

Statement of the American College of Physicians
for the Record of the
Hearing on Value-Based Purchasing for Physicians under Medicare

Committee on Ways and Means
Subcommittee on Health

July 21, 2005

The American College of Physicians (ACP), representing over 119,000 doctors of internal medicine and medical students, is pleased to provide testimony on the issue of value-based purchasing for physicians under Medicare. This testimony is provided for the July 21, 2005 hearing held by the Health Subcommittee of the United States (U.S.) House of Representatives Ways and Means Committee. Our testimony will focus on the following areas:

1. The steps the College is taking to lay the groundwork for value-based purchasing by helping internists understand how to incorporate proven quality improvement methods in their practices and to provide them with the technological capacities to support quality improvement.
2. The College's leadership role in selecting performance measures for ambulatory care that could be used in a Medicare value-based purchasing program as well as in other quality improvement programs.
3. The College's views on how to design a legislative framework for value-based purchasing that will support and strengthen the ability of physicians to engage in continuous quality improvement.
4. The College's views on the importance of carefully assessing the impact of provider-based purchasing on practicing internists and the relationships they have with their patients.
5. The College's views on the need to engage in a comprehensive re-examination and restructuring of Medicare payment policies to support quality improvement, particularly for patients with multiple chronic diseases.

LAYING THE GROUNDWORK FOR VALUE BASED PURCHASING

ACP firmly believes that the medical profession has a professional and ethical responsibility to engage in activities to continuously improve the quality of care provided to patients. ACP was among the first medical professional organizations to support the concept of linking payments to physician performance on evidence-based measures. We recognize, however, that pay-for-performance cannot by itself lead to quality improvements if physicians in practice lack the capabilities to incorporate proven quality improvement methods in their practices. Accordingly, the College is engaged in *over forty projects* to improve the quality of care provided to patients, including two new grant-funded programs to improve the care of patients with diabetes and to implement quality measures for the frail elderly.

ACP is also actively engaged in initiatives to develop the health information technology infrastructure to support quality improvement. We serve on the boards of the Certification Commission for Health Information Technology and the Electronic Health Initiative; co-chair the Physicians Electronic Health Record Coalition (PEHRC), and are actively involved in the

Connecting for Health initiative. We have developed recommendations for legislation to provide initial funding and sustained reimbursement support to help clinicians, particularly those in small practices, acquire and use HIT to support their participation in quality improvement projects. The College has joined with other stakeholders to submit proposals in response to Secretary Leavitt's requests for proposals on standard harmonization and certification of electronic health records.

The College is also committed to providing practice internists with practical tools to help them improve quality. ACP's Physicians Information and Education Resource (PIER) provides ACP members—at no cost to them—with access to “actionable” evidence-based guidelines at the point of care for over 300 clinical modules. PIER has also been incorporated into several electronic health record systems. PIER is currently in the process of aligning its evidence-based content to support a starter set of measures selected by the Ambulatory Care Quality Alliance (AQA). PIER is also creating paper order sets that imbed such quality measures in the order set, so that physicians who have not made the transition to electronic health records could still rely on PIER content to support their participation in performance measurement initiatives.

ACP's Practice Management Center has developed resources to help internists go through the decision-making process on electronic health records and is in the process of working with other entities in the College to provide internists with tools and best practices to help them redesign their office processes to improve health care quality.

ACP is also directly involved in supporting several federal demonstration projects to improve quality. We are directly involved in implementation of the Chronic Care Improvement Program/Medicare Health Support pilots in Mississippi and Pennsylvania as authorized by Section 721 of the Medicare Modernization Act, working with the awardees to develop mechanisms to support physicians' roles in coordinating and improving care of patients with diabetes and congestive heart failure. The College has also endorsed the Doctor's Office Quality Information Technology (DOQ-IT) demonstration project and is working with the American Health Quality Association to support the 8th Scope of Work.

Through these and other initiatives, the College is laying the groundwork for Medicare value-based purchasing by educating internists on how to incorporate performance measurement and improvement in their practices, by providing them with evidence-based clinical decision support, by partnering with others to develop the health information technology infrastructure to support quality improvement, by providing internists with practical tools to help them redesign office processes to improve quality, and by gaining first-hand knowledge from federal demonstration projects and pilot programs on how to incorporate quality improvement in the Medicare program.

SELECTING PERFORMANCE MEASURES FOR AMBULATORY CARE

ACP's long-standing commitment to evidence-based medicine and continuous quality improvement is also evidenced by our active involvement in the Ambulatory Care Quality Alliance (AQA), which in May 2005 took a major step toward improving the quality of the U.S. health care system by selecting a "starter set" of 26 clinical performance measures for the ambulatory care setting. (We ask that the starter set of measures, which is attached to this statement, Attachment 1, be recorded in the official record on this hearing.) ACP is one of four original organizations that organized and convened the first AQA meeting in the fall of 2004 (the other three co-conveners are America's Health Insurance Plans, the American Academy of Family Physicians, and the Agency for Healthcare Research and Quality) and we continue to serve on its steering committee.

The AQA, a national consortium of large employers, public and private payers, and physician groups, aims to improve health care quality and patient safety through a collaborative process in which key stakeholders agree on a strategy for measuring, reporting and improving performance at the physician level. The AQA also works to promote uniformity in order to provide consumers and purchasers with consistent information and to reduce the burden on providers. This approach is similar to the Hospital Quality Alliance, which involved a broad array of stakeholders with the goal of producing a standardized set of measures for inpatient care.

The AQA's starter set of ambulatory care measures is intended to provide clinicians, consumers and purchasers with a set of quality indicators that may be utilized for quality improvement, public reporting and pay-for-performance programs. The rationale behind the measurement starter set is to allow physicians to get used to tracking a few simple performance goals, while more sophisticated measurements and implementation guidelines are developed. While the College and other medical groups would prefer to take an evidence-based approach by waiting for results from pay-for-performance pilots and demonstrations, the market simply will not wait. Instead, ACP is confident that the AQA's starter set of measures represents the first of several generations of increasingly sophisticated performance measurement sets that can be used with confidence to measure quality of care in the ambulatory area.

AQA's uniform starter set comprises prevention measures for cancer screening and vaccinations; measures for chronic conditions including coronary artery disease, heart failure, diabetes, asthma, depression, and prenatal care; and, two efficiency measures that address overuse and misuse. Except for the two efficiency metrics, the AQA limited its review to those measures that are currently under review by the National Quality Forum.

ACP, and the other members of the consortium, worked hard to ensure that the initial set of measures relied principally on administrative data that is readily available for most practices, thereby reducing the administrative burden of having to extract information from medical records. In addition, they ensured that the starter set met the standards of scientific validity, feasibility, and relevance to physicians, patients and purchasers. AQA participants are also beginning to seriously address the complex issues associated with creating the infrastructure for performance reporting. The AQA is also working on a model for aggregating, sharing and stewarding data that maintains appropriate restrictions on privacy and confidentiality, as well as principles for reporting information to providers, consumers and purchasers.

ACP'S VIEWS ON A LEGISLATIVE FRAMEWORK FOR VALUE BASED PURCHASING

The College recently released a detailed draft proposal for a legislative framework for Medicare that linked financial incentives to performance quality, which was shared with the staff of the Ways and Means Health Subcommittee and other key health committees. ACP, along with other national organizations representing primary care physicians, also sent a letter to Congressional leaders that affirmed our joint commitment to work with Congress to develop effective legislation on Medicare quality improvement (Attachment 2). There are several key elements, as outlined in our recommended framework and in the joint letter that we believe should be incorporated into any legislation to establish a Medicare value-based purchasing program.

THE USE OF AQA PRINCIPLES IN A VALUE-BASED PURCHASING SYSTEM

First, it is critical that any value-based purchasing system that links physician reimbursement to evidence-based performance measures follow principles similar to those that guided the AQA process. For one, there must be an explicit role for a consensus-oriented multi-stakeholder group to select and validate quality and efficiency measures for clinical conditions and to evaluate issues of feasibility and meaningful data collection. It is absolutely necessary that this process be transparent. It is also important that adequate feedback be provided on why certain measures are not selected in order to allow the measures to be further refined and resubmitted and to ensure that the scientific evidence behind the measure, administrative feasibility of data collection, and other elements are well considered. This multi-stakeholder group must also have strong representation of national physician specialty societies in the leadership and governing board structure of the entity. The leadership of ACP and others in the AQA process has been essential for the credibility of the process, and we would hope to maintain a comparable leadership role in any new entities created by legislation.

THE USE OF EFFICIENCY MEASURES

Second, ACP supports evidence-based clinical performance measures in a value-based purchasing program that address overuse, underuse and misuse, but we are concerned that efficiency measurement will be driven by statistical economic profiling rather than a review of the clinical evidence. Appropriate quality measures take into account evidence to support or not support particular interventions based on evidence-based guidelines on overuse and underuse rather than just using a statistical profile of cost and volume. A strict volume/cost analysis derived from claims data for utilization patterns will not provide accurate data on quality or cost and should not be used to determine payments based on performance. Comparisons of utilization patterns are not a substitute for true efficiency measures that consider the quality *and* costs associated with treatment of particular conditions.

It is unlikely that a risk adjustment methodology will soon be developed that can adjust for all problems related to reporting on the efficiency of individual physicians in providing care to patients based on a comparative analysis of claims. Statistical comparisons need to take into account not only the need to risk adjust for severity of illness, but also for socioeconomic factors such as income, race, culture, and language proficiency, which significantly influence a patient's willingness to trust the health care provider and comply with recommended treatments. Without such adjustments, physicians who see a disproportionate number of low-income or racial/ethnic minority patients would be penalized for factors outside their control and dissuaded from participating in quality improvement programs. Quality improvement programs should not inadvertently exacerbate health disparities or create other unintended consequences for patients or physicians who have sicker patient populations as well as noncompliant patient populations.

PUBLIC REPORTING

Third, while ACP understands that public reporting *potentially* provides patients and purchasers with a more informed choice about physicians; public reporting can create severe adverse unintended consequences for patients if not done correctly. Studies show that public reporting can create unintended incentives for physicians to avoid higher risk or non-compliant patients that will result in their public report being less favorable. This is particularly a concern for patients with certain ethnic, racial, socioeconomic or cultural characteristics that make them less compliant with recommended treatments, less likely to see a physician for preventive care, and less likely to take prescribed

medications. Sufficient risk adjustment and methodologies to reduce the risk that public reporting will create such unintended consequences are essential before physician-specific quality data are released to the public. In addition, many patients function at a health literacy level that makes it difficult for them to understand basic medical information given to them by their clinician, never mind comparative data on quality. More studies are needed on whether patients benefit more from seeing reports on whether or not their physician surpasses a minimum threshold of quality improvement or from ranking of physicians based on quality indicators. For this reason, the College has advocated for a well-designed demonstration project on public reporting of quality improvement data.

ACP agrees with the Medicare Payment Advisory Commission (MedPAC) recommendation that physician performance profiling first be shared confidentially with physicians as an educational tool. Furthermore, ACP believes that when public reporting is implemented, physicians should be allowed to not only review data before it is released but to appeal it to an independent reviewer that would be charged with resolving concerns relating to the public report in a way that assures that all information that is reported is unbiased and accurate. Physicians should also have the right to have their comments on the report included along with the data that are reported.

A PHASED IN APPROACH

Fourth, ACP strongly supports a phased in approach to value-based purchasing linked to physician performance.

The College believes that a Medicare value based purchasing program should start with pay for achieving basic structural measures (pay-for-reporting), followed by payment for participating in quality improvement programs that use evidence-based clinical measures (pay-for-participation), followed by pay for achieving quality gains as measured by such evidence-based measures (pay-for-performance):

Stage One: Pay-for-Reporting

ACP recommends Medicare institute a *pay-for-reporting* initiative beginning in 2007 using a structure along the lines of the MedPAC recommendation to begin paying for structural measures (i.e., assessing whether the provider has the capability to deliver quality care) consisting of quality-enhancing functions and outcomes facilitated by the use of information technology (HIT) and other improvements. A process should be created for physicians to begin reporting during the calendar year that they have the structural capabilities to support quality improvement. Additional payments would then be allocated to physicians, during the same calendar year, who met the pay-for-reporting requirements.

Stage Two: Pay-for-Participation

ACP recommends that Medicare should institute a more robust and voluntary *pay-for-participation* program beginning in 2008 that would allocate additional payments (i.e., in addition to and separate from the annual Medicare fee schedule update) to physicians on a *graduated* basis who agree to voluntarily participate in quality improvement programs that use *evidence-based measures* for clinical conditions that have the greatest potential to yield the greatest quality improvements and potential system-wide savings stemming from improved quality. During the pay-for-participation phase, payment should be based on documentation of

participation in such programs, not on how well the individual physician does in meeting the actual measures.

Such additional payments should be graduated and proportionate to the level of commitment on the part of the physician to participating in approved performance measurement programs. Because participation in performance measurement programs involves substantial costs (for HIT, data collection and reporting) and time commitment from physicians and their staffs, pay should increase proportionately based on the number of dimensions of care being measured, the number of measures, the time and costs associated with documenting performance based on the measures, and the level of HIT acquired by the practice to support participation in approved quality improvement programs. For example, physicians who just meet the basic structural measures as outlined in Stage One should receive a lower bonus payment than physicians who are participating in programs that use multiple evidence-based measures designed to improve care of patients with high cost chronic diseases. A graduated payment structure would create stronger incentives for physicians to participate in performance improvement programs (and for specialties to develop evidence-based measures of performance) than paying all physicians the same amount regardless of their level of commitment to such programs.

Stage Three: Pay-for-Performance

ACP recommends that HHS be directed to consult with medical professional societies and other stakeholder groups on development of a *pay-for-performance* program that would be initiated no earlier than calendar year 2010. The pay-for-performance program would provide graduated bonus payments to physicians who demonstrate success in meeting evidence-based performance measures.

ASSURING SUFFICIENT FUNDING

Fifth, the College believes it is essential that Congress assure adequate funding for the value-based purchasing program, starting with repeal of the sustainable growth rate (SGR) formula. The need for a long term solution for updating the Medicare physician fee schedule is underscored by continued projections of deep cuts. Despite Congress' success in preventing cuts from taking effect in 2003-2005, payment reductions of over 4 percent next year and 26 percent from 2006-2011 are forecast. The underlying flaw of the SGR formula is the link between the performance of the overall economy and the actual cost of providing physician services. The medical needs of individual patients are not related to the overall economy.

ACP strongly urges Congress to pass legislation to replace the SGR formula once and for all. In the future, annual updates in Medicare payments should instead be linked to increases in the actual costs of medical practice. ACP supports basing updates on the projected change in input prices less an adjustment for productivity growth, as has been recommended by MedPAC. Applying this methodology would result in a 2.7 percent increase in the fee schedule conversion factor next year and a similar increase in 2007 (currently projected to be 2.4 percent).

ACP also supports the MedPAC recommendation that volume should be managed through a process in which the reasons for each significant volume increase are identified, and specific measures be taken either administratively or through legislation to control those increases not related to improvements in quality of care. Addressing volume through careful analysis and consideration, with

appropriate policy interventions, will be far more effective in assuring that appropriate care is provided than the flawed SGR.

APPLYING ACP'S RECOMMENDED FRAMEWORK TO CHAIRMAN JOHNSON'S PROPOSED DRAFT LEGISLATION

The College understands that Chairman Johnson will be introducing a value-based purchasing bill. Based on our understanding of what the bill likely will include, the College anticipates that the overall approach will be consistent with the College's recommendations, as summarized above.

We are very pleased that the bill will likely include repeal of the SGR and will base future updates on the Medicare Economic Index, minus a productivity factor, as recommended by MedPAC. By doing so, it recognizes that successful implementation of Medicare quality improvement cannot take place in an environment where physician fees are being cut. We also understand that the proposal will reduce the update by a yet-to-be-defined percentage for physicians who decline to participate in the performance measurement and reporting program.

Although the College would prefer that new money be provided to support the value-based purchasing program, we understand that budget constraints may limit the initial funding to an amount that is no higher than levels recommended by MedPAC. However, we urge the subcommittee to establish a floor on the annual updates in 2006, 2007, and 2008, so that all physicians receive a positive update. The College specifically recommends that all physicians receive an update that is no lower than 1.5 percent, and that an additional amount be provided to those who participate in the performance reporting and measurement program, up to the full amount recommended by MedPAC.

We also recommend that the bill give HHS the authority to weigh the performance-based payments so that those physicians who engage in reporting data using multiple measures can qualify for higher payments than those who report on only a few structural measures. For instance, an internist who participates in a program that uses the AQA starter set will be obligated to report performance for as many as 24 separate measures (the two measures relating to pediatric care are not applicable to most internists), requiring a substantial investment of time and practice resources. Unless performance-based payments are commensurate with effort, physicians will be discouraged from doing anything more than the most elementary and basic measurement and reporting required to qualify for the full update.

We also understand that the bill likely will call for a gradual phase-in of the measures, starting with pay-for-reporting of structural and quality measures before Medicare begins paying physicians on the measures themselves, similar to the step-wise approach recommended by ACP.

We also understand that the proposal will likely recognize the critical role played by medical specialty societies in *developing* measures that are then *validated* through a consensus building organization involving multiple stakeholders. As noted above, our experience with the AQA demonstrates that a consensus process, with physician leadership, can result in getting "buy-in" from physicians, purchasers, payers, and consumers on a practical set of measures.

The College is concerned that the value-based purchasing program for physicians is funded totally out of savings in Medicare Part B and in reductions and set asides from the conversion factor paid to physicians. Value-based purchasing should recognize physicians' collective and individual contributions to achieving system-wide savings through better quality. Accordingly, we urge that a

provision be included in the legislation directing the Secretary to develop a methodology, in consultation with the Medicare Payment Advisory Commission (MedPAC), the Practicing Physician Advisory Council (PPAC), national membership organizations representing practicing physicians and other appropriate experts to increase the total pay-for-quality bonus pool available to physicians based on evidence that the value-based purchasing program for physicians has resulted in system-wide Medicare savings. Such savings should include savings in Medicare Part A, such as from preventing unnecessary hospitalizations caused by complications. The methodology should allow for individual physicians to share in such system-wide savings that are attributable to their participating in performance measurement and improvement programs and physician-guided chronic care coordination. The methodology and recommendations should be reported to Congress no later than December 30, 2006. Legislation should be required to institute the methodology.

In summary, based on our understanding of the overall direction that Chairman Johnson is likely to propose in her bill, the College expects that we will be able to support the legislation, although we hope to have the opportunity to continue to recommend ways to make the framework as effective as possible, including assuring that the overall funding for the program is sufficient to result in the desired changes. We commend Chairman Johnson for her leadership on this issue and her responsiveness to the views offered by ACP and other medical organizations on how to structure the legislation.

ASSESSING THE IMPACT OF VALUE-BASED PURCHASING ON PRACTICING INTERNISTS

As Congress moves forward on developing a Medicare value-based purchasing program, we believe that it is essential that Congress be mindful of the potential impact on practicing internists and potential unintended adverse consequences.

Internists are encountering an aging population that requires substantial care and support as a result of an increasing number of chronic conditions. These practitioners, who provide the predominance of care to our Medicare beneficiaries, are also aware of the significant gaps in health care quality as reflected by the landmark Institute of Medicine report, *Crossing the Quality Chasm*. Our members are primed to meet this challenge to improve healthcare quality, safety and access, and make the necessary changes in their practices to better meet the needs of their patients. These changes include the increased need to coordinate care, to reach out to patients to ensure they are following their treatment regimens and to implement available health information technology (e.g. electronic health records, patient registries, e-prescribing, clinical decision support tools) into their daily office routine. These changes are difficult to make in an environment characterized by the specter of payment cuts throughout the foreseeable future. Repealing the SGR is an essential first step, but by itself, will not stabilize the economic environment for many internists sufficiently to allow them to provide high quality care and engage in continuous quality improvement.

For most primary care physicians, Medicare payments are not keeping up with their practice expenses. Many are reluctantly considering closing their doors to new Medicare patients or even getting out of practice. They worry that pay-for-performance will be another unfunded mandate, leading to more paperwork, more expense, less revenue, and less time with patients. They are concerned that it could create unintended adverse consequences for sicker and non-compliant patients. It is not just physicians in practice who express these concerns. Medical students do not see a future in primary care, as evidenced by the marked decline in recent years in the number of physicians who are being trained in general internal medicine and family practice.

Done correctly, value-based purchasing can help. By doing it right, it means assuring that Medicare money is sufficient to provide updates based on inflation and to create positive incentives for performance improvement. It means providing rewards commensurate with an individual physician's commitment of time and resources to support quality improvement. It means lifting up all boats rather than leaving some to founder. It means assuring that the data collection does not impose a heavy administrative burden. It means supporting the crucial role played by primary care physicians, working with a team of skilled subspecialist consultants, in assuring that patients get the best care possible. Most importantly, it means that better quality must be the measure of success; cost savings should be the *result* of quality improvement but never at its expense.

Primary care is at an important crossroads at this time. Fewer physicians are choosing to enter into primary care and those in the profession are expressing increased dissatisfaction. Primary care can be re-energized to the extent this current pay-for-quality discussion in Congress results in an improved payment system that adequately rewards physicians for providing the coordinated quality care required and implementing necessary practice changes. If the discussion results in a pay-for-quality system perceived as punitive by our practitioners, replete with additional unfunded demands and unproductive "time stealers" from the physician and their staff, it can serve as the straw that figuratively breaks the camel's back and leads to an unfortunate acceleration in the shortage of primary care practitioners. Reduced access to primary care physicians would be very detrimental to our Medicare beneficiaries. The majority of Americans have demonstrated a preference for a sustained relationship with a primary care provider and studies indicate that a continuous patient-physician relationship correlates with patient satisfaction, improved health, positive outcomes, reduced malpractice litigation, as well as reduced emergency department use and reduced health care costs per patient.

RE-EXAMING AND REFORMING DYSFUNCTIONAL PAYMENT POLICIES

Finally, the initial framework should be followed by a comprehensive re-examination of Medicare payment policies. Unfortunately, Medicare payment policies are based on the way that care was provided in 1965—not the way it is being delivered today *or will be in the future*. When Medicare was created in 1965, patients generally were treated only when sick (acute condition); there was little or no emphasis on prevention and coordination; care was based on doctor's best judgment as informed by continuing medical education and journals but not on scientific guidelines; and payment was made only for work involved in a specific visit or procedure, not on results. Medical care today and in the future will involve treating patients' chronic conditions, not just acute illnesses; preventing and managing illness rather than just treating disease; care will be rendered by coordinated teams of health professionals; clinical judgment will be informed by evidence-based clinical decision support; and the results of care will be rewarded.

The College specifically advocates a new payment model to reward physicians for coordinating team-based care of patients with chronic diseases in a way that will result in better quality and potential cost-savings, including the work that falls outside of the traditional office visit, such as working with family caregivers on helping patients manage their own diseases and arranging for team-based care involving other health professionals. This "patient-centered, physician-guided" chronic care model is based on the work of Ed Wagner, MD, FACP and it provides physicians designated by beneficiaries as their "medical home" with payments based on their ability to effectively manage and coordinate care. We welcome the opportunity to discuss our ideas with the subcommittee.

CONCLUSION

In conclusion, the College supports the goal of aligning Medicare's incentives with physicians' commitment to improve quality and we commend Chairman Johnson for her leadership on developing a practical approach to value-based purchasing that includes repeal of the SGR. As Congress moves forward on the legislation, we ask that you keep in mind two critical questions: will we end up with a system that supports the physician-patient relationship by providing resources to help physicians improve care of their patients? Or will it be a system that undermines that relationship, resulting in more paperwork, more expense, less revenue, and less time with patients? The College is dedicated to working with the subcommittee to assure that it is the first question, not the second, which gets a resounding yes from physicians and their patients.