



Statement for the Record

American College of Physicians

Hearing before the House Energy & Commerce Subcommittee on Health

“The Need to Move Beyond the SGR”

May 5, 2011

The American College of Physicians (ACP) applauds Chairman Upton and Ranking Member Waxman for holding this hearing and for the committee’s bipartisan request for ideas on how to move to a new Medicare payment system that “reduces spending, pays physicians fairly, and pays for services according to their value to the beneficiary.” ACP is pleased to provide this statement, which outlines its proposal for stabilizing, improving, and innovating Medicare payment policies that will lead to broad adoption of new value-based payment models.

ACP is the largest medical specialty society and second largest physician membership organization in the United States, representing 130,000 internal medicine physicians who specialize in primary and comprehensive care of adolescents and adults and medical students who are considering a career in internal medicine.

The Flawed Sustainable Growth Rate (SGR) Formula

ACP has long-advocated that the SGR formula needs to be repealed and replaced with positive, predictable and permanent payment updates. While the SGR produces/threatens annual Medicare payment cuts that harm all physicians, the adverse impact on internal medicine practices can be devastating. With the dark cloud of the SGR hanging over their heads, these practices are not only unable to invest in the capability to enhance care coordination; they struggle to even keep their doors open to patients.

Every year since 2001, the current, fatally flawed SGR formula has threatened to impose steep cuts in Medicare physician fee schedule payments for care provided to America’s seniors. While Congress typically acts to avert payment reductions, the average Medicare payment rate this year is essentially the same as it was in 2001. By consistently postponing the cuts, Congress has dug a hole that has resulted in an estimated 30 percent scheduled cut in January, 2012. The current cost to dig out of this hole has grown to hundreds of billions of dollars.

Unless Congress acts to fix this flawed payment formula, doctors will face a projected cut of more than 29 percent on January 1 and cuts up to 40 percent in the coming decade. With practice costs increasing 20 percent over this period, cuts of this magnitude will create an access crisis for Medicare patients.

The Value of Primary Care

The demand for primary care in the United States is expected to grow at a rapid rate while the nation's supply of primary care physicians for adults is dwindling and interest by U.S. medical school graduates in pursuing careers in primary care specialties is steadily declining. Primary care physicians provide 52 percent of all ambulatory care visits, 80 percent of patient visits for hypertension, and 69 percent of visits for both chronic obstructive pulmonary disease and diabetes, yet they comprise only one-third of the U.S. physician workforce, and if current trends continue, fewer than one out of five physicians will be in an adult primary care specialty. There are **over 100 studies that show primary care is associated with better outcomes and lower costs of care**

(http://www.acponline.org/advocacy/where_we_stand/policy/primary_shortage.pdf).

According to a study published in the April 25, 2011 issue of *Archives of Internal Medicine*, only 2 percent of fourth year medical students plan to work in general internal medicine, compared to 9 percent in 1990. The number of third-year internal medicine residents choosing to pursue a career in an internal medicine subspecialty or other specialties has risen each year for the past eight years, while the percentage choosing careers in general internal medicine has steadily declined. In 2010, only 23 percent of third-year internal medicine residents intended to pursue careers in general internal medicine, down from 54 percent in 1998. Even more disheartening, only 17 percent of first-year internal medicine residents intend to pursue general internal medicine. While the 2011 match rate for both internal medicine and family medicine increased slightly for the second year in a row, these new physicians are only a fraction of what is needed to treat the population.

The Institute of Medicine (IOM) reports that it would take 16,261 additional primary care physicians to meet the need in currently underserved areas, prior to the enactment of the Affordable Care Act (ACA). The Association of American Medical Colleges (AAMC) estimates that there will be a shortage of 124,000 physicians by 2025. Primary care accounts for 37 percent of the total projected shortage in 2025—about 46,000 FTE primary care physicians. These findings are consistent with recently published projections by researchers from the University of Missouri and the Health Resources Services Administration. The study also predicted that population growth and aging will increase family physicians' and general internists' workloads by 29 percent between 2005 and 2025. **Error! Bookmark not defined.** Since its initial analysis, AAMC estimated that universal health care coverage will add to overall demand for doctors and increase the projected shortfall by an additional 25 percent. The ACA will increase coverage by an estimated 32 million Americans. This will have a significant impact on the health care workforce, particularly, primary care physicians, who the newly insured will seek to coordinate and manage their care.

Summary of ACP's Physician Payment Proposal

The College proposes a two-stage process that is intended to lead to a permanent replacement of the current flawed Medicare payment system, including the SGR, and, in so doing, recognizes the value of primary and comprehensive care provided by internists and other medical specialists and provides stability in payments for all specialties. During the first stage, Medicare would stabilize and improve payments under the current Medicare fee schedule for the next five years by eliminating the sustainable growth rate (SGR) as a factor in establishing annual updates and by ensuring higher payments and protection from budget neutrality cuts for undervalued evaluation and management services. Also, during this stage, physicians who voluntarily participate in specific, designated Physician Payment Innovation Initiatives—including Patient-Centered Medical Homes, Accountable Care Organizations, and other models that meet suggested criteria for value to patients—could qualify for appropriately higher payments. Then, during stage 2, physicians would be given a set timetable to transition their practices to the models that Congress and the Department of Health & Human Services (HHS) has determined to be most effective based on experience with the payment initiatives evaluated during stage 1, leading to permanent replacements to the existing Medicare payment system. An important feature of the ACP proposal is that we recommend the development of different payment initiatives for different specialties and types of practice, rather than a “one-size-fits-all” model for all physicians.

Stage One: Stabilize, Improve and Innovate (CY 2012-16)

A. Stabilize and *improve* current Medicare payment system:

1. Enact legislation this year to eliminate the SGR as a factor in determining updates and to establish the annual conversion factor (CF) updates in advance for the next five years so that no services would experience CF cuts in calendar years 2012 through 2016. By setting the CF updates now by statute for each of the following five years, Congress will ensure an essential period of stability to help ensure beneficiary access to care and allow for innovation and transition to new payment models.
2. In addition, undervalued evaluation and management services (E/M), consisting of office, nursing home, home, custodial care, preventive and wellness visits, emergency room, and hospital visits, would receive higher payments and be protected from budget-neutrality cuts.
 - a. Set the annual update for non-E/M services at no less than zero percent and E/M services at no less than 2.0 percent in calendar years 2012 through 2016.
 - b. Require that any budget neutrality reductions *resulting from RVU or volume increases in other non-E/M categories of services* be applied only to such non-E/M HCPCS codes. Overall budget-neutrality within the Medicare physician fee schedule would be maintained.
 - c. Continue the Medicare primary care bonus program. This program provides for a 10 percent increase in payments for designated

- primary care services provided by internists, family physicians, geriatricians and pediatricians.
- d. Continue the Electronic Health Records (EHR) Incentive Program, which will provide physicians with increased Medicare and Medicaid payments for adopting certified health information systems that meet “meaningful use” criteria.
 - e. Continue the Medicaid primary care pay parity program for at least the entire five years of stage 1. This program requires and provides funding to the states to reimburse primary care physicians at no less than the Medicare rates for E/M services and immunizations.

Rationale: a five-year period of stability is needed to preserve beneficiary access and allow for broad testing and adoption of new payment models. Higher updates for E/M services would support the long-standing and bipartisan policy objectives of attracting and retaining more primary care physicians into the workforce to avert a growing shortage and to address long-standing inequities in payments between “E/M” and “non-E/M” services. The undervaluation of E/M services also acts as a barrier to physicians spending sufficient time with patients. In addition, E/M services have experienced lower volume growth than many other categories of services, yet they are penalized when budget neutrality adjustments resulting from Relative Value Units (RVU) and volume increases in other categories are applied across-the-board to all services. As the Medicare Payment Advisory Commission (MedPAC) noted in a June 2008 study, http://www.medpac.gov/chapters/Jun08_Ch02.pdf, “primary care services—which rely heavily on cognitive activities such as patient evaluation and management (E&M)—are undervalued and they risk being underprovided relative to procedurally-based services. Indeed, the share of U.S. medical school graduates entering primary care residency programs has declined over the last decade, and internal medicine residents are increasingly choosing to subspecialize rather than practice as generalists.”

Physicians who principally provide E/M services should not be subjected to cuts due to volume and RVU increases for services they do not provide. The Medicare primary care bonus program and the Medicaid pay parity program, both of which provide an important incentive to recruit and retain primary care physicians as Medicare and Medicaid transition to new payment systems for primary care, should be maintained. Since electronic health records will be an important tool for practices to participate in new payment models, Congress also should maintain the existing EHR incentives programs.

3. Improve the accuracy of relative value units (RVUs):
 - a. Ensure that HHS uses its existing authority to ensure the accuracy of RVUs, using both new and existing processes, including

requiring HHS to convene an independent expert panel to identify potentially mis-valued RVUs, as recommended by MedPAC. This expert panel would supplement but not replace the RVS Update Committee (RUC).

- b. Provide for automatic reviews of RVUs that may have experienced changes over time in the work involved, based on factors such as changes in length of stay, as recommended by MedPAC.
- c. Any reductions in RVUs resulting from such review should be redistributed to all other RVUs for physician services, E/M as well as non E/M services.

Rationale: the current Medicare fee schedule undervalues E/M services and over-values other services. MedPAC has recommended improvements in the processes used by CMS to determine RVUs and current federal law requires that HHS use new and existing processes to assess the accuracy of RVUs.

MedPAC recommended improvements to the process for reviewing the relative value of physician services in its June 2006 report, http://www.medpac.gov/publications/congressional_reports/Mar06_Ch03.pdf These recommendations sought to address concerns that cognitive services—mainly E&M services—were being devalued over time. MedPAC recommended, among other things, that the secretary of HHS should establish a standing panel of experts to help CMS identify overvalued services and to review recommendations from the RUC. The secretary, in consultation with the expert panel, should initiate the five-year review of services that have experienced substantial changes in length of stay, site of service, volume, practice expense, and other factors that may indicate changes in physician work. This is significant because mis-valued services distort incentives and may result in the overuse or underuse of specific services on the basis of financial, as opposed to clinical, reasons. Inappropriate valuation of services also affects physicians' decisions to enter or remain in specialty fields that perform undervalued services. Refining the RBRVS remains crucial until new payment models are designed and implemented on a widespread basis. Innovative payment models are likely to be tested, and even models that dramatically change incentives may still, at least in part, be based on current fee-for-service payment rates that are built by RVUs. In addition, Medicare can make payment policy changes within the context of the RBRVS to facilitate a transition to models of care that focus more explicitly on improving care coordination.

- B. During stage 1, accelerate development and voluntary adoption of innovative models aligned with value to later serve as the basis for permanent replacement of the current payment system.

1. During stage 1, physicians who voluntarily and successfully participate in one or more designated *Physician Payment Innovation Initiatives (PPIIs)*, as described below, would be paid outside of the current Medicare physician fee schedule as modified above—that is, they would have the opportunity to earn additional payments by successfully participating in a designated PPII.
2. A designated PPII would be an initiative that the Secretary of HHS, hereafter referred to as the Secretary, with the advice of MedPAC, has determined offers the potential of improving value for beneficiaries by aligning better outcomes and effective care. In determining models that might qualify as a designated PPII, the Secretary, with advice from MedPAC, would give priority to models that have the greatest potential to achieve the following deliverables:
 - a. Reduce prevalence of chronic diseases including incentives for prevention
 - b. Reduce unnecessary, marginal and ineffective care and promote shared clinical decision-making based on evidence of effectiveness including research undertaken or initiated by the Patient-Centered Outcomes Research Institute, and considering initiatives by physician membership organizations to help physicians provide the best care possible, such as ACP’s High Value, Cost Conscious Care Initiative, www.acponline.org/clinical_information/resources/hvccc.htm¹
 - c. Improve care coordination across clinical settings and specialties
 - d. Recognize and support the value of care provided by primary and comprehensive care physicians and create incentives for physicians to go into primary and comprehensive care specialties and other specialties facing shortages
 - e. Recognize and support the value of physicians spending time with patients

¹ ACP launched the clinical component of its High Value, Cost-Conscious Health Care initiative with the publication of “[High-Value, Cost-Conscious Health Care: Concepts for Clinicians to Evaluate the Benefits, Harms, and Costs of Medical Interventions](#)” in the February 1, 2011, issue of *Annals of Internal Medicine*. In the paper, ACP explains the purpose of the initiative: to help physicians and patients understand the benefits, harms, and costs of an intervention and whether it provides good value, and to slow the unsustainable rate of health care costs while preserving high-value, high-quality care. [Diagnostic Imaging for Low Back Pain](#) is the first clinical topic addressed by ACP. In a paper also published in the February 1 issue of *Annals*, ACP found strong evidence that routine imaging for low back pain with X-ray or advanced imaging methods such as CT scans or MRIs does not improve the health of patients.

- f. Recognize and support the value of care provided outside of a face-to-face clinical encounter
- g. Promote patient-centered care including timely access to services, having an on-going relationship with a primary care physician, objective evaluation of patients' experience with the care provided, continuous improvement, and patient participation in clinical decision-making
- h. Support physician-directed team-based care
- i. Allow for shared savings and elimination of Medicare payment "silos" between Medicare Parts A and B
- j. Reduce administrative burdens for physicians who successfully participate in the new models
- k. Provide for competition and transparency in pricing and quality of services to empower consumers/patients to choose the physicians and treatments most appropriate for them
- l. Create incentives for patients to share in the responsibility to achieve better health and clinical outcomes
- m. Allow practices of varying sizes, including smaller independent practices, to effectively participate
- n. Support the sharing of information on utilization and expenditure data by geographic area to encourage local and regional collaboration on quality improvement and cost-constraint projects
- o. Improve outcomes, effective use of medical resources, and patient experience with the care provided

Rationale: the potential deliverables recommended above would provide necessary direction from Congress to the Secretary on the types of models that should be broadly tested during the "stability and innovation" phase to achieve the Energy and Commerce Committee's goal to "move to a system that reduces spending, pays providers fairly, and pays for services according to their value to the beneficiary"

3. In designating PPIIs, the Secretary, with the advice of MedPAC, will give particular consideration to innovative payment and delivery models recommended and funded by the Center for Medicare and Medicaid Innovation (CMMI).

Rationale: the CMMI already has dedicated funding to support innovative payment and delivery models, including models to improve primary care, without the limitations (such as requiring that all demonstrations be budget neutral) in the usual agency demonstration authority. Congress should preserve the dedicated funding for the CMMI and the Secretary should build upon the work of the CMMI in selecting the most promising models to be designated as PPIIs.

4. The Secretary shall ensure that the designated PPIIs include, but not necessarily be limited to, the following models:
- a. Qualified Patient-Centered Medical Homes (PCMHs)/Advanced Primary Care Initiatives with one of the following payment methodologies.
 - a. *Hybrid*: a weighted combination of fee-for-service for E/M codes based on the existing Medicare fee schedule (MFS) as improved above; per patient-per-month risk adjusted prospective payments for care coordination services; pay-for-reporting/achieving value benchmarks including clinical outcomes and patients' experience with the care provided; and shared savings for reducing combined Part A and B expenses below baselines projections.
 - b. *Global payment*: partial or total risk-adjusted per patient per month prospective payment with shared savings and performance/value bonuses.
 - b. Accountable Care Organizations (ACOs) with fee-for-service (FFS) payments and shared savings.
 - i. It is essential that at least one of the designated PPIIs be an ACO model that allows for effective participation of smaller, independent primary care practices.
 - ii. CMS's proposed ACO rule will need to be modified to remove barriers to participation by smaller practices and/or Congress and CMS will need to authorize other ACO models that would be more suitable for successful participation by smaller practices.
 - c. Bundled payments as authorized under current law.

Rationale: PCMHs already are being testing in multiple sites around the country and have produced promising results on their ability to improve value. In a November 2010 study by the Patient-Centered Primary Care Collaborative (PCPCC), a PCMH project at Group Health Cooperative of Puget Sound, in Washington State, has achieved a \$10 per patient per month (PMPM) reduction in total costs, a 16 percent reduction in hospital admissions, and a \$14 PMPM reduction in inpatient hospital costs relative to the controls. Private payer initiatives have also achieved similar successes. For example, a Blue Cross Blue Shield PCMH project in North Dakota saw hospital admissions decrease by 6 percent and emergency department visits decrease by 24 percent in the PCMH group from 2003 to 2005, while increasing by 45 percent and 3 percent, respectively, in their control group. Medicaid-sponsored PCMH programs have been successful at reducing costs as well. In North Carolina, through

their Community Care program, they have achieved a cumulative savings of \$974.5 million over 6 years (2003-2008), a 40 percent decrease in hospitalizations for asthma, and a 16 percent lower emergency department visit rate. The PCPCC study can be found at: http://www.pcpcc.net/files/evidence_outcomes_in_pcmh.pdf.

Congress first mandated in 2006 that CMS initiate a Medicare Medical Home Demonstration project; however that specific project will no longer be pursued by CMS due to other Medicare PCMH initiatives, such as the Advanced Primary Care Multi-payer demonstration, the Federally Qualified Health Centers Advanced Primary Care Practice Demonstration, and additional planned PCMH projects under the new CMMI. ACOs and bundled payments also have been identified as potentially promising models, and existing law calls for implementation of both. CMS's proposed ACO rule, although having many positive elements, falls short of reducing the barriers to smaller, independent practices effectively participating in an ACO. Given the fact that most care to Medicare beneficiaries is provided by smaller practices, it is essential that ACOs and other payment reforms allow for the successful participation of practices of all sizes.

5. In selecting additional designated PPIIs, the Secretary, with the advice of MedPAC, shall consider different payment models that may be more applicable to different types of physician practices, specialties, and systems of care, including payment methodology or methodologies that are suitable for:
 - a. General internists, family physicians, internal medicine subspecialists, geriatricians and other physician specialists and their teams who are principally engaged in providing comprehensive and longitudinal primary, preventive and comprehensive care, including medical subspecialists who take over the role of the primary physician while caring for a patient for a prolonged episode of treatment.
 - b. Medical subspecialists who principally provide diagnostic and treatment on a consultative or episodic basis.
 - c. Surgical specialists and their teams who principally provide surgical interventions and treatment on an episodic basis.
 - d. Physicians and their teams who are principally involved in providing diagnostic evaluations on imaging and laboratory testing on an episodic basis.
 - e. Physicians and their teams who are principally involved in providing anesthesia services on an episodic basis.
 - f. Physicians who practice principally in a hospital setting including hospitalists.
 - g. Physicians in solo or small group practices as well as medium to larger group practices.

Rationale: There is no “one-size-fits-all” payment model that will be effective for every specialty and type of practice. The goals should be to develop and test different payments models that are most appropriate for each.

Stage Two: Evaluate and decide on the models that will be approved for broad adoption in Medicare to replace the current payment system. Physicians would be given a clear timetable to transition to the new models by a date set by Congress. (CY 2015-19, partially overlaps with stage 1).

- A. No later than June 30, 2015, the Secretary, with advice from MedPAC, would submit to Congress a report with recommendations on which models would be approved for broad adoption by Medicare, based on their effectiveness in meeting the key deliverables discussed under Stage 1, B-2. Congress would make the final decision.

Rationale: once sufficient experience is gained with the PPIIs to be evaluated during Stage 1, the Secretary, with the advice of MedPAC, would be in a position to make an assessment and recommendation to Congress of which ones are ready for broad implementation by the Medicare program.

- B. Starting in 2016, physicians would be given a set timetable (no less than four years, with a longer period for smaller practices) to make the transition to the PPIIs that have been approved by Congress and implemented by the Secretary through a rule-making process to achieve broad adoption throughout the program.
1. During this phase, the medical profession would have at least four years to demonstrate that most physician practices have transitioned to one or more of the PPIIs approved by Congress with implementation by the Secretary for broad adoption by the program.
 - a. The timetable for implementation should take into account the different characteristics, size and capabilities of practices to adopt the new payment models. Accordingly, smaller practices and practices in rural areas should be granted additional time to make the decision on participation and receive the necessary technical support.
 - b. Until most physicians have fully transitioned to an approved PPII, a transitional FFS payment system would need to remain in place to pay for physician services provided during the transition phase. This transitional system would provide for lower payments than would be available to practices that have transitioned to a new PPII.
 - c. A modified and improved FFS system may also need to remain, even after the transition, for specialties and types of practice that cannot transition to the new practice models through no fault of their own.

- d. All new payment models should include mechanisms for annual updates to reflect increases in the overhead costs incurred by physicians and their practices to deliver covered services, including costs associated with medical liability expenses and defensive medicine.
- C. If not enough physicians (e.g. as determined by a percentage threshold of participation in the new approved PPIIs) have made the transition to the new payment models by 2019, Congress could re-establish spending targets or other cost control mechanisms, similar to the approach recommended by the Bipartisan Commission on Fiscal Responsibility and Reform, but with Congress making the final decision on establishing new spending targets or other cost control mechanisms.

Rationale: Once new models are selected for broad implementation; physicians will need some time to transition to them. Smaller practices will likely require more time and technical support. During the transition, a modified FFS system would have to remain in effect to compensate physicians for care provided during the transition, but there should be enough of a financial incentive for them to transition to the new payment models. For some physicians in some types of practices, a continued but modified FFS system may be the only viable approach to pay for their services. If not enough physicians transition to the new payment models by a date certain (e.g. 2019) Congress would be able to re-impose spending targets or other cost controls.

In the near term, the Fiscal Commission recommends replacing the reductions scheduled under the current formula with a freeze through 2013 and a one percent cut in 2014. In the medium term, the Commission recommends directing CMS to develop an improved physician payment formula that encourages care coordination across multiple providers and settings and pays doctors based on quality instead of quantity of services. The Commission calls for reinstating the SGR formula in 2015 (using 2014 spending as the base year) until CMS develops a revised physician payment system. ACP's proposal is similar to the Commission's in that it encourages the testing of care coordination payment models as possible replacements for the SGR, but ACP's approach differs in that it establishes a longer period of stabilized payments, in the near term, with the clear goal, in the long term, of testing and eventually adopting new care coordination models to permanently replace the SGR, with ultimate congressional approval.

Conclusion

ACP's recommendations, as outlined above, are based on a comprehensive position paper developed by ACP, *Reforming Physician Payments to Achieve Greater Value in Health Care Spending*, available at www.acponline.org/advocacy/where_we_stand/policy/reforming_pp.pdf. The College looks forward to continued discussion on how our ideas might be incorporated into legislation that meets the Energy and Commerce Committee's bipartisan objective "to begin the process of developing a long-term solution" instead of "the unwanted choice of extending a fundamentally broken payment system or jeopardizing access to care for Medicare beneficiaries."