedule and recommends the following additions to the polices proposed in the options paper, including:

1. Require a study of the processes used by HHS to obtain expert input on relative value units, including the adequacy of representation of primary care physicians in such processes.
2. Establish an expert advisory panel to identify potentially over-valued services; any changes resulting from reduction in RVUs for mis-valued services should be redistributed into the physician payment pool.
3. Direct the Secretary to change the equipment utilization assumptions for advanced imaging to more accurately reflect actual utilization rates.
4. Change Medicare fee schedule budget neutrality rules to direct the Secretary to estimate the impact of paying for primary care, prevention and care coordination services in achieving overall savings in Medicare, including in Medicare Parts A and D. Any such anticipated savings should be applied to funding payments for such services, in addition to directing the Secretary to provide additional funding, not limited to anticipated savings, as necessary.

Sustainable Growth Rate

Senate Finance Committee Proposal

The delivery system reform proposal lists two policy options for reforming the Medicare payment formula known as the Sustainable Growth Rate (SGR). The first option would update the fee schedule by 1 percent in 2010 and 2011 and 0 percent in 2012. The update would then revert back to the current law for 2013.

The second option would have the same schedule of updates for 2010-2012 as the first option listed above. However, once the update calculation reverted to current law SGR for 2012, a floor of -3 percent would be in effect. Beginning in 2014, the fee schedule update for localities with 2 year average fee-for-service growth rates at or greater than 110 percent of the national average would have a -6 percent floor.

ACP Reaction and Recommendations

Payment increases for primary care will be ineffective if they are applied to a Medicare baseline that assumes deep cuts in years three and four. Congress should assure that any primary care payment increases over five years are applied to positive baseline updates, leading to repeal of the SGR. **ACP recommends the following:**

1. Provide positive Medicare baseline updates for at least five years, which would serve as the baseline on which additional payments for primary care, as described above, would apply.
2. Sunset the SGR no later than at the conclusion of this five-year time-frame

Long-Term Payment Reforms-Options to Foster Care Coordination and Collaboration

Senate Finance Committee Proposal

The Secretary of HHS would establish at CMS a Chronic Care Management Innovation Center (CMIC) for the purpose of testing and disseminating payment innovations that foster patient centered care coordination for high-cost, chronically ill Medicare beneficiaries. CMIC would be given permanent authority to broadly test care coordination models that show promise of improving the quality and cost effectiveness of care delivered to chronically ill beneficiaries in fee-for-service Medicare.

ACP Reaction and Recommendations

The proposal is largely consistent with the ACP position that Congress provide the Health and Human Services (HHS) Secretary (“the Secretary”) with the authority to conduct voluntary tests of innovative models to better align physician payment to improve quality, cost-effectiveness, and efficient patient-centered care using a fast-track process that allows for widespread adoption of the models that demonstrate success. ACP appreciates that the Secretary would not be

constrained by upfront budget neutrality rules and that cost would be assessed on Medicare system-wide basis.

While the College understands the focus on beneficiaries with multiple chronic conditions, physician interest/ability to participate in an innovative payment model is likely to be proportional to the number of beneficiaries/patients covered by a model. Models that pertain to all or a significant number of beneficiaries/patients, such as we envision for the Patient Centered Medical Home model, will increase the likelihood that physicians will be able to increase their practice capability.

In addition, ACP believes that there is an urgent need to test and broadly disseminate innovative physician payment models that move away from volume-based payments to ones that align payment with value, including models that realign incentives for non-primary care specialists. By limiting the authority of the new Center only to high-cost patients with chronic illnesses, the federal government will be strictly limited in the types of innovations it can support through the Center. ACP has proposed specific criteria for selecting innovative models for widespread testing and dissemination, timelines for reporting on such innovations to Congress, and creating an expert advisory body to assist the Secretary in selecting, evaluating and funding the most promising models. **Accordingly, we recommend several changes to allow for fast-track testing and dissemination of innovative payment models to improve value for patients beyond those with high-cost, multiple chronic diseases:**

1. Expand the charge and authority of the Center to broadly test innovative physician payment reform models that show promise of improving the quality and cost effectiveness of care delivered to Medicare beneficiaries, not limited to high-cost patients with multiple chronic diseases.
2. Establish criteria for prioritizing the selection of models for broad testing and dissemination.
3. Create an expert advisory group to advise the Center on criteria and selection of models for testing.
4. Specify that the Patient-Centered Medical Home will be among the models selected for testing and dissemination.

Payment for Transitional Care Activities

Senate Finance Committee Proposal

Medicare would reimburse physicians for care management activities performed by nurse care managers and others who perform "qualified activities." Physicians could hire a care manager or obtain services on a contract basis. Payment would be made for beneficiaries who have been discharged from the hospital within the past six months after a stay for one of several common clinical conditions. Medicare would pay a "modest" supplemental fee to a primary care physician who sees a beneficiary in the ambulatory setting within 30 days of discharge from a hospital stay for one of the common conditions if the patient is not readmitted within 60 days.

ACP Reaction and Recommendations

ACP policy supports payment policy that rewards quality, care coordination, and efficiency; aligns incentives across settings; and supports transitions. Specifically, the College supports payment to physicians for qualified nurse-provided care management activities in support of patients with a hospital stay in the past six months. The amount of the payment would likely determine the physician's ability to hire or contract with a care manager if the practice does not already have sufficient capability. While ACP understands the focus on beneficiaries with a hospital stay within the past six months, providing care management support payments not limited to those recently admitted would assist in preventing admissions in addition to avoiding readmissions. ACP also supports providing coverage and care management payments for comprehensive geriatric assessments.

ACP recommends the following:

1. The Secretary should be directed to provide payments for proven interventions to prevent hospital admissions, especially for patients with multiple chronic illnesses, in addition to the Senate Finance Committee proposal to pay physicians for post-discharge transitional services.
2. Provide coverage and care management payment for comprehensive geriatric assessments, as proposed in S. 1004, the RE-Aligning Care Act.

Comparative Effectiveness Research

Senate Finance Committee Proposal

The Committee considers several options to establish a long-term or permanent framework to set national priorities for comparative clinical effectiveness research and to provide for the conduct of such research. Comparative clinical effectiveness research compares clinical outcomes of alternative therapies or strategies used to prevent, treat, diagnose, and manage the same condition. The purpose of this type of research is to assist patients and clinicians in making informed health decisions.

One option to support this type of research would be to fund existing HHS entities through annual appropriations. One limitation of this option is that discretionary funding can be inconsistent and unstable. Also the research agenda could be unduly influenced through the political process.

An alternative option, as presented in S. 3408, would be to establish a private, non-profit, corporation that would generate and synthesize evidence on what works in health care through a focus on comparative effectiveness research. As outlined in S. 3408, an independent Institute could be governed by a multi-stakeholders board that would include clinicians, patients, manufacturers, as well as researchers, scientists, and private and public payers. The Board composition should be balanced so that no stakeholder interest dominates.

ACP Reaction and Recommendation

The College strongly supports the establishment of an adequately funded, independent entity, to sponsor and/or produce trusted research on comparative effectiveness. The College believes that the federal government should have a significant role in the funding, implementation, and maintenance of this comparative effectiveness entity, but takes no formal position on the structure of such an entity, and recommends that the entity be protected from undue public and private interference and have a sustainable funding source.

PQRI

Senate Finance Committee Proposal

The Committee is considering two options for extending PQRI incentive payments beyond 2010. The first option would extend the 2 percent physician reporting bonus through 2011 and 2012 (for the 2010 and 2011 reporting periods). In 2013-2014 physicians who failed to participate successfully in the program would face a 2 percent penalty, which would be calculated as 2 percent of their total allowable charges. If the Secretary determines that less than 85 percent of eligible professionals are satisfying the requirement to participate in the program, then the Secretary would increase the penalty by 1 percentage point per year (to a maximum of 5 percent in a single year) until 85 percent of eligible professionals enrolled in the Medicare program comply.

The second option under consideration would be identical to the first option except that the incentive payments would only be available in 2011 (for the 2010 reporting period) and a non-compliance penalty of 1 percent would begin in 2012 (for the 2011 reporting period). The penalties for non compliance in 2012 and 2013 for the previous year's reporting period would remain at 2 percent, and the requirement that the Secretary increase the penalty by 1 percent per year up to a 5 percent CAP until 85 percent of practitioners meet the requirement.

ACP Reaction and Recommendations

ACP supports positive incentives for PQRI participation, but is strongly concerned that the PQRI bonus payment would be replaced by a payment penalty within the next few years. The remaining years of bonus payments maintain the incentive payment at its current 2 percent level. 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 evaluation and management services, the cost of participating often exceeds the potential PQRI payment.

ACP supports the proposal to improve the PQRI program by establishing an appeals process and by providing more timely feedback on participation.

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 serves as a repository of

information, that can be shared for PQRI purposes and that the agency is testing direct from EHR reporting. While it is assumed that these promising options will be available to significantly more than the few who can exercise them, the PQRI experience to-date prompts great skepticism. The significant problems physicians have experienced—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 make a short-term transition to payment penalties a concern. In addition, we note that the payment penalty which could reach a maximum of -5 percent by 2014, would exceed the primary care bonus payment. We also are concerned that physicians who participate in the PQRI would also be penalized with payment cuts if overall physician participation did not meet the specified threshold.

Accordingly, we recommend the following:

1. Congress should continue to provide positive incentives for entry in the PQRI program.
2. Congress should consider increasing the amount of positive incentives available to physicians to ensure that the costs of participating in the program are fully covered.
3. Congress should vary the incentive payments to take into account the degrees of work involved in reporting on the measures applicable to different specialties.
4. Congress should not subject physicians to penalties for individual non-participation or because overall participation falls below a specified threshold.
 - a. Substantial improvements in the PQRI program should be made before any consideration is given to phasing out positive incentives.
 - b. Physicians who participate in the PQRI especially should not be penalized for something outside of their control because total physician participation rates are below a required threshold.

Workforce

Senate Finance Committee Proposal

The Senate Finance Committee has proposed a plan that would establish a re-distribution of currently unused residency training slots as a way to encourage increased training, particularly in the areas of primary care and general surgery. In this proposal, the Centers for Medicare and Medicaid Services would calculate the number of unused resident slots over the last three fiscal years. Unused slots would be defined as the difference between total available resident slots and a hospital's actual FTE of residents. Based on this calculation, 80 percent of unused slots would be included in a pool for redistribution. Rural teaching hospitals with less than 250 beds would be exempt from the redistribution of any other unfilled positions.

The Secretary would be authorized to increase the otherwise applicable resident limit for each qualifying hospital that submits a timely application addressing the criteria below, by such number as determined by the Secretary. Seventy-five percent of new slots would be allocated toward primary care or general surgery residency training positions for at least five years. Teaching hospitals would be allowed to request up to 50 resident FTE positions from the pool of re-distributed slots.

The proposal recommends that the Secretary should be directed to work with external stakeholders to develop and set forth a national workforce strategy that will set the nation on a path toward recruiting, training, and retaining a health workforce that meets our nation's current and future health care needs. The Committee looks forward to working in cooperation with the Senate Committee on Health, Education, Labor, and Pensions to further explore and develop policies in this area.

The Committee is considering ways to provide more flexibility in laws and regulations governing graduate medical education funding in the Medicare program. Proposals being considered include counting time for certain non-patient care activities, such as didactic and scholarly activities in a non-hospital setting for purposes of calculating GME payments, removing current disincentives placed on training programs that rely on volunteer supervisory physicians to provide training in outpatient settings and providing flexibility in the operation of residency programs involving more than one teaching hospital.

ACP Reaction and Recommendation

The federal government should establish a permanent national commission on the health care workforce to provide explicit planning at the federal level by setting specific targets for increasing primary care capacity, including training and retaining more primary care physicians whose training is appropriate for the present and anticipated health care needs of the nation. The Commission should also recommend policies, including changes in graduate medical education funding, to achieve those targets and metrics to evaluate the success of each policy intervention.

As an initial step, ACP recommends that the number of Medicare-funded graduate medical education positions available each year in adult primary care specialties be increased in order to graduate 3,000 additional primary care physicians each year for the next 15 years to meet the nation's anticipated health care needs.

ACP also supports efforts to train physicians in ambulatory care settings and recommends that GME payments should be provided for services provided by residents in training outside the hospital setting. Traditionally, medical education has been inpatient-oriented. Such training rarely provides medical students and residents with opportunities to learn about the vast majority of primary care delivered in ambulatory care settings.

ACP favors and has endorsed the "Resident Physician Shortage Reduction Act of 2009" (H.R. 2251/S. 973). This legislation would increase the number of Medicare-supported training positions for medical residents by 15 percent (approximately 15,000 slots). The training slots would be targeted preferentially to institutions that increase the number of residency positions in primary care, general surgery, and those that train physicians in non-hospital settings. The legislation would also change existing rules to allow residents to be trained in non-hospital settings such as physician offices, community health centers, and other ambulatory care sites. In addition, it would allow communities to continue training residents, supported by Medicare, when teaching hospitals close. The College urges the Senate Finance Committee to use the

provisions in this bill rather than what it has outlined in its options paper. This legislation will have a greater impact on the physician workforce crisis.

Conclusion

ACP appreciates the opportunity to provide our policy recommendations to the Senate Finance Committee concerning its proposal to reform the health care delivery system. As Congress considers health reform legislation in the weeks ahead, we look forward to working with you to improve the quality of health care for providers and patients.