

STATEMENT OF
THE AMERICAN COLLEGE OF PHYSICIANS
TO THE SENATE HEALTH, EDUCATION, LABOR,
AND PENSIONS COMMITTEE

Hearing on “Health Care Coverage and Access: Challenges and Opportunities.”

January 10, 2007

The American College of Physicians (ACP) – representing 120,000 physicians of internal medicine and medical student members – is the largest physician specialty organization in the United States. On behalf of its members, ACP is releasing sweeping new policy recommendations to reform Medicare, Medicaid, S-CHIP, and other programs supported by the federal government to advance patient-centered primary care. Patient-centered primary care is a model of health care delivery that has been proven to result in better quality, more efficient use of resources, reduced utilization, and higher patient satisfaction.

Patient-centered primary care will facilitate the ability of physicians, working in partnership with their patients, to implement a systems-based approach to delivering patient-centered services that have been shown to result in better quality, lower costs, and higher patient satisfaction. It will also avert an impending collapse of primary care medicine by restructuring payment policies to support the value of care provided by a primary care physician. Moreover, patient-centered primary care will extend the benefits of a patient-centered health care system to all Americans by taking immediate steps toward making affordable coverage available to the uninsured and by giving them direct access to patient-centered health care through a medical home.

ACP’s recommendations acknowledge that the State of America’s health care in 2007 is inadequate and that comprehensive reforms are needed to determine how medical care is organized, valued, financed and reimbursed.

America’s health care system is inadequate in the following ways: 1) According to most recent estimates by the U.S. Census, almost 47 million Americans do not have health insurance coverage.¹ The U.S. is the only major industrialized nation in the world that does not provide health insurance coverage to all of its citizens; 2) The uninsured are less likely to have access to regular care by a personal physician, less likely to receive needed and recommended preventative services and medications, and are more likely to succumb to preventable illnesses, more likely to suffer complications from those illnesses, and

¹ U.S. Census Bureau. Health Insurance Coverage 2005. Accessed at <http://www.census.gov/hhes/www/hlthins/hlthin05/hlth05asc.html>

more likely to die prematurely;² 3) Per capita health care expenses are considerably higher in the United States, and consume a higher proportion of the national Gross Domestic Product (GDP) than other industrialized nations;³ 4) Americans receive preventative and other health care less than half of the times recommended by evidence based guidelines⁴ and often receive health care that is unnecessary, excessive, and possibly even harmful;⁵ 5) The United States has a much lower proportion of primary care physicians to specialists than other industrialized nations that score better on measures of cost and quality; pays more for procedures provided by specialists than for evaluation and management services provided by primary care physicians; and enables huge earnings inequities that favor procedural specialists over primary care;⁶ 6) This imbalance between specialty and primary care exists even though dozens of studies show that the availability of patient-centered primary care is positively and consistently associated with better quality, reduced mortality, higher patient satisfaction and lower costs of care.⁷

The problem in primary care is consistently getting worse: as ACP reported in January 2006 in its State of the Nation's Health Care report, the U.S. health care system is facing a collapse of primary care medicine. Very few new physicians are going into primary care and many of those currently in practice are leaving the field or are planning to retire in the near future. These changes are occurring at the same time that demographic trends – an aging population with more chronic conditions – will require more primary care physicians. The result of this collapse of primary care will be higher costs, lower quality, diminished access, and decreased patient satisfaction.⁸

ACP proposes a solution to such inadequacies that would redirect federal health care policy toward supporting patient-centered health care that builds upon the relationship between patients and their primary and principal care physicians and supports the systems needed to achieve better results. This would involve applying systems based models that have been proven to work in other nations' health systems (adapting them to the unique circumstances and needs of the United States) and in successful patient-centered health programs within the U.S.

A patient-centered health care system is one that provides continuous access to a personal primary or principal care physician who accepts responsibility for treating and managing care for the whole patient through an advanced medical home (AMH), also know as a

² Institute of Medicine, *Care without Coverage: Too Little, Too Late*, National Academy Press, 2002

³ Reinhardt U, Hussey P, Anderson G. *U.S. health care spending in an international context*. Health Affairs 2004;23(3): 12-25

⁴ McGlynn, EA et. al *The quality of health care delivered to adults in the United States*. NEJM 2003; 348:2635-2645

⁵ Fisher, E et. al *Avoiding the Unintended Consequences of Growth in Medical Care: How Might More be Worse?*, Journal of the American Medical Association, February 3, 1999; Vol 281, No. 5

⁶ Starfield B, Shi L, and Macinko J., *Contributions of Primary Care to Health Systems and Health*, Millbank Quarterly, 2005;83:457-502

⁷ Barbara Starfield, *The Primary Solution*, Boston Review, November/December 2005, <http://bostonreview.net/BR30.6/starfield.html>

⁸ Thomas Bodenheimer, MD, *Primary Care – Will it Survive?*, New England Journal of Medicine, 355;9, August 31, 2006

patient-centered medical home rather than limiting practice to a single disease condition, organ system, or procedure. A patient-centered health care system also supports the specific characteristics or care that evidence shows results in the best possible outcomes for patients. It recognizes the importance of implementing systems-based approaches that will enable physicians and other clinicians to manage care, in partnership with their patients, and to engage in continuous quality improvement. At the same time, a patient-centered health care system will introduce transparency in consumer decision making and accountability for getting better results. Moreover, this system will create a new financing, reimbursement, and delivery models that support the ability of a physicians and patients to provide and receive patient-centered care. Finally, a patient-centered health care system will assure that all individuals will have access to care through a patient-centered medical home (PC-MH) by providing affordable health insurance coverage to all and creating models that will provide everyone with the option of receiving care through a PC-MH.

More specifically, the Commonwealth Fund has suggested that patient-centered primary care should have most of the following characteristics:

- 1) Superb access to care including ease of making an appointment and email and telephone visits when they are an appropriate substitute for in-person care and electronic prescription refills.
- 2) Patient engagement in care: option for patients to be informed and engaged partners in their care, including a recasting of clinician roles as advisers, with patients or designated surrogates for incapacitated patients serving as the locus of decision making (when desired by patients); information for patients on conditions, treatment options, and treatment plans; clear delineation of roles and responsibilities for patients, caretakers, and clinicians; patients reminders and alerts for routine preventative care or when special follow up is necessary.
- 3) Clinical information systems that support high-quality care, practice-based learning, and quality improvement: registries; monitoring adherence; ease of access to laboratory and diagnostic test results; physicians and patient reminders or alerts; decision support for physicians and patients; information on recommended treatment plans; and longitudinal charts on risk factors, use of services, and outcomes.
- 4) Care coordination: coordination of specialist care, including systems that monitor whether recommended referrals take place; prompt feedback of specialist consultation reports to primary care physicians and patients; information about the availability and quality of specialty services and community resources; systems to prevent errors that occur when multiple physicians or sites are involved in care; post-hospital follow up and support; tracking of tests, test results, procedures, and the filling of prescriptions to monitor patient adherence to mutually agreed-upon diagnostic and treatment plans; and communication among health care providers who care for a patient, but do so in different geographic locations or at different times.

- 5) Integrated, comprehensive care and smooth information transfer across a fixed or virtual team of providers: including physicians, advanced practice nurses, nurses, and others as needed (i.e.: social workers, nutritionists, health educators, exercise physiologists, and behavioral health specialists), and elimination of information and testing.
- 6) Ongoing and routine patient feedback to a practice: using, for example, low-cost, internet-based, patient-centered care surveys, leading to targeted plans for practice improvement. Such surveys following a patient encounter or episode of care could be used by the physician or practice to understand what went right or wrong from the perspective of the patient and suggest opportunities for improvement.
- 7) Publicly available information on practices; information by which a patient could choose a physician or practice most likely to meet the patient's needs.⁹

Many U.S. physicians already are providing some of the characteristics of patient centered care, but few provide all of them.¹⁰ In comparison, many other industrialized countries have made a deliberate policy decision to build their health care systems around patient-centered care, and physicians in those countries are far more likely to report that they have all or most of the characteristics associated with patient-centered care.¹¹

A principal reason why the United States does not consistently deliver patient-centered care is that payment systems used by the Centers for Medicaid and Medicare Services (CMS) and most private payers reward physicians for the volume of procedures generated and the number of office visits performed, rather than for ongoing continuous and longitudinal management of the patients' whole health, supported by systems-based practice improvements that lead to better results.

There is substantial and growing evidence that a health care system built upon a foundation of patient-centered primary care will improve outcomes, result in more efficient use of resources, and accelerate systems-based improvements in physician practices. According to an analysis by the Center for Evaluative Clinical Sciences at Dartmouth, states that have relied more on primary care have lower Medicare spending (inpatient reimbursements and Part B payments), lower resource inputs, lower utilization rates, and better quality of care.

Starfield's review of dozens of studies on primary-care oriented health systems found that primary care is consistently associated with better health outcomes, lower costs, and

⁹ Davis, Karen, Schoenbaum, Stephen C. & Audet, Anne-Marie. A 2020 Vision of Patient-Centered Primary Care. *Journal of General Internal Medicine* 2005;20: 953-957

¹⁰ Audet, Anne-Marie, Davis, Karen, & Schoenbaum, Stephen C. Adoption of Patient-Centered Care Practices by Physicians. *Archives of Internal Medicine*. 2006;166:754-759

¹¹ Schoen C, Osborn R et. al. On the Front Lines: Primary Care Office System's, Experiences and Views in 7 Countries. *Health Affairs* 2006;25: w555-w571.

greater equity in care. Primary-care oriented countries such as Australia, Canada, New Zealand, and the United Kingdom rate higher than the United States on many aspects of care, including the public's view of the health care system not needing completely rebuilding, finding that physicians' advice is helpful, and coordination of care. "The United States rates the poorest on all aspects of experienced care, including access, person-focused care over time, unnecessary tests, polypharmacy, adverse effects, and rating of medical care received." However, in the United States, adults with a primary care physician rather than a specialist, had 33 percent lower cost of care and 19 percent less likely to die. It is important to also note that the supply of primary care physicians is consistently associated with improved health outcomes for conditions like cancer, heart disease, stroke, infant mortality, low birth weight, life expectancy, and self-rated care. In both England and the United States, each additional primary care physician per 10,000 people is associated with a decrease in mortality rates of 3 to 10 percent. Specifically in the United States, an increase of one primary care physician is associated with 1.44 fewer deaths per 10,000 people, and the association of primary care with decreased mortality is greater in the African American population than in the white population.¹²

Another analysis found that when care is managed effectively in the ambulatory setting by primary care physicians, patients with chronic diseases like diabetes, congestive heart failure, and adult asthma have fewer complications thus leading to fewer avoidable hospitalizations.¹³

Patient-centered primary care will also accelerate the transformation of physician practices by making the business case for physicians, including those in small practice settings, to acquire and implement health information technologies and other systems-based improvements that contribute to better outcomes. Yet authors of a recent survey found that a "gap exists between knowledge and practice – between physicians' endorsement of patient-centered care and their adoption of practices to promote it. Physicians reported several barriers to their adoption of patient-centered practices, including lack of training and knowledge and costs. Education, professional and technical assistance, and financial incentives might facilitate broader adoption of patient-centered care practices. With the right knowledge, tools, and practice environment, and in partnership with their patients, physicians should be well positioned to provide the services and care that their patients want and have the right to expect."¹⁴

In ACP's new position paper, "*A System in Need of Change: Restructuring Payment Policies to Support Patient-Centered Care*," the College proposes that the federal government take the lead in restructuring payment policies to achieve patient-centered health care. The College's recommendations would transition Medicare from paying doctors solely on the number of procedures or visits generated to paying them for providing patient-centered health care. The College also proposes a pathway for

¹² Starfield, presentation to The Commonwealth Fund, Primary Care Roundtable: Strengthening Adult Primary Care: Models and Policy Options, October 3, 2006

¹³ Commonwealth Fund, Chartbook on Medicare, 2006

¹⁴ Commonwealth Fund study, "[Adoption of Patient-Centered Care Practices by Physicians: Results from a National Survey](#)" (*Archives of Internal Medicine*, April 10, 2006)

eliminating automatic cuts in payments generated by the flawed Sustainable Growth Rate, or SGR, formula, because continued SGR payment cuts will make it impossible for physicians to invest the resources in the systems required to provide patient-centered care, accelerate the collapse of primary care medicine and result in severe limitations on access to care for Medicare beneficiaries. ACP proposes the following payment reforms to support patient-centered care:

1. Institute a multi-component payment structure that facilitates more effective and efficient care delivery for patients through the Patient-Centered Medical Home that would include:

- A bundled and prospective payment component that would include all of the physician work associated with coordinating care that is not included in payments for face-to-face visits, such as arranging care with other health professionals and family-caregivers and following up with patients on self-management plans. *Bundled* means that the payment would include a defined package of services related to care coordination rather than billing for such services on an a la carte basis. *Prospective* means that the payment would be made on a regularly scheduled timetable, such as monthly, for each patient who receives care in the patient-centered medical home without necessitating that the physician generate a bill for a specific procedure or visit.
- A bundled and prospective payment component that provides sustained funding for the systems needed for a physician practice to deliver patient-centered care, such as patient-registry systems, evidence-based clinical decision support at the point of care, computerized order entry and e-prescribing systems, secure email, and electronic health records that have the functionalities required to provide patient-centered care.
- Risk-adjustment of the prospective bundled payment to account for differences in the health status, disease conditions, chronic illnesses, and severity of illness of the patient population seen by physicians in a patient-centered medical home.
- A fee-for-service visit component that would allow physicians to continue to bill for face-to-face encounters with patients.
- A performance-based component that provides additional bonus payments based on reporting of evidence-based quality, cost of care, and patient satisfaction measures.

This payment structure would:

- Recognize the value of the time and work required of physicians and their staffs to manage and coordinate the care of patients, rather than paying them only for the work involved in providing a face-to-face visit or procedure.
- Accelerate practice transformation by providing sustained funding to support the ability of physicians to acquire and use health information technology and other systems-based tools needed to provide patient-centered care; such expenses are not currently supported by Medicare payment policies.
- Be risk-adjusted to create a strong incentive for physicians to accept responsibility for providing patient-centered care to patients' with multiple chronic illnesses.
- Combine the prospective payment structure with fee-for-service payments for face-to-face visits to assure that physicians will continue to see patients in their offices, unlike traditional capitation models that created disincentives for physicians to see patients. This "hybrid" system of prospective bundled payment and FFS payments has been implemented successfully in countries like Denmark that have patient centered health care systems.¹⁵

The following example illustrates how ACP's new bundles payment structure would work in an internal medicine practice:

Dr. Smith is an internist in a four person internal medicine practice in Des Moines, Iowa. Her practice has demonstrated, through an independent review process, the necessary characteristics required to be qualified as a patient-centered medical home. To assist the physicians in providing patient-centered care, the practice recently implemented a software patient registry program to allow them to track the care provided to patients by medical condition. It also has established a secure email consultation service that generates "reminders," based on evidence based guidelines, on steps that patients can take to improve or maintain their own health as part of an integrated self-management plan that Dr. Smith developed in partnership with each patient.

Fifty percent of the practice's patients are Medicare enrollees who have selected the practice as their medical home, and 10 percent of those patients have four or more chronic conditions, like diabetes, congestive heart failure, and asthma. Medicare would pay Dr. Smith a baseline monthly "care coordination" payment that includes the value of the time that she and her colleagues spend coordinating care outside of the face to face visits. The prospective payment also includes an allowance for the costs incurred by the practice in acquiring and sustaining the patient-registry software and the secure email service. The baseline payment would be increased for those Medicare patients who have multiple chronic diseases.

¹⁵ Karen Davis, PhD, Stephen C. Schoenbaum, MD, and Anne-Marie Audet, MD, *A 2020 Vision of Patient-Centered Primary Care*, Journal of General Internal Medicine, October 2005; 20(10): 953-957

The secure email program allows Dr. Smith to communicate with patients after regular hours on non-urgent medical issues, and to generate secured email reminders to them that follow up on recommended treatment plans. This reduces the number of times that patients have come into the office to see Dr. Smith and her colleagues. This frees up time so that when patients do need to be seen in her office, Dr. Smith is able to spend more time with them. She bills Medicare on a fee-for-service basis for the office visits using existing codes and relative value units.

Dr. Smith's practice also regularly reports on its performance using evidence based measures for primary care that have been approved by the National Quality Forum and the AQA, multi-stakeholder bodies that respectively endorse and implement quality measures based on criteria that have been broadly accepted by physicians, health plans, employers, and consumers. At the end of the calendar year, Dr. Smith's practice receives a Medicare bonus payment based on excellent performance and measures.

2. Make changes within the resource-based relative value scale (RBRVS) system to improve accuracy of work and practice expense relative values, support physician-directed care coordination, provide an incentive for the adoption of health information technology linked to quality improvement efforts, and provide incentives for physicians to participate in programs to continuously improve, measure and report on the quality and cost of the care provided. Medicare should specifically allow for separate "care coordination" procedure codes and relative value units that would allow physicians in practices that have not been recognized as qualified patient-centered medical homes to bill for care coordination on a retrospective, fee-for-service basis with appropriate documentation of the work involved.
3. Enact legislation to provide an "add on" to the Medicare office visit fee for small physician practices when it is supported by a certified electronic health record that has the functional capabilities needed to provide patient-centered care and to measure and report on the quality of care provided, as proposed in bipartisan legislation introduced in the 109th Congress called the National Health Information Incentive Act. (This "add on" would not apply to physician practices that qualify as patient-centered medical homes because such practices would be reimbursed on a prospective basis for the systems improvements needed to deliver patient-centered care).
4. Replace the Sustainable Growth Rate (SGR) Formula with a new methodology that will provide positive and predictable baseline payments and create powerful incentives for physicians to design, implement and participate in programs to improve quality and achieve more efficient use of resources:
 - The College proposes a transitional pathway to eliminate the SGR that will culminate in a stable and predictable methodology for updating physician payments and create a strong incentive for physicians to participate voluntarily in a Medicare pay-for-reporting program. During the transition period, changes would be made in the transitional program pay-for-reporting

program now being instituted by Medicare to provide greater bonus payments to physicians who acquire the systems needed to deliver patient-centered care and who do more to improve quality, rather than a “one size fits all” program that pays all physicians the same amount for reporting a few measures, regardless of the impact of those measures on improving patient care.

- At the end of the transition, the SGR would be replaced with a new update system that would have three components:
 - A baseline physician payment update that takes into account the costs of delivering care, beneficiary access to services, workforce and other data on trends that may affect access and quality.
 - A separate pool of funds that would be set aside to fund qualified physicians’ quality improvement programs that have the greatest potential to achieve quality improvements and cost efficiencies for the Medicare population, including programs that are designed to support patient-centered care.
 - Performance payments to physicians would be paid on a weighted basis to physicians who agree to participate in the quality improvement programs funded by the pool.
 - This physician payment quality improvement pool would be funded in part by system-wide Medicare savings that are attributable to quality improvement programs funded out of the pool. For example, the pool could fund programs that reward physicians for helping to keep patients with multiple chronic diseases out of the hospital. A portion of Medicare Part A savings would then be redistributed back into the physician performance pool.
 - “Weighted” payments mean that physicians who successfully participate in programs that have the greatest impact on quality and cost would receive greater bonus payments than those who do not participate, or who participate in programs that will have a lesser impact on quality and cost. This is fundamentally different from the current “one size fits all” transitional Medicare pay-for-reporting program, which will pay physicians the same percentage bonus payment for as few as three measures regardless of the impact of the measures on improving quality and reducing costs.
 - A process that would direct the Medicare Payment Advisory Commission to consider making formal recommendations to

Congress on discretionary bonus payments to achieve specific policy objectives, such as increasing the supply of primary care physicians.

The benefits of a patient-centered health care system should not be limited only to those who currently have health insurance coverage. The 47 million Americans who now lack health insurance coverage are much less likely to have a regular source of care, never mind having access to physician practices that are organized to provide patient-centered primary care. The College believes that immediate steps must be taken to expand health insurance coverage, with the goal of providing coverage to all Americans. Proposals to expand health insurance coverage should also assure that patients have access to a core set of benefits that includes preventive and primary care services and other services associated with patient-centered care. In addition, proposals to expand coverage should provide funding and incentives to assure that all patients will have access to care through a patient-centered medical home. To accomplish this goal, the College proposes that Congress:

1. Provide dedicated federal funds to support state-based programs that will reduce the number of uninsured and provide access to services through patient-centered medical homes.
2. Provide waivers to states that wish to redesign their Medicaid and S-CHIP programs to give enrollees access to services through a patient-centered medical home including changes in reimbursement policy to support PC-MHs.
3. Enact federal legislation to implement a step-by-step plan to provide health insurance coverage to all Americans by a defined date through changes in federal entitlement programs, tax credits and other subsidies to allow low-income working Americans to buy into the Federal Employees Health Benefit Program, and insurance market reforms.

Translating the College's proposals for redesigning American health into action will require Congress, the Centers for Medicare and Medicaid Services, employers, and health plans take immediate steps to create pathways for building and implementing patient-centered changes through U.S. health care. The federal government has a particular responsibility to use its enormous purchasing authority to drive the systems changes needed to support patient-centered care.

ACP's policy proposal for implementation of legislative action to accelerate and advance patient centered care would include the following:

1. Expanding the new Medicare demonstration of patient-centered care.
2. Redesigning the voluntary Medicare physician pay-for-reporting program to emphasize systems-based approaches to delivering patient-centered care and to vary payments based on the impact of the systems and processes being measured and the practice expenses associated with obtaining the tools required.

3. Creating additional reimbursement incentives for physician-directed care coordination and systems improvements that lead to better care.
4. Replacing the SGR with a new payment methodology that would provide predictable and positive baseline payments, emphasize systems-based approaches to improving quality and reducing costs, provide dedicated funding for quality improvement programs that will have the greatest impact on quality and cost, and allow physicians to share in non-Part B program savings associated with better care management in the ambulatory setting.
5. Providing states with dedicated funding and increased flexibility to expand coverage and redesign Medicaid and S-CHIP around the patient-centered medical home.
6. Expanding health insurance coverage through a combination of public and private funding resources.

President Bush and the 110th Congress have an historic opportunity to join with the College, other physician organizations, employers, and health plans to redesign the American health care system to deliver the care that patients need and want, to recognize the value of care that is managed by a patients' personal physician, to support the value of primary care medicine in improving outcomes, and to create the systems needed to help physicians deliver the best possible care to patients. The College's policy recommendations and implementation roadmap are offered as a comprehensive plan for achieving a high quality, affordable, and patient-centered health care system for all Americans.