



November 12, 2013

The Honorable Max Baucus
Chairman
Senate Finance Committee
United States Senate
Washington, DC 20510

The Honorable Orrin G. Hatch
Ranking Member
Senate Finance Committee
United States Senate
Washington, DC 20510

The Honorable Dave Camp
Chairman
House Ways and Means Committee
U.S. House of Representatives
Washington, DC 20515

The Honorable Sandy M. Levin
Ranking Member
House Ways and Means Committee
U.S. House of Representatives
Washington, DC 20515

Dear Leaders of the Senate Finance Committee and the House Ways and Means Committee:

On behalf of the American College of Physicians (ACP), I appreciate this opportunity to respond to your request for comments on a discussion draft, as released on October 30th, to repeal the Medicare sustainable growth rate (SGR) and reform the Medicare physician payment system. We congratulate you on developing a bipartisan, bicameral draft proposal to permanently repeal the SGR and create powerful incentives for physicians and other health care professionals to transition to value-based payment and delivery models. Overall, we believe that the discussion draft provides a solid foundation to create a better Medicare physician payment system that incorporates key policies recommended by the College. However, we would like to provide some recommendations for the Committees to consider as they further develop this proposal.

ACP is the largest medical specialty organization and second-largest physician group in the United States, representing 137,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum, from health to complex illness.

SGR Repeal and Annual Updates

The SGR formula creates significant uncertainty in the Medicare program for both physicians and beneficiaries; therefore, ACP fully supports the permanent repeal of the SGR update mechanism. The discussion draft goes on to state that it would freeze current payment levels through the ten-year budget window (until 2023), while allowing individual physicians and other health care professionals to earn performance-based incentive payments through a compulsory budget-neutral program—or to opt out into advanced alternative payment models (APMs).

ACP continues to believe that after a decade of updates that have not kept up with increases in the costs of practice, positive and stable baseline updates for all physicians during a transition phase, and the addition of higher baseline updates for undervalued evaluation and management services, is the best course of action to ensure that Medicare patients have continued access to physicians. **If Congress determines that the fiscal realities do not allow such increases at this time, and instead “freezes” the baseline**

update for ten years, then it will be essential that Congress, MedPAC, GAO and others monitor the impact of a freeze on updates on access, and if access problems occur, or if inflation increases substantially, provide for future increases in the annual updates. Such increases could be targeted toward services that are undervalued, or towards specialties facing severe shortages, such as primary care.

Further, ACP strongly believes that the Medicare Primary Care Incentive Payment program, which creates a 10% bonus payment from 2011 through 2015, must be extended beyond its current expiration of December 31, 2015. Failure to extend this program would mean that primary care—which already is undervalued, and is facing a shortage of more than 40,000 primary physicians for adults by the end of this decade—would in fact take a severe and unsustainable cut under a freeze in updates, the only category of physicians that would take such a deep cut. Expiration of the 10% primary care bonus would do grave damage to primary care and the Medicare program, by creating immediate and continued access problems and exacerbating the primary care shortage. It would also set back delivery system reforms, like Patient-Centered Medical Homes, which are predicated on high performing primary care. Primary care clinicians are critical to the overall success of the value-based payment and alternative model approaches that have been proposed by the Committees. Allowing the primary care incentive program to expire would also increase costs to the Medicare program, given the solid evidence that the availability of primary care in a community is associated with better outcomes and lower costs. **If such an extension cannot be included in this legislative framework, then action will need to be taken by Congress to extend and reauthorize the program before it sunsets at the end of 2015. We cannot be supportive of a freeze on updates if the Medicare primary care bonus program is allowed to sunset.**

We do very much appreciate that the draft framework provides many opportunities for physicians to earn incentive payments or higher Medicare payment from participating in Alternative Payment Models (APMs) above the freeze in annual updates. While the terminology used in the discussion draft uses the term “freeze”, ACP believes that some physicians will mistakenly conclude from this terminology that they will get the same amount they are currently being paid, and same revenue from Medicare for the next 10 years, when neither of those scenarios is true. Rather, physicians could earn more (or less) than a freeze in any given year because of their score within the new Value-Based Payment program. They could also earn additional payments for participating in an APM. In fact, the structure of the proposed VBP essentially allows physicians to determine their own annual individual conversion factor, within the available budget neutral performance pool, based on their performance on quality and resource use measures, their clinical practice improvement activities, and by demonstrating meaningful use of their EHR.

We also appreciate that the newly proposed VBP program would sunset the current CMS incentive-based reporting programs starting at the end of 2016—including PQRS, the Value-Based Modifier program, and Meaningful Use—for practices remaining in FFS and for those that are in advanced APMs. The penalties associated with these programs will now remain in the physician payment pool, whereas they are currently planned to be removed from the pool—resulting in an increase in the neighborhood of \$10 billion over the period of 2017-2023. This means that the “freeze” in payments is not entirely a freeze, but rather a stable baseline conversion factor that is built on a larger payment pool (on which physicians would build their own individual conversion factor as discussed earlier). We have recommendations later in this letter for improving the VBP program.

We also support and appreciate that the discussion draft also offers the opportunity for physicians and other clinicians to earn incentive payments above the stable baseline via use of new complex chronic care management codes beginning in 2015, with improvements as discussed below.

Finally, we appreciate and support the policies of exempting physicians in “advanced APMs” from the VBP program and providing them with a 5% bonus, starting in 2016 (which then drops to 2% in 2024). This 5% bonus would be in addition to any increased revenue that APMs may earn from the specific payment rules that apply to their model (for instance, shared savings for ACOs, or risk adjusted per capita payments plus FFS for PCMHs). We have suggestions for improving the APM program later in this letter.

The provision of these multiple avenues for eligible professionals (EPs) to essentially set their own individual or group conversion factor above the baseline is critical to the success of this approach—and to ACP’s support for this approach.

Value-Based Performance Payment Program

The discussion draft calls for Medicare payments to professionals to be adjusted based on performance on a single budget-neutral incentive payment program. Payments would be adjusted beginning in 2017 based on professionals’ performance in a prior period. Under this new Value-Based Performance (VBP) program, the following current law payment penalties would sunset at the end of 2016:

- Failure to successfully report on quality measures (Physician Quality Reporting System, or PQRS), a two percent penalty;
- Budget-neutral payment adjustment based on quality and resource use (Value-Based Modifier, or VBM); and
- Failure to demonstrate meaningful use of certified EHR technology (EHR MU), a three percent penalty that can increase up to five percent starting in 2019.

The penalties that would have been assessed under PQRS, VBM, and EHR MU would now remain in the physician payment pool.

The College strongly supports alignment across the various CMS reporting programs to reduce the reporting burden on physicians—and it appears that this new VBP program would facilitate that alignment and also leverage the infrastructure that has been built for the existing Medicare programs rather than recreating it.

The College is also supportive of having the penalties that would have been assessed for these programs remain in the physician payment pool, particularly since the discussion draft includes flat baseline updates to the conversion factor through 2023 (as discussed earlier).

However, ACP would like to outline some concerns and recommend some areas for improvement in the initial rollout of the new VBP program.

First, the penalties for the existing Medicare programs will still be in place during the transition period to this new system (between 2014-2016); this could potentially hamper the ability of many EPs, particularly those in small practices, to prepare for this new, more comprehensive program. ACP has called on both Congress and CMS to consider delaying the penalties for not successfully participating in quality reporting programs, *if* it appears that the vast majority of physicians will be subject to penalties due to limitations in the programs themselves. And, the participation data for PQRS is concerning—with only 32 percent of all physicians participating in the program as of 2011.¹ **Therefore, ACP recommends that the penalties for these programs over the next two years be delayed, until the new VBP program is put into place.**

¹ 2011 PQRS & eRx Experience Report (<http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html?redirect=/PQRS/>)

Second, even if the penalties for these programs are delayed, small practices are likely to have a difficult time with this transition—even with the assistance that has been proposed in this discussion draft—and so **ACP recommends that the Committees consider a longer transition timeframe and/or hardship exemptions for practices of 10 or fewer EPs.**

VBP Assessment Categories:

The VBP program would assess eligible professionals' performance in the following categories: 1) Quality; 2) Resource Use; 3) Clinical Practice Improvement Activities; and 4) EHR Meaningful Use.

Quality measures used in the current law PQRS and other incentive programs would be used for the quality category. In addition, the Secretary would solicit recommended measures for inclusion annually, and funding would be provided to develop additional measures. Professionals would be given credit for attainment and achievement, with higher overall weight given to outcomes measures. To prevent duplicative reporting, professionals who report quality measures through certified EHR systems would meet the meaningful use clinical quality measure component.

The College strongly supports alignment of this new program with the measures being used in the existing programs. We also support the concepts of giving credit for attainment and achievement and higher overall weight given to outcomes measures. However, it will be important for CMS to continue to improve the measures and reporting systems to be used in the new program to ensure that they measure the right things, moving toward clinical outcomes and patient experience, and do not create unintended adverse consequences. A recent article by Berenson and Kaye,² noted that “the current PQRS measures reflect a vanishingly small part of professional activities” and that there are currently many “overlooked aspects of physician performance that we would want to measure include[ing] making accurate diagnoses, avoiding overuse of diagnostic and therapeutic interventions, and caring for the growing number of patients with multiple chronic conditions and functional limitation.” The article also notes that patients care about “physicians’ confidence, empathy, humanity, personability, forthrightness, respect, and thoroughness” but that “available measures in PQRS and elsewhere are relevant to few of these professional qualities.” Improvements such as these must be made in an ongoing way as this new VBP program is developed. The measurement targets must also remain patient centered and reflect potential differences in risk/benefit for specific populations. For example, targets for the frail elderly frequently differ from younger patients.

Additionally, efforts made to improve the existing PQRS program, as it is transitioned to be used in the new VBP program, should include increasing alignment of the measures and measurement strategies with those being used by private payers and other quality improvement efforts. Greater alignment should significantly decrease the reporting burden faced by physicians and practices, thus allowing them to focus on using the data to make meaningful, ongoing improvements.

ACP is also supportive of providing adequate funding for the measure development and maintenance processes, which is critically important—but more clarity is needed on where the funding for measure development and maintenance will be targeted. **ACP recommends that all measures, regardless of source, go through a multi-stakeholder evaluation process—a role that is performed by the National Quality Forum (NQF) as a trusted evaluator of measures.** Therefore, ACP encourages the Committees to ensure that there is stable and sustainable financing for the NQF as the trusted validator for

² Berenson, Robert A. and Deborah R. Kaye. “Grading a Physician’s Value—The Misapplication of Performance Measurement.” *NEJM*. 2013. Accessed at: <http://www.nejm.org/doi/full/10.1056/NEJMp1312287>.

quality measures and for the measure development, testing, and maintenance processes, as recommended by the Stand for Quality proposal.³

Resource use metrics used in the current law VBM program and the methodology that is under development to identify resources associated with specific care episodes would be enhanced and used for the resource use category. The proposal would also establish a process to involve professionals in furthering the measurement of resource use through identifying episodes of care and require them to indicate their specific role in treating the beneficiary (e.g., primary care or specialist) and the type of treatment (e.g., chronic condition, acute episode) on the claim form rather than having this determined by a formula. Payment would be reduced for a service if the professional failed to provide the information.

ACP is supportive with alignment of these measures with the methodology that is currently under development at CMS for use in the current Medicare Value-Based Modifier program—and appreciates the specific inclusion of a process to involve clinicians in the development of resource use measures. However, as was noted in the Berenson and Kaye article, “current methods for case-mix adjustment do not adequately capture variations on patients’ illness severity, complicating coexisting conditions, or relevant socioeconomic differences”, which can impact the total cost of care. Therefore, it will be critical that this new VBP program attempt to address case-mix adjustment issues, as well as make other improvements in an ongoing way to ensure that any costs assigned to individual physicians are accurately attributed. Additionally, when measuring efficiency it is important that the barriers between Medicare silos be removed. A physician’s treatment decisions during office visits (Part B) could significantly save resources in other parts of Medicare, such as reduced hospitalizations (Part A) or more appropriate medication management (Part D).

It is also critical that the reporting methodology that is established for clinicians to “indicate their specific role in treating the beneficiary” is clearly laid out and not burdensome (even if it is done via claims submissions as proposed), particularly since the discussion draft calls for a penalty for those that fail to report.

There also must be sufficient time allowed for CMS to: (1) prepare for this reporting methodology, (2) ensure that the information that is reported can be used effectively by CMS to help determine resource use, and (3) educate clinicians on how to report and on the importance of this reporting. ACP also recommends that the Committees consider including hardship exemptions for those clinicians that are unable to effectively report this information through no fault of their own.

Clinical practice improvement activities, which will prepare professionals to transition to an advanced APM(s), would be established through a collaborative process with professionals and other stakeholders and give special consideration to those practicing in rural areas and Health Professional Shortage Areas (HPSA). Specific activities from which professionals can select would fall under the following sub-categories:

- Expanded practice access, such as same-day appointments for urgent needs and after-hours access to clinician advice;
- Population management, such as tracking individuals to provide timely care interventions;
- Care coordination, such as timely communication of clinical information (e.g., test results) and use of remote monitoring or telehealth;

³ The full Stand for Quality Proposal can be accessed at: http://www.standforquality.org/draftlegnarrative_91212.pdf

- Beneficiary engagement, such as establishment of care plans for patients with complex needs and self-management training; and
- Participation in any Medicare APM.

Because many of these criteria are components of medical homes, a primary care or specialist professional practicing in a certified medical home would receive the highest possible score for this category. A professional participating in any Medicare APM would automatically receive half of the highest possible score and could achieve the highest possible score by engaging in additional clinical improvement activities.

The College strongly supports the inclusion of clinical improvement activities, in addition to quality and resource use measures, as a component of the composite VBP score, and is also supportive that the activity categories include access to care, care coordination, beneficiary engagement, prevention and population health, and participation in a Medicare APM. ACP is particularly pleased that patient-centered medical homes (PCMHs) and PCMH Specialty Practices would receive the highest possible score for this category.

Additionally, ACP notes that the ABMS maintenance of certification (MOC) is a multi-source assessment program that addresses competencies for good medical practice and provides a program of continuous professional development and a platform for quality improvement. **Therefore, ACP recommends that the proposal include direction to the Secretary to allow successful participation in ABMS MOC as an additional clinical improvement activity category.** This would allow physicians choice in reporting so that they can align their quality improvement activities in ways that are relevant to their practices.

EHR Meaningful Use requirements, demonstrated by use of a certified system, would continue to apply to achieve compliance in this category.

ACP currently supports the overall goals and objectives of the MU program. However, the College has objected to specific measures and methods that we feel work counter to the goals and objectives. For instance:

- ACP supports de-coupling certification requirements from eligible professional implementation and reporting requirements.
- ACP supports switching to a scoring system that recognizes the differences in practices and the differences between incentives and penalties.
- ACP has encouraged a less prescriptive approach to workflow requirements that allows practices to address the unique characteristics of their practice, specialty, and patient population.
- ACP supports Stage 3 rulemaking that is guided by the intent of Meaningful Use and further informed by where most providers should be at that point in their Meaningful Use journey—which is the ability to successfully attest solely by their participation in an appropriate variety of deeming activities, such as participation in Million Hearts®, national registries, or other specified Maintenance of Certification (MOC) programs.
- ACP has noted that the all-or-none, pass-fail requirement placed on providers attempting to participate in Meaningful Use is counter-productive.

More details on ACP’s positions and recommendations on the current EHR Incentive Program/ Meaningful Use can be found in a letter recently submitted to the Department of Health and Human Services, CMS, and the National Coordinator for Health Information Technology.⁴

It is critical that these improvements in the EHR Meaningful Use program still be made, even as it is wrapped into the new VBP program. Additionally, more clarity is needed as to how use of a certified system could be demonstrated within this new program and, as noted above, this should not be considered a pass/fail element within the new composite score, but rather allow for partial credit for those working toward meeting the requirements.

Additionally, the standards across multiple recognition and accreditation processes for PCMHs and PCMH specialty practices, all generally include compliance with the Meaningful Use program. **Therefore, ACP recommends that, as proposed for clinical practice improvement activities, PCMHs and PCMH Specialty Practices should receive the highest possible score for this category.**

VBP Performance Assessment and Weights for Performance Categories

The discussion draft outlines that:

Professionals would be assessed and receive payment adjustments based on a composite score that encompasses all of the applicable composite categories and associated measures. A professional would get a score in each category, which would add up to a single composite score. These scores would reflect the differences in professionals’ performance and would be tied to VBP incentive payments.

It then further proposes a set of weights for the performance categories, as follows:

Category	PY 2017 Weight	PY 2018 Weight	PY 2019 Weight	
Quality	60% total with neither category less than 15%		30%	
Resource use			30%	
Clinical practice improvement activities	15%		15%	15%
EHR meaningful use ²	25%		25%	25%
Total	100%		100%	100%

The College supports the concepts in the proposed performance assessment approach; however, any benchmarks that will be used must be very clearly defined in advance of the program’s implementation. Additionally, any comparison of performance compared to peers must be carefully adjusted to reflect differences in the complexity of the patient population being treated and especially, to ensure that it does not disadvantage physicians who are taking care of underserved patient populations who may be at greater risk of poor health and outcomes.

ACP also recommends that the Committees be less prescriptive in its proposed weights. These weights could be more effectively established via the regulatory rule-making process, which would allow greater time for meaningful input from physicians, consumers, and other key stakeholders. Keeping that level of specificity out of the statute also ensures a greater level of flexibility, which will likely be needed for the initial establishment of the payment approaches and for any necessary modification to those approaches over time.

⁴ ACP Letter to HHS, CMS, and ONC re: ACP Concerns with the Meaningful Use Program. September 12, 2013. (http://www.acponline.org/acp_policy/letters/acp_letter_meaningful_use_concerns_2013.pdf)

However, if the Committees move forward with establishing weights for performance categories or guidance for those weights in the legislative language, then ACP would strongly recommend that clinical practice improvement activities receive a higher weight than 15%—and that any increase in the weight for practice improvement activities should be balanced by a decrease in the weight for quality measures. As discussed earlier, there are still a number of issues with the current set of quality measures within the PQRS program that warrant ongoing improvement efforts as it is transitioned into the new VBP program. Additionally, in order to provide truly high quality care (in terms of process and outcomes measures, as well as patient experience), physicians and practices must make significant and ongoing improvements in their day-to-day clinical practice workflows, practice management policies and processes, approaches to team-based care (within and outside of the practice walls), etc. These efforts add value in ways that current measures simply cannot capture fully—and should therefore be rewarded at a higher level than is currently proposed.

Performance Pool Funding

As outlined in the discussion draft, “for 2017, the funding available for VBP incentive payments would be equal to eight percent of the total estimated spending for VBP eligible professionals” (which is the projected 2017 amount tied to performance under the current law programs). “The entire funding pool for a year would be paid out to eligible professionals based on their VBP composite score for a specified performance period [which is still to be determined], with those achieving the highest scores receiving the greatest incentive payment.” The proposal then calls for the funding pool to be increased to nine percent in 2018 and ten percent in 2019. Starting 2020, the Secretary would have the authority to increase, but not lower, the funding pool.

To date, ACPs recommendations and feedback in terms of the SGR repeal discussions have focused on the provision of positive incentives; typically only supporting penalties (or negative annual “updates”) after an extended period of time. However, ACP notes that this program is very much aligned with the current Medicare Value-Based Modifier (VBM) program, for which ACP currently provides qualified support, and offers regular, ongoing feedback and recommendations to CMS for how to implement and improve the program. Therefore, the College understands that a budget neutral program likely will result in a spectrum of participation and performance across all clinicians, some of whom may receive higher payment and some may be subject to lower payments. **The College is willing to support this approach, but again wants to note the significant importance of continuing the 10 percent primary care bonus beyond 2015 and of providing meaningful support to small practices—beyond those located in health professional shortage areas (HPSAs) or rural areas.**

Additionally, ACP strongly recommends that the Committees take into account lessons learned by CMS in rolling out the VBM program and also follow CMS’ lead in providing multiple opportunities for stakeholder feedback in the implementation of the newly proposed VBP program.

Assistance to Small Practices

ACP is strongly supportive of assistance being provided to EPs in HPSAs or rural areas—and appreciates that the discussion draft details funding to provide this assistance. However, we would recommend expanding the assistance and the funding available to also help small practices in other areas of the country.

ACP would also like the Committees to consider including hardship exemptions, like those included in the “Medicare Physician Payment Innovation Act of 2013” (H.R. 574), for physicians who cannot make such a transition through no fault of their own (e.g., due to limitations in the nature of a medical practice or other special circumstances, such as those in smaller practices, late career physicians, and physicians in underserved areas).

Feedback for Performance Improvement

ACP is strongly supportive of the Secretary providing confidential feedback on performance in the quality and resource use categories to professionals on a timely basis, such as quarterly, and via multiple mechanisms, such as a web-based portal or qualified clinical data registries.

Encouraging Alternative Payment Model Participation

As noted earlier, physicians in “advanced APMs” will be exempt from the VBP program and will receive a 5% bonus, starting in 2016 through 2021 (which then drops to 2% in 2024). This 5% bonus would be in addition to any increased revenue that APMs may earn from the specific payment rules that apply to their model (for instance, shared savings for ACOs, or risk adjusted per capita payments plus FFS for PCMHs).

ACP understands that advanced APMs are defined as programs that involve two-sided financial risk and a quality measurement component (e.g., ACOs/the Medicare Shared Savings Program); however, it would also apply to PCMH practices that are part of the current Medicare Comprehensive Primary Care Initiative (CPCI) should that program be deemed successful (by CMS actuaries—via improved quality while maintaining or reducing cost or reduced costs while maintaining quality), as well as future PCMH practices to which that program might expand. The justification for this exemption from the two-sided financial risk requirement for advanced APMs is the strict milestones required of the CPCI practices, along with the external validation from the actuarial analysis.

ACP is strongly supportive of this approach in that it creates a true “off ramp” from traditional fee for service for physicians participating in alternative payment models. ACP is also appreciative that the overall discussion draft offers PCMH practices essentially two pathways for improved Medicare payment over the flat baseline—either through the highest possible clinical process improvement score within the VBP or through recognition as an advanced APM and thus be able to receive the 5 percent bonus.

ACP would strongly recommend that the Committees ensure that the bonuses for advanced APMs be seamless. As outlined above, the current proposal includes a 5% bonus from 2016 to 2021 and then a 2% bonus starting in 2024—therefore, it is not clear what bonus, if any, advanced APM participants would receive in 2022 and 2023. This should be remedied in the legislative language, with the 5% bonus being extended through the end of 2023.

The revenue thresholds proposed for advanced APMs in the discussion draft seem reasonable, but should perhaps be established via rulemaking rather than formalized in the statute. This would allow for time for input from multiple stakeholders and for consideration of any intended or unintended impacts these revenue thresholds may have.

Finally, ACP would like to recommend that the Committees allow additional flexibility in terms of the definition of advanced APMs. The legislation should include opportunities for specialty societies and other stakeholders to propose additional new models, some of which may not include a 2-sided risk component. However, if those models are deemed successful through an actuarial analysis that determines the model improves quality while maintaining or reducing cost or reduces costs while maintaining quality (in line with the standards that have been established for the Medicare CPCI program discussed above), then they too should be approved as advanced APMs and considered exempt from the VBP program.

Care Coordination for Complex Chronic Care Needs

The proposal would establish payment for one or more codes for complex chronic care management services, beginning in 2015. Payments for these codes could be made to professionals (physicians,

physician assistants, nurse practitioners, and clinical nurse specialists) practicing in a patient-centered medical home or comparable specialty practice certified by an organization recognized by the Secretary who are providing care management services. In order to prevent duplicative payments, only one professional or group practice could receive payment for these services provided to an individual. Payments for these codes would be budget-neutral within the physician fee schedule.

ACP is pleased to see that the bill would solidify in statute new complex chronic care management codes that will be extremely beneficial to internal medicine and many other specialties. The establishment of these codes has been a top priority of the College for several years—and we believe that they are an important and welcome step in recognizing the full breadth of primary care through the fee-for-service payment system.

Therefore, the College strongly supports allowing practices that have received independent certification or recognition as a PCMH or PCMH-N (specialty practice) to be recognized by CMS as satisfying the requirements to bill and be reimbursed for the complex chronic care management without necessitating that they provide additional documentation to CMS. Additionally, ACP recommends that the Committees establish a pathway that would allow physicians who are not in a PCMH-certified practice to demonstrate that they meet the standards to bill and to be paid for these proposed new codes.

Accurate Valuation of Services Under the Physician Fee Schedule

The discussion draft outlines the following:

In each of 2016, 2017, and 2018, the target for identifying misvalued services is one percent of the estimated amount of expenditures under the physician fee schedule. If the target is met, that amount would be redistributed in a budget-neutral manner within the physician fee schedule. If the target is not met, fee schedule payments for the year would be reduced by the difference between the target and the amount of misvalued services identified that year. This approach allows approximately \$3 billion in reduced expenditures to remain in the physician payment system.

The College would like to express our qualified support of this provision. ACP agrees with the Committee's viewpoint that misvalued services need to be identified and corrected; therefore, we support setting a specific numerical goal for achieving RVU reductions—but it is critically important that any savings achieved in this process be redistributed back to the physician payment pool, even if the target is not met. Removing those funds from the physician payment pool will be detrimental to all physicians, but particularly to those providing services already widely recognized to be undervalued (e.g., evaluation and management codes). **However, if the Committees do move forward with the proposed approach, then the College strongly recommends that they consider not reducing payments for evaluation and management codes even if the target is not met so as not to adversely impact primary care clinicians, which are critical to the overall success of the value-based payment and alternative model approaches that have been proposed in the discussion draft.**

Additionally, the College calls on the Committees to consider the significant work that has already been undertaken by the AMA/Relative Value Scale Update Committee (RUC) and CMS to address overvalued services—the RUC has reviewed approximately 60 percent of the codes to date, resulting in an estimated savings of approximately \$1.5 billion with more in the pipeline. These efforts should be credited toward the 1 percent target over the next 3 years. Additionally, there are studies currently underway by the HHS Assistant Secretary for Planning and Evaluation (ASPE) and the RAND Corporation focused on various aspects of how existing codes are valued. The recommendations

from these studies are expected to be released in the coming year and should also be taken into account by the Committees and CMS in the longer term for how to meaningfully address misvalued codes.

The discussion draft also calls for a Government Accountability Office (GAO) study of the RUC processes for making recommendations on the valuation of physician services. **ACP is not opposed to such a study, but also recommends that the Committees consider the recent, significant changes the RUC is making in their processes in terms of representation, transparency, and survey methodology,⁵ as well as the ongoing studies by ASPE and RAND (referenced above) to determine the focus of this GAO study in order to ensure that it adds information that can be used to meaningfully improve how clinical services are valued.**

Another aspect of the discussion draft's approach to improving valuation of services under the physician fee schedule is as follows:

The Secretary would solicit information from selected professionals to assist in accurate valuation under the fee schedule. Professionals who submit the requested information may be compensated, while those who do not submit information would receive a ten percent payment reduction for all services in the subsequent year. Practices with ten or fewer professionals, as well as practices that submitted information the previous year, are exempted from these submission requirements.

ACP would again like to offer our qualified support for this aspect of the proposal. The College is supportive of using multiple valid data sources to improve the accuracy of relative values within the fee schedule—and of having a significant physician input into the process of improving those values. Therefore, we are pleased to see that the Committees included a specific call for physician reporting of data—and that they would be compensated for submitting information. However, the penalty associated with not reporting the requested information is significant and out of proportion with the anticipated savings that improvements in misvalued services are expected to generate. **Therefore, the College opposes the inclusion of these penalties.**

Recognizing Appropriate Use Criteria

The proposal would implement a program requiring ordering professionals to consult with appropriate use criteria for advanced imaging and electrocardiogram services. The discussion draft states:

In consultation with stakeholders, the Secretary would specify appropriate use criteria from among those developed or endorsed by national professional medical specialty societies or other entities. The Secretary would identify mechanisms, such as clinical decision support (CDS) tools, that could be used by ordering professionals to consult with appropriate use criteria and communicate to the Secretary that such consultation occurred. Payment would not be made for the advanced imaging or electrocardiogram service if consultation with appropriate use criteria did not occur. Prior authorization would apply to outlier professionals whose ordering is inconsistent as compared to their peers. Based on the experience with this program, the Secretary could expand the use of appropriate use criteria to other services.

⁵ AMA Wire. AMA Announces RUC Process Improvements in Transparency, Methodology (October 29, 2013) <http://www.ama-assn.org/ama/pub/ama-wire/ama-wire.page?plckController=Blog&plckBlogPage=BlogViewPost&UID=e38cf47a-fc5f-473b-9234-c9e714c1c8f0&plckPostId=Blog%3ae38cf47a-fc5f-473b-9234-c9e714c1c8f0Post%3a74566ece-7b67-4621-a427-052dfdbffba&plckScript=blogScript&plckElementId=blogDest#.UnxMFRko6P9>.

ACP supports monitoring practices that are outliers in their utilization of advanced imaging services, particularly those that own their own facilities, and encouraging educational interventions and use of professionally-developed appropriate use criteria for such outliers. **Therefore, ACP would like to express qualified support for such a requirement and recommend that it be required only for outlier practices that have higher utilization than peers or have shown to have an unusually high number of advance imaging and electrocardiogram services that are not supported by appropriate use criteria, and should also include educational interventions .** An example of an educational intervention that could be employed is ACP’s High Value Care Initiative (HVC),⁶ which includes clinical, public policy, and educational components, and has been designed to help physicians and patients understand the benefits, harms, and costs of an intervention and whether it provides good value, as well as to slow the unsustainable rate of health care cost increases while preserving high-value, high-quality care. ACP would then support applying prior authorization to outlier professionals whose ordering remains inconsistent as compared to their peers (even after documented consultation with appropriate use criteria and educational interventions). **Physicians who are not currently outliers should not be required to document consultation with appropriate use criteria (or be subject to prior authorization), as it would impose an additional burden on those that are clearly not contributing to overuse and excessive costs in the system.**

Additionally, ACP would recommend that the Committees direct CMS to authorize incentive payments for all physicians (not just outliers) who employ shared decision-making with patients, as well as those who use clinical-decision support tools based on appropriate use criteria, potentially via a modifier to E/M codes, which would then be budget neutral within the Medicare physician fee schedule.

Expanding the Use of Medicare Data for Performance Improvement

ACP is generally supportive of the proposal for allowing those that currently receive Medicare data for public reporting purposes (qualified entities, “QEs”) to provide or sell non-public data analyses to physicians and other professionals to assist them in their quality improvement activities. However, it will be important that costs to practices associated with obtaining these data be reasonable so that practices can truly benefit from this expansion and be able to meaningfully use their data.

Transparency of Physician Medicare Data

The proposal would require HHS to publish utilization and payment data for physician and other practitioners on the Physician Compare website in order to assist beneficiaries in selecting professionals by enabling them to search for professionals by name, specialty, and services. The draft goes on to note that professionals would continue to have an opportunity to review and correct their information prior to its posting on the website.

The College supports the overall goals of the Physician Compare Website and supports efforts to improve transparency in the health care system. Transparent healthcare information is useful for a wide range of stakeholders, and can help a patient and their families make more informed health care choices. ACP recommends that evaluation of physician performance be based on a number of important criteria, including information being reliable and valid; transparent in its development; open to prior review and appeal by the physicians and other health care professionals referenced; minimally burdensome to the reporting physician and other healthcare professionals; and comprehensible and useful to its intended audience including a clear statement of its limitations. **The College further emphasizes the importance of physicians and other health care professionals having timely access to**

⁶ Additional information on ACP’s High Value Care Initiative can be found at: http://www.acponline.org/clinical_information/resources/high_value_care/ .

performance information prior to public reporting and a fair chance to examine and appeal potential inaccuracies.

Conclusion

ACP is committed to facilitating efforts to repeal the Medicare SGR and reform the Medicare physician payment system and sincerely appreciates the release of this discussion draft by the leaders of the Senate Finance Committee and the House Ways and Means Committee. The College encourages the Committees to consider our recommendations as they move forward and is happy to respond to any questions that the Members or staff may have regarding our feedback. Please contact Richard Trachtman at rtrachtman@acponline.org or 202-261-4538 or Brian Buckley at bbuckley@acponline.org or 202-261-4543 if you have any questions or would like additional information.

Sincerely,

A handwritten signature in black ink that reads "Molly Cooke". The signature is written in a cursive, flowing style.

Molly Cooke, MD, FACP
President

Cc: Members, Senate Finance Committee
Members, House Ways and Means Committee