



May 31, 2013

The Honorable Max Baucus
Chairman, Finance Committee
U.S. Senate
Washington, DC 20510

The Honorable Orrin Hatch
Ranking Member, Finance Committee
U.S. Senate
Washington, DC 20510

Dear Chairman Baucus and Ranking Member Hatch:

On behalf of the American College of Physicians (ACP), I appreciate the opportunity to respond to your request for ideas on how to improve the Medicare physician fee schedule and the fee-for-service (FFS) system overall to provide stability for physician reimbursement and lay the necessary foundation for a performance-based payment system following the repeal of the Sustainable Growth Rate (SGR). We applaud you for your leadership in addressing the flawed SGR and for your initiative in working to advance a solution with input from physicians, physician organizations, and other stakeholders.

ACP is the largest medical specialty organization and second-largest physician group in the United States, representing 133,000 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.

The College has a number of specific recommendations for the Committee to consider in response to the questions posed in your letter dated May 10, 2013. These recommendations and supporting evidence and implementation details are described below.

Question 1:

MedPAC and others have suggested changes they believe would improve the accuracy of fee schedule payment amounts and the validity of resource inputs used to establish payments for services under the fee schedule. What specific reforms should be made to the physician fee schedule to ensure that physician services are valued appropriately?

ACP recommendations in response to question 1:

1. Direct HHS to use multiple sources of data and feedback to determine the RVUs for services, in addition to the existing RVU Update Committee (RUC) process.
2. Authorize HHS to gather data on efficient delivery of services from a representative cohort of practices to inform decisions on RVUs.
3. Beginning in 2015, authorize HHS to set a numerical goal—not a requirement—for RVU reductions of at least 1.0 percent of fee-schedule spending for five consecutive years, to be redistributed back to the total pool of RVUs and, specifically, toward increasing the RVUs for undervalued evaluation and management services.
4. Authorize HHS to make payment for services to enhance care coordination, particularly for patients with complex chronic diseases, including payment for work associated with such services that falls outside of a face-to-face visit.

5. Direct HHS to quantify the system-wide savings expected to result from payments for physician services that improve care coordination and provide patient-centered care (often via non face-to-face activities)—through new codes, as well as alternative delivery and payment models, such as patient-centered medical homes (PCMHs) and accountable care organizations (ACOs)—and use the amount of expected savings to increase the limit by which aggregate expenditures may rise before triggering an offsetting downward adjustment to maintain budget neutrality.
6. Direct HHS to explore incentives within FFS for care coordination services provided by recognized PCMHs and Patient-Centered Medical Home Neighborhood practices, including enhanced FFS payments for evaluation and management services and/or payment for specific PCMH-related activities.
7. Eliminate provider-based billing delivered in an outpatient, hospital-system owned practice when the care being provided is not dependent on the hospital facility and its associated technologies. However, elimination of provider-based billing in such circumstances should only be carried out in conjunction with other new and innovative approaches, building on payment and delivery system reform efforts, in order to ensure adequate support of safety-net facilities.

Each of these recommendations, in response to question 1, is discussed in more detail below.

Use of Multiple Data Sources to Value Services

MedPAC has noted that the Secretary lacks current, objective data needed to set the fee schedule's relative value units (RVUs) for practitioner work and practice expenses. It further recommends that, "the Congress direct the Secretary to regularly collect data—including service volume and work time—to establish more accurate work and practice expense values."

ACP agrees that CMS should use multiple sources of data and feedback in order to determine the RVUs for services. The College also believes that any efforts to collect additional data to ensure the accuracy of RVUs should supplement *and not replace* the excellent work being done by the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC) to provide CMS with expert advice on improving RVU accuracy. We note that RUC has, on its own, made major improvements in its representation and processes, including adding new primary care and geriatric seats and disclosing the aggregate votes on RVU recommendations. Data sources to improve the accuracy of RVUs should include:

- Continuation of RUC and CMS initiative to identify and correct potentially misvalued services. This effort has focused on codes that have experienced substantial changes in length of stay, site of service, volume, practice expense, and other factors that may reflect on the amount of physician work. It also involves a review of evidence that the work for a specific service may have changed since it was originally valued.
- Ongoing review by CMS of data analysis conducted by independent researchers, including those focused on clinician work time, service volume, and practice expenses. CMS should also encourage these researchers to conduct assessments of other possible data sources, such as from electronic health records, patient scheduling systems, cost accounting, and other physician practice-based sources of data.
- The establishment of a group of independent experts to advise CMS in its process of reviewing RVUs, as recommended by MedPAC. This group should focus on identifying potentially over-valued services and data sources that can be used to improve the accuracy of RVUs. The group should supplement the advice that is currently provided by the RUC. Congress could direct CMS to take this action or the agency can use its existing authority.
- Per MedPAC's testimony before the Senate Finance Committee on May 14, 2013, the collection of data on a recurring basis from a cohort of practitioner offices and other settings where

practitioners work. MedPAC noted that participating practices and other settings could be recruited through a process that would require participation in data reporting among those selected. The cohort would consist of practices with a range of specialties, practitioner types, patient populations, and furnished services. Further, MedPAC recommends that the cohort should consist of practices with features that make them efficient (e.g., economies of scale, reorganized delivery systems).

- ACP supports this recommendation, with the caveat that collection of data from a cohort of practices must ensure that practices in underserved communities (rural, inner city, etc.) and small practices are included in the data collection. Those practices may have unique challenges that may require more resources and therefore make them appear to be less efficient due to the patient populations they serve, their location, and/or their size. Additionally, the definition of the term “efficiency” must be clearly defined and the process for finalizing that definition should include physician and other key stakeholder input. Also, collection of data on practice “efficiency” needs to consider the clinical outcomes (quality) of care provided.

Identify & Reduce Payment for Overpriced Services

MedPAC further recommends that the Secretary should be directed to analyze the data collected by the cohort of efficient practices (discussed above), identify overpriced services, and adjust the RVUs of those services. Then, “starting in 2015, the Congress should specify that the RVU reductions achieve an annual numeric goal—for each of five consecutive years—of at least 1.0 percent of fee-schedule spending.”

ACP supports the concept of setting a specific numerical goal—but not as a requirement—for achieving RVU reductions to be redistributed back to the physician RVU pool, with the following caveats and clarifications:

- First, we would caution against making this a strict goal, which could create problems in a year where the data may be incomplete or inconclusive or could even limit RVU reductions in a given year to 1.0 percent when the data may support even greater reductions. Rather ACP recommends making 1.0 percent a target to strive toward.
- Second, while the cohort of practices should be a significant data source, it should not be the only one used by the Secretary to make RVU changes—as discussed earlier, multiple data sources should be employed.
- Third, Congress should ensure that the focus of these RVU reductions be exclusively on those services that have been determined, via valid data sources, to be overvalued.
- Fourth, while MedPAC does call for these reductions to occur in a budget neutral manner, **ACP strongly recommends that these adjustments be redistributed back into the overall RVU pool and specifically re-allocated to E/M codes without regard to the specialty of the physician who is billing the E/M code** (with the exception of those E/M codes included within global surgical periods). This has not been the case to date, with previous savings sometimes being distributed outside of the physician fee schedule.

Provide Payment for Care Coordination and Patient-Centered Care

ACP further recommends that Medicare pay for services that facilitate care coordination and promote patient-centered care. There has been movement toward this end via the recent development, valuation, and implementation of the transitional care management (TCM) codes. And this movement should continue—therefore, ACP is calling for Medicare to begin paying for services relating to management of patients with complex chronic conditions. These code sets are designed to allow physicians to report their non-face-to-face time, and the clinical staff (team) time spent on patient cases—an important element of the overall PCMH model. ACP is continuing to be actively engaged in this

process in order to ensure that the complex, chronic care codes can become part of the Medicare physician fee schedule in the near future.

Congress should facilitate these efforts by directing CMS to account for system-wide savings expected to result from payments for physician services that improve care coordination and provide patient-centered care (often via non face-to-face activities)—through these codes, as well as alternative delivery and payment models, such as PCMHs and accountable care organizations (ACOs)—and use the amount of expected savings to increase the limit by which aggregate expenditures may rise before triggering an offsetting downward adjustment to maintain budget neutrality. The Medicare fee schedule (Part B) should get the benefit of these savings from specific codes and RVUs for care coordination and PCMH activity that can reduce preventable hospitalizations, which would typically be seen in Part A of the program. **Additionally, like savings achieved from reductions in overvalued services, these savings could also be specifically re-allocated to E/M codes for all specialties.**

In addition, Congress should specifically authorize CMS to pay for work associated with care coordination that falls outside of the face-to-face encounter with the patient. ACP understands that CMS has questioned whether it has the statutory authority to pay physicians for the work that falls outside of the face-to-face visit associated with coordination of care with other clinicians, family caregivers, and others involved in the patient's care, even though such work is an essential component of effective care coordination.

While this will be discussed further in our response to the Senate Finance Committee's question number 3, it is also worth noting here that ACP believes that the PCMH model, and the related Patient-Centered Medical Home neighbor (specialty practice) model, has advanced enough to be scaled up for widespread implementation throughout Medicare in the immediate future. The growing amount of experience in both the public and private sectors on how to organize care around PCMHs, the thousands of physician practices that have already achieved recognition or accreditation as a PCMH, and the growing amount of data on the effectiveness of the model in improving care and lowering cost, makes it a logical approach to scale up to the broader Medicare program.

In addition to providing incentives for PCMHs through a value-based incentive program, as discussed under our responses to question 3, CMS can begin to take steps now to support the PCMH model within the FFS payment system. Merrell and Berenson¹ recently discussed options for how PCMH could be paid for in the short term, primarily within the existing fee-for-service system:

- **Enhanced fee-for-service evaluation and management payments.** This approach would be based on the current fee-for-service model, but would pay providers more for visits to help pay for medical home functions like use of technology, patient communication via phone or e-mail, and care coordination. This approach would create minimal administrative burden on providers and payers, but could perversely encourage more office visits rather than the complementary medical home activities it is meant to encourage.
- **Additional codes for medical home activities within fee-for-service payments.** The approach would create new current procedural terminology (CPT) codes to recognize important services not often paid for, such as smoothly transitioning patients from hospital to home or expanding hours of service. This approach has the advantage of building on the current system, but adds to administrative complexity.

¹ Merrell and Berenson (2010). Commonwealth Fund, <http://www.commonwealthfund.org/Publications/In-the-Literature/2010/May/Structuring-Payment-for-Medical-Homes.aspx>. Accessed May 28, 2013.

- **Per-patient per-month medical home payment to augment evaluation and management fee-for-service payments.** This hybrid model introduces a capitation (i.e., per-patient per-month) element into the fee-for service model. This approach will allow physicians flexibility with minimal administrative burden, but will likely require some variation in the monthly payment amount to account for the population served.
- **Risk-adjusted, comprehensive per-patient per-month payment.** A new approach to capitation, this method would set a single payment to cover all primary care services, not just medical home activities. Risk adjustment would have to be made at the individual level and mechanisms may be required to ensure that needed services are provided, given the potential incentive to withhold services.

Eliminate Provider-Based Billing

Another approach ACP recommends to ensure proper valuation of physician services—and achieve savings that can be distributed back into the RVU pool—is that Congress require the elimination of provider-based billing—where a service is charged at a higher rate when delivered in an outpatient, hospital-system owned practice, particularly when the care being provided is not dependent on the hospital facility and its associated technologies. This is also in line with previous statements made by MedPAC. However, the College notes that this approach should *only* be carried out in conjunction with other new and innovative approaches, building on payment and delivery system reform efforts, in order to ensure adequate support of safety-net facilities.

Question 2:

Physician services are critical to the ongoing health of Medicare beneficiaries. Appropriate utilization of physician services can lessen disease burden and reduce avoidable emergency department visits and hospitalizations. However, inappropriate or excessive utilization of physician-related services can negatively impact beneficiary health and drive up Medicare spending. Volume control mechanisms are not an inherent component of a FFS system. The SGR was intended to address excessive volume, but its mechanism is fatally flawed. What specific policies should be implemented that could coexist with the current FFS physician payment system and would identify and reduce unnecessary utilization to improve health and reduce Medicare spending growth?

ACP recommendations in response to question 2:

1. Direct HHS to explore alternatives to prior authorization, including creating incentives for use of appropriate use criteria, and exempting practices from prior authorization that are participating in value-based payment programs.
2. Authorize HHS to conduct a pilot-test of utilization benchmarking tools to enable physicians to compare their utilization patterns with their peers and make voluntary improvements as appropriate based on such data.
3. Direct HHS to explore ways to provide physicians with accurate data on the quality and total cost of care provided by other clinicians and hospitals within their geographic communities to enable them to make informed referral decisions.
4. Fund and certify shared decision support tools. Authorize payment to physicians who use such tools to engage their patients in shared decision-making, focused on the top twenty most expensive and/or most frequent, high priority performed procedures, particularly those that are considered preference-sensitive or are elective.
5. Continue to support and fund research on comparative effectiveness through the Patient-Centered Outcomes Research Institute.
6. While ACP supports continuation of the in-office ancillary services exemption under the Stark self-referral laws in order to provide patients with convenient, one-stop access to testing,

especially in models like the PCMH, the College is aware of concerns and data that physician ownership of diagnostic facilities may be associated with higher utilization, and therefore the College would support a program to monitor such utilization that is targeted at identifying practices that are outliers. Specifically, we recommend that Congress direct the Secretary to monitor utilization of high cost/high frequency testing in practices where physicians own their own facilities, to provide education feedback to outliers, and to encourage more extensive use of specialty-developed appropriate use criteria like those discussed below, particularly targeted at practices that are outliers in terms of their utilization of high frequency testing compared to practices that do not have an ownership interest in such facilities.

7. Authorize the Secretary to provide adequate Medicare payment for the extended and complex counseling required for physicians to develop end of life care plans with their patients

Each of the above recommendations, in response to question 2, is discussed in more detail below.

Alternatives to Prior Authorization

One of the most common approaches used to control utilization is prior authorization of services. While prior authorizations may serve this purpose, they are often a significant burden for physicians and patients—and can have a negative impact on the critically important physician-patient relationship—and therefore should have a strong base of utilization data that confirms patterns of overuse or misuse before being employed. ACP supports the use of prior authorization for specified services *only* if there is clear evidence that: (1) routine use of prior authorization substantially reduces the number of medically unnecessary services; and (2) the costs of conducting the prior authorization—including costs incurred by the physician's office in complying with the prior authorization requirements—do not exceed the potential savings. **ACP strongly recommends that the Committee direct HHS to examine alternative approaches to prior authorization, including:**

- **Incentivizing the use of appropriate use criteria (AUC), such as those developed by the American College of Cardiology (ACC)², and clinical guidelines by physicians in practice, which could be captured via a code modifier and backed up by documentation in the clinical record.**
- **Exempting practices from prior authorizations that are participating in delivery and payment models where a substantial portion of their payment is linked to: achieving structural capabilities to deliver care efficiently and effectively (such as PCMHs), shared savings and risk (ACOs), and/or bundled pay for episodes of care.**
- **Exempting practices from prior authorizations that are still operating in a fully fee-for-service system, but where a specified and significant percentage of their payments (e.g. more than 40%) are linked to performance metrics and those practices that consistently fall within accepted guidelines for particular tests after a determined observation period.**

Pilot Test Utilization Benchmarking Tools

To support these efforts to implement alternatives to prior authorization, ACP calls for the medical profession to be involved in the development of valid utilization guidelines on the frequency for which certain services are provided for patients with given diagnoses, as well as valid physician-specific utilization data that could be used as a basis of comparison with accepted community norms.

One method of collecting and reviewing the necessary data is via available utilization benchmarking tools, for example:

² Additional information on the appropriate use criteria developed by the American College of Cardiology (ACC) can be accessed at: <http://www.cardiosource.org/en/News-Media/Publications/Cardiology-Magazine/Choosing-Wisely-Update.aspx>

- AAPC E/M Utilization Benchmarking Tool³
- Proprietary tools developed by consulting groups, such as, such Milliman⁴ and MDTools⁵.

Therefore, ACP recommends that Congress call on the Secretary to investigate the validity of these available tools for physicians to compare their E/M utilization with that of other physicians, establish a deeming mechanism for those tools—and then implement a pilot incentive program for physicians that actively use them. The initial focus would be on the use of these tools; however, over time, the Secretary could then study the feasibility of more widespread, ongoing use of these tools and begin to assess their impact on overall quality and cost (by pairing the utilization data with other sources, such as data from the Medicare value-based payment program). Careful consideration would need to be given as to whether this approach might inadvertently lead to upcoding or downcoding and, if so, how that could be mitigated.

The tools discussed above are primarily focused on the use of E/M codes; however ACP recommends that Congress direct HHS to explore ways to provide physicians with accurate data on the quality and total cost of care provided by other clinicians and hospitals within their geographic communities to enable them to make informed referral decisions. Such data should not be focused only on E/M codes but on the total cost of care and outcomes associated with each clinician and hospitals in their community.⁶ This approach would not only be informative to specialists and subspecialists, but would also help primary care physicians to make more informed referral and hospital selection decisions by providing them with transparent and ongoing data on the types of tests and procedures their subspecialists colleagues are ordering.

Shared Decision Making and Patient Decision Aids

Patient decision aids are educational tools that can help patients and caregivers better understand and communicate their preferences about reasonable treatment options. Randomized trials consistently demonstrate the effectiveness of patient decision aids. In January 2013, Lee and Emanuel⁷ investigated the potential of shared decision making approaches, such as the use of patient-decision aids, on improving care and reducing cost. A subset of the evidence they highlight includes:

- A 2011 Cochrane Collaborative review of 86 studies showed that as compared with patients who received usual care, those who used decision aids had increased knowledge, more accurate risk perceptions, reduced internal conflict about decisions, and a greater likelihood of receiving care aligned with their values.
- Studies that illustrate the potential for wider adoption of shared decision making to reduce costs. The authors noted that, consistently, as many as 20% of patients who participate in shared decision making choose less invasive surgical options and more conservative treatment than do patients who do not use decision aids.

³ Information on the AAPC E/M Utilization Benchmarking Tool can be accessed at: http://www.aapcps.com/resources/em_utilization.aspx.

⁴ Information on Milliman health care benchmarking tools can be accessed at: <http://www.milliman.com/expertise/healthcare/services/benchmarking/>

⁵ Information on MDTools utilization benchmarking tools can be accessed at: <http://www.mdtools.com/mdtools/utilization-review/utilization-review.asp>

⁶ A May 2013 Kocher and Emanuel article in Annals of Internal Medicine, “The Transparency Imperative” outlines the significant need for greater price, utilization, and quality data transparency. Accessible at: <http://annals.org/article.aspx?articleid=1691701>.

⁷ Lee and Emanuel (2013). “Shared Decision Making to Improve Care and Reduce Costs” NEJM. Accessed at: <http://www.nejm.org/doi/full/10.1056/NEJMp1209500>.

- In 2008, the Lewin Group estimated that implementing shared decision making for just 11 procedures would yield more than \$9 billion in savings nationally over 10 years.
- A 2012 study by Group Health in Washington State showed that providing decision aids to patients eligible for hip and knee replacements substantially reduced both surgery rates and costs — with up to 38% fewer surgeries and savings of 12 to 21% over 6 months.

ACP recommends that Congress authorize a program to encourage broad adoption of patient decision aids to improve care as well as reduce costs and overutilization. Such a program could include:

- The development of and funding for implementation of decision aids focused on high cost or high frequency elective or preference-sensitive procedures/tests via a certification approach (discussed further below).
- Positive incentive payments for physicians who use guidelines to encourage high value care, such as those from ACP’s High Value Care Initiative⁸ and the *Choosing Wisely* Campaign⁹, and engage their patients in shared decision making using certified decision support tools in a patient visit.
- Measurement of utilization of such elective procedures in practices that use and document the decision tools compared to physicians and practices that do not.

Specifically, ACP recommends that CMS rapidly certify patient decision aids that have been rigorously evaluated by independent researchers for the top 20 most expensive and/or most frequent, high priority performed procedures, particularly those that are considered preference-sensitive or are elective—and then require that the use of those aids be documented. In addition, Medicare should create a methodology for physicians to document that they are using high value care guidelines and associated decision support tools in their practices. For instance, Medicare could allow physicians to indicate via a modifier to an E/M visit code (backed up with the appropriate documentation, which should ideally be facilitated by the electronic health record) that they have engaged their patients in shared decision-making, using a specialty society’s clinical guidelines to reduce utilization of marginal and ineffective care, supported by certified patient decision aids as available and appropriate. Physicians who provide such documentation would receive a higher payment for that E/M visit.

Comparative Effectiveness Information

The College strongly supports the explicit consideration of comparative clinical and cost-effectiveness information by all payers, physicians, and consumers in their evaluation of a clinical intervention.

Therefore, ACP strongly supports continued funding and support for the Patient Centered Outcomes Research Institute (PCORI) and its efforts to produce comparative effectiveness information that physicians and their patients can use to engage in a robust shared-decision process regarding healthcare needs. Over time this information can be translated into more specific mechanisms to ensure appropriate utilization.

Physician Self-Referral

The Ethics in Patient Referrals Act (1989), also known as the “Stark Law”, prohibits physicians from referring Medicare patients for “designated health services” (DHS) to entities with which they (or an immediate family member) have a financial relationship unless the relationship fits within an exception. This act has been revised and updated on multiple occasions. While initially it covered only laboratory

⁸ Additional information on ACP’s High Value Care Initiative can be accessed at: <http://hvc.acponline.org/>

⁹ Additional information on the Choosing Wisely effort can be accessed at: <http://www.choosingwisely.org/>.

and x-rays ancillary services, it has been expanded over time to include such DHS as imaging, radiation therapy, home health, durable medical equipment, and physical therapy.

The in-office ancillary services (IOAS) exception allows physicians to provide most DHS to patients in their offices under certain conditions. Physicians, particularly in certain specialties, have expanded their practices over time to provide these DHS services under the in-office exception. These services—particularly diagnostic imaging—account for a significant share of Part B revenue for certain specialties. (e.g. Cardiology, Vascular Surgery, Orthopedic Surgery, Urology and to a lesser extent Internal Medicine).¹⁰

ACP believes that the IOAS exemption enables physicians to provide patients with convenient, on-site access to high quality services at the point of care. For instance, patients benefit by having access to on-site laboratories for routine tests done in their own physician offices. Patient-Centered Medical Homes also strive to provide patients with the full spectrum of services they need, often within the practice itself. Accordingly, the College does not support elimination of the IOAS exception.

However, the College is aware of concerns and data that suggest that the IOAS exception may in some cases be associated with excess utilization of services and may not always result in greater convenience for patients. In 2010, MedPAC explored the validity of a key (but not the only) rationale for the IOAS exception, which is that patients should be able to receive ancillary services during their office visits to enhance patient convenience. MedPAC explored this rationale by examining the share of ancillary services received by patients on the same day as a visit. The analysis of Medicare claims data indicates that several types of ancillary services are infrequently provided on the same day as a patient's visit. Specifically outpatient therapy services are rarely provided on the same day as a related evaluation and management (E&M) or consultation office visit; fewer than half of advanced imaging, ultrasound, and clinical lab tests are performed on the same day as an office visit; and about half of standard imaging studies are performed on the same day as an office visit.

Additionally, the GAO released a study in September 2012 examining self-referrals for advanced imaging services. The results indicated that from 2004 through 2010, the number of self-referred and non-self-referred advanced imaging services—magnetic resonance imaging (MRI) and computed tomography (CT) services—both increased, with a larger increase among self-referred services. For example, the number of self-referred MRI services increased over this period by more than 80 percent, compared with an increase of only 12 percent for non-self-referred MRI services. Likewise, the growth rate of expenditures for self-referred MRI and CT services was also higher than for non-self-referred MRI and CT services. The GAO's analysis also showed that clinicians' referrals of MRI and CT services substantially increased the year after they began to self-refer; that is, they purchased or leased imaging equipment, or joined a group practice that already self-referred.

It is important to note, though, that neither the GAO nor MedPAC, however, have recommended that the IOAS be eliminated.

Therefore, ACP recommends that Congress direct the Secretary to monitor utilization of high cost/high frequency testing in practices where physicians own their own facilities, to provide timely education feedback, and to encourage more extensive use of specialty-developed appropriate use criteria like those discussed earlier, directed at practices that are outliers in terms of their

¹⁰ MedPAC Report to Congress, June 2008. Accessible at: http://www.medpac.gov/documents/Jun08_EntireReport.pdf.

utilization of high frequency testing compared to practices that do not have an ownership interest in such facilities.

Payment for End-of-Life Care Planning

Research is showing that provision of end of life counseling is leading to better care and reduced utilization:

- A 2012 study conducted by researchers for the Commonwealth Fund¹¹ found that programs focused on end-of-life care have provided physicians with techniques for delivering bad news, managing transitions to palliative care, and handling requests for therapies that are likely to be futile. The researchers also found that these programs helped to elicit patient preferences, leading to lower utilization in some locations.
- Other researchers¹² using a predictive model concluded that telephonic end-of-life counseling provided as an ancillary Medicare service, guided by a predictive model, can reach a majority of individuals needing support and can reduce costs by facilitating voluntary election of less intensive care. Average Medicare costs were \$1913 lower for intervention group decedents compared with control group decedents in the last 6 months of life for a total savings of \$5.95 million.

ACP recognizes that physicians should routinely raise the issue of advanced care planning with competent adult patients during outpatient visits and encourage them to discuss their values and preferences with their surrogates and family members. Physicians, patients, and their family or caregivers should work prospectively in developing a plan that recognizes the patient's views and treatment preferences for their last months and years of life. **Therefore, ACP recommends that Congress call on the Secretary to provide adequate Medicare reimbursement for the extended and complex counseling required for physicians to develop end of life care plans with their patients.** This payment approach should also be applied to care for patients with dementia and the critical time physicians and their teams spend working with the families of individuals at the end of life or with dementia to ensure appropriate care is provided.

Medicare Value-Based Payment Program

ACP is supportive of the Medicare Value-Based Payment (VBP) Program—if it is implemented in a reasonable and meaningful way for physicians—and is providing ongoing feedback to CMS as they work to implement this program in line with the statutory requirements. The VBP program is focused on reviewing cost and quality data, which can be indicators of utilization of services but are not necessarily predictors of whether those services are being overutilized. However, the data from this program could be used in conjunction with other data sources on utilization (discussed above) to understand the impact of approaches to reduce overutilization on the cost and quality of care.

Question 3:

Shifting from a FFS system to an alternative payment model will be a major change for many physicians. Within the context of the current FFS system, how specifically can Medicare most effectively incentivize physician practices to undertake the structural, behavioral, and other changes needed to participate in alternative payment models?

¹¹ Commonwealth Fund, June/July 2012 - <http://www.commonwealthfund.org/Newsletters/Quality-Matters/2012/June-July/In-Focus.aspx>.

¹² Hamlet et al., Am J Manag Care (2010) "Impact of predictive model-directed end-of-life counseling for Medicare beneficiaries." Accessed at: <http://www.ncbi.nlm.nih.gov/pubmed/20469958>.

ACP recommendations in response to question 3:

1. Provide positive and stable annual Medicare payment updates to all physicians, with a higher update for undervalued evaluation and management services, for a period of at least five years, during which physicians would begin to transition to value-based payment models. The College does not support the MedPAC proposal for a ten year freeze in payments for primary care services and an across-the-board reduction in payments for all other services.
2. Authorize HHS to implement a phased approach to repealing the SGR and progressing to better, value-based payment and delivery models.
3. Direct the Secretary to facilitate a broad transition to value-based delivery and payment approaches, including PCMH, PCMH-N specialty practices, ACOs, and other alternative models using a clearly laid out set of criteria for selecting/deeming programs that would qualify for additional VBP updates during a five year transition period.
4. Authorize the Secretary to test and study optional, alternative payment models that practices could opt into—i.e., practices could remain under traditional FFS or opt for either the “Prometheus” Evidence-informed Case Rate (ECR) Model, where available, or the Comprehensive Global Payment Model.
5. Expand payment bundles to increase coordination of care and facilitate the adoption of broader payment and delivery system reform—and Congress could call on the Secretary to conduct this expansion, likely via a broadening of the bundled payment effort already underway within the CMS Innovation Center (CMMI).

Each of the above recommendations, in response to question 3, is discussed in more detail below.

Review of MedPAC’s Proposal for Post-SGR Payment Updates

ACP believes that it is essential that post-SGR payment updates provide a period of stability that is long enough to allow physicians to transition to VBP models, as discussed in more detail below. The College’s support for positive and stable updates stands in contrast to the recommendations made by MedPAC in 2011, and reaffirmed more recently by the Commission, to freeze primary care payments and reduce payments to non-primary care services. In 2011, MedPAC released a proposal for repealing the SGR that included a freeze in payments for some services provided by some primary care physicians for the next 10 years, and a 5.9 percent reduction each year for 3 years—followed by a freeze—for all other physician services. This proposal has now been updated, based on the new, significantly reduced CBO cost estimate for SGR repeal, to state that the non-primary care services should be reduced by 3 percent or less each year for 3 years (approximately 9 percent overall). While ACP appreciates that MedPAC has put forward a comprehensive proposal to eliminate the SGR with the intent of protecting access to primary care for Medicare beneficiaries, the College has very substantial concerns that have precluded us from supporting it—these concerns were outlined in detail in a letter to MedPAC.¹³ In brief these concerns include:

- With a freeze, primary care payments would continue to lose value due to inflation.
- Many primary care physicians who would qualify under the MedPAC proposal (i.e., who are designated as primary care specialists and whose primary care E/M charges are 60 percent or more of total billings) also provide ancillary services that would be subject to the approximately 9 percent cut over the next three years.
- This two tiered system for defining eligible primary care physicians and designated services by specialty and percentage of billing may leave out many primary care internists who truly provide comprehensive primary care, because their ancillary services and/or hospital visits combined make up more than 40 percent of their total Medicare billings.

¹³ ACP letter to MedPAC re: their SGR repeal proposal, September 23, 2011. Accessible at: http://www.acponline.org/acp_policy/letters/medpac_proposal_repeal_sgr_2011.pdf.

- The approximately 9 percent cut in payments to non-primary care specialists will adversely affect patient access to care to physicians in every other specialty, including specialties that are facing substantial workforce shortages, and without any evidence to justify that such a cut is merited, appropriate, or serves important policy goals.
- The MedPAC proposal will unintentionally undermine the goal of transitioning to new payment models aligned with value.
- A ten-year freeze for primary care services, and the reduction in payments for other services followed by a freeze, will result in more cost shifting to the private sector. More cost shifting to the private sector will result in further cost sharing and benefit erosion for workers.
- The approximately 9 percent cut in payments for non-primary care services will make it much harder to get other changes in payment policies, such as redistributing payments for mis-valued RVUs to the physician payment pool as MedPAC intends, because specialists who already are being cut will likely strongly resist any other changes that will further reduce payments and potentially, reduce access to their services

Due to these significant concerns, **ACP does not support the MedPAC proposal for a ten year freeze in payments for primary care services and an across-the-board reduction in payments for all other services.** The College offers an alternative approach for the Committee’s consideration below.

ACP Recommended Key Elements of a New Medicare Physician Payment System

In our recent testimony before the House Ways & Means Committee¹⁴, ACP recommended that a permanent solution to the SGR problem should facilitate a transformation of the Medicare physician payment system from one that incentivizes volume to one that rewards high-quality and efficient care.

The College supports a phased approach to repealing the SGR and progressing to better, VBP and delivery system models that include the following seven key elements:

1. Eliminate the SGR, effective with enactment of the authorizing legislation.
2. Provide stable and positive baseline annual payment updates for all physicians, during which physicians would begin to transition to VBP models over the next five years. The baseline updates should be set by statute, and provide higher baseline updates for undervalued E/M services (without regard to the specialty of the physician providing such services).
3. During the period of guaranteed baseline updates described above, create opportunities for physicians to have their baseline update increased, on a graduated scale, for participating in an approved/deemed transitional VBP model or program.
4. Allow reasonable but not unlimited time for all physicians to get on a transitional VBP pathway that works for their specialty, practice setting, and patient population served, without holding back those who have already begun the journey. Those who are ready now to begin delivering care in models or programs that have shown the potential to result in better clinical outcomes, with more efficient and effective use of resources, should be able to qualify for higher VBP updates as early as January 2014.
5. The pathways to qualify for transitional VBP updates should consist of designated payment/delivery system models—including PCMHs, PCMH-Neighborhood (PCMH-N) specialty practices, ACOs, bundled payments—based on specified criteria, and deemed private sector quality improvement programs. Such a deeming process must ensure that deemed programs have core capabilities to advance quality and effectiveness and can produce measurable results on performance.
6. Performance measures used in transitional VBP programs should go through a transparent, multi-stakeholder review and validation process, regardless of the source of the measure.

¹⁴ ACP’s full statement for the record, on May 7, 2013, titled “Developing a Viable Medicare Physician Payment Policy” can be accessed at: http://www.acponline.org/acp_policy/testimony/ways_and_means_medicare_physician_payment_testimony_2013.pdf.

7. At the end of the five year transitional period, the expectation would be that most physicians would be in or well on their way to participating in an approved program. We believe it would be appropriate to consider a mix of positive incentives but also potential reductions in payments, *after a reasonable transition period with pathways for all physicians and specialties to participate in an approved VBP program*, for physicians who decline to participate in a meaningful program by a specified date. However, there should be hardship exemptions for physicians (such as those in smaller practices, late career physicians, and physicians in underserved areas) who will be particularly challenged in making the transition. We note that a similar approach of positive incentives and penalties with hardship exemptions is included in the *Medicare Physician Payment Innovation Act* (H.R. 574), which we have endorsed.

As was outlined in detail in our testimony, as well as in additional feedback the College has provided over the past several months to the House Ways & Means and Energy & Commerce Committees,¹⁵ **ACP believes that the groundwork is already in place for Congress to begin to facilitate a broad transition to VBP and delivery approaches, including PCMH, PCMH-N specialty practices, ACOs, and other models, using a clearly laid out set of criteria for selecting/deeming programs that would qualify for additional VBP updates during a five year transition period.** Such a transition must recognize that physicians are starting out in different places on incorporating best practices to achieve greater value for their patients, with some physicians already being very far down the road in redesigning their practices to achieve better value, while others are just getting started on the entrance ramp to VBP and delivery models. Physicians at all points along this spectrum need to have models available to them that are appropriate and realistic for their particular stage of development, but with the opportunity for them to *earn additional VBP updates* (above the baselines to be set in the statute) on a graduated VBP payment scale that *provides greater rewards for those who are doing more to improve outcomes and effectiveness of care*. Such a graduated VBP scale should be based on how much a particular deemed or approved program has demonstrated core capabilities to achieve better clinical outcomes, with more effective use of resources. Studies suggest that the most effective programs have some or all of the following components associated with better outcomes and more effective care:

- Reporting on *validated* clinical performance measures appropriate for the specialty of the physician patient population being served.
- Coordinated, interdisciplinary and team-based care “best practices” to overcome fragmentation of medicine into distinct “silos” of care.
- Tracking of patient outcomes through patient-registry systems.
- Patient engagement and shared decision-making.
- Commitment to evidence-based practice guidelines to reduce ordering of marginal, ineffective, low value or even harmful care, such as ACP’s High Value Care Initiative, and the *Choosing Wisely* effort organized by the American Board of Internal Medicine.
- Informed and pro-active clinical care management team and empowered patients, as described in the Chronic Care Model (CCM),¹⁶ within a practice or across a group of practices. The CCM has

¹⁵ The letters responding to the House Ways & Means and Energy & Commerce Committees’ staff proposals to repeal the SGR can be accessed at: http://www.acponline.org/acp_policy/letters/gop_sgr_framework_proposal_as_released_by_the_ways_means_energy_commerce_committees_2013.pdf and http://www.acponline.org/advocacy/where_we_stand/assets/eliminating_sgr.pdf.

¹⁶ Additional information on the Chronic Care Model can be accessed at: http://www.improvingchroniccare.org/index.php?p=The_Chronic_Care_Model&s=2

proven itself over the past decade as a meaningful framework for practice redesign that leads to improved patient care and better health outcomes.¹⁷

- A strong emphasis on primary care and appropriate valuation of primary care services as being critical to delivering high value, coordinated care for the whole person, including programs that incorporate the elements of PCMH (primary care model) and PCMH-N practices (specialty practice model), described in more detail later in this testimony.

Although many of the above elements may be found in integrated delivery models, they can also be incorporated into independent physician practices in a FFS environment. For example, an independent FFS physician practice might employ a nurse as a care coordinator to help patients with chronic illnesses take control of their own health, develop protocols to ensure that all clinicians involved in that patient’s care are sharing information among themselves, reporting on measures of quality appropriate to that practice and specialty, and tracking patient outcomes through a registry system.

Each level of graduated VBPs could reflect how many of the above elements each particular approved or deemed program has, as well as other criteria that may be appropriate for a particular specialty program or type of practice. Physicians who successfully participate in a program with more of the required elements would qualify for a higher graduated payment than one who participated in a program with fewer elements.

Some illustrative examples of how such a graduated VBP structure might work are outlined below. The items in each column would not all be required for a practice to meet that level, but are intended to propose some alternative pathways that may be available to practices of different make-ups and sizes and/or physicians of different specialties. Working across the rows, achievements at each level could be considered additive or could each be done on their own. Again, it is important to reiterate that this is illustrative—there could be fewer or more tiers of graduated VBPs aligned with participation in a program that meets the criteria applicable to each category. An important element to reiterate about these tiers is that they should allow for every physician/specialty and practice to have a pathway that works for their own specialty, practice setting, and size.

Level 1 VBP Program 0.25% VBP update above baseline*	Level 2 VBP Program 0.50% VBP update above baseline*	Level 3 VBP Program 0.75% VBP update above baseline*	Level 4 VBP Program 1.00% VBP update above baseline*
Implements ACP’s High Value Care Initiative	Level 1 PCMH	Level 2 PCMH	Level 3 PCMH
Implementing care coordination agreements, in line with the PCMH-N and with other physicians	Level 1 PCMH Specialty Practice	Level 2 PCMH Specialty Practice	Level 3 PCMH Specialty Practice
Reporting on a limited performance measure set, primarily focused on processes; and showing improvement in those measures over time	Reporting on a more robust set of performance measures, including a mix of process and outcome measures (either within a PCMH program or independently); and showing improvement in those measures over time	Reporting on a more robust set of performance measures that are more focused on outcomes (either within a PCMH program or independently); and showing improvement and/or consistently high quality in those measures	Reporting on a more robust set of performance measures, focused on outcomes, (either within a PCMH program or independently) that includes composite, population, outcomes, and cost measures; and showing improvement

¹⁷ Katie Coleman, Brian T. Austin, Cindy Brach and Edward H. Wagner. Jan/Feb 2009. “Evidence On The Chronic Care Model In The New Millennium” Accessed at: <http://content.healthaffairs.org/content/28/1/75.short>.

Level 1 VBP Program 0.25% VBP update above baseline*	Level 2 VBP Program 0.50% VBP update above baseline*	Level 3 VBP Program 0.75% VBP update above baseline*	Level 4 VBP Program 1.00% VBP update above baseline*
		over time	and/or consistently high quality in those measures over time.
			Participation in an ACO or other alternative delivery model that involves robust measurement

However, it is critical that these different pathways do not result in an uneven playing field, where some specialties, physicians, or practices are disadvantaged by being held to more robust standards due to the availability and comprehensiveness of relevant measures for their specialty. Additionally, it will be important to allow more time for smaller practices, those that provide care to underserved populations, and late-career physicians to fully advance into alternative models, likely through the provision of hardship exemptions; however, there should be no free pass for anyone.

The updates described in these illustrative tiers are proposed to be applied to Medicare FFS services in the Medicare Physician Fee Schedule. The College recognizes that these updates would likely need to be modest given the current fiscal environment and would not be the true or only driver behind the efforts of the physicians in those alternative delivery models. Physicians participating in PCMH, PCMH-N, and ACO models, in particular, are often—but not always—receiving risk-adjusted care coordination payments, shared savings based on quality metrics, etc. However, even in those cases, it is important that the Medicare FFS payments also continue to provide positive incentives by allowing them to qualify for the higher levels of graduated VBP FFS updates. There are a number of reasons for this:

- As noted earlier, FFS still remains an underlying tenet for most of the alternative delivery and payment models, such as PCMHs and ACOs—some of which may be built entirely on FFS payments.
- Alternative revenue streams for formal PCMH programs typically are not entirely from Medicare—and in many cases, Medicare is not an official participating payer at all (other than providing some regular FFS payments), rather the program is funded entirely by private payers. However, the practices still need to transform the way they provide care for all of their patients regardless of payer, which involves significant investment in infrastructure improvements, workflow changes, staff team roles, etc. For example, although there are thousands of recognized (by accreditation bodies and/or private payers) PCMHs around the country, very few of them are receiving any increased reimbursement from Medicare. Medicare is supporting only a few hundred PCMH practices nationwide that have been selected for its Comprehensive Primary Care Initiative or one of the few other PCMH programs that have been launched by CMS. Allowing PCMHs that have achieved recognition through an independent evaluation process to qualify for the higher graduated payments is necessary to allow the PCMH model to grow. Conversely, if such practices were unable to qualify for higher VBPs during the transition, Congress would actually be *disadvantaging* physicians who have made the biggest steps into incorporating the PCMH model into their practices.
- There are a number of practices across the country that are interested in, or working toward transforming to a PCMH or PCMH-N model—or are taking on other robust quality improvement activities, such as the ACP High-Value Care Initiative—and do not have a formal payment program in their region to support their efforts. Thus they are relying entirely on FFS—and a reformed FFS system should be structured to incentivize this work.
- Physicians and practices that are involved in PCMH and ACO programs are already taking on significant financial risk, both directly and via the infrastructure investments required to participate,

so it is important that the underlying FFS payments involved in those programs include positive incentives and updates.

Supporting Broad Adoption of Patient-Centered Medical Home (PCMH)/ PCMH Neighborhood

ACP strongly believes that the PCMH and PCMH-N models are ready to be a part of a new, value-based health care payment and delivery system, given all of the federal, state, and private sector activity to design, implement and evaluate these models and the growing amount of data on its effectiveness in improving care and lowering costs.¹⁸

The CMS Innovation Center's Comprehensive Primary Care Initiative (CPCI) provides an appropriate starting point for discussing how the PCMH model could be more immediately incorporated into the Medicare physician fee schedule. The five comprehensive primary care functions that serve as the framework for the CPCI project—risk-stratified care management, access and continuity, planned care for chronic conditions and preventive care, patient and caregiver engagement, and coordination of care across the medical neighborhood—are in line with the PCMH and PCMH-N concepts, championed by ACP and other national membership organizations representing physicians and other clinicians and are supported by thousands of business, consumer, and payer groups represented in the Patient-Centered Primary Care Collaborative (PCPCC).

Physician practices that were selected for the CPCI are supported by a Medicare payment structure that consists of: (1) risk-adjusted per patient per month Medicare payment to cover the extensive costs and work associated with care coordination; (2) FFS payments as determined by the Medicare fee schedule (RBRVS and conversion factor as affected by the SGR); and (3) opportunities to share in Medicare savings. Participating practices will be accountable for achieving substantial milestones and performance metrics.

Physicians and practices that transition to the PCMH model should be measured by distinct measures that are focused on delivery of patient-centered care, such as the core measures recommended by the PCMH Evaluators' Collaborative established by the Commonwealth Fund, which includes measures in the following domains: clinical quality (process and outcome), utilization, cost, and patient experience of care. In addition, the Agency for Healthcare Research and Quality (AHRQ) has available an atlas of care coordination measures.¹⁹ And the National Quality Forum (NQF) has established a platform for the development of care coordination measures consisting of a set of domains, principles and preferred practices.²⁰

ACP believes that the advancement of the PCMH model also is being facilitated through several recognition and accreditation programs including the National Committee for Quality Assurance's

¹⁸ A sampling of recent data on the effectiveness of PCMH programs can be accessed at: <http://www.pcpcc.net/guide/benefits-implementing-primary-care-medical-home>, <http://content.healthaffairs.org/content/29/5/819.full>, http://www.bcbsm.com/content/dam/public/Providers/Documents/help/R007532_2012PartnersReport_01WEB.pdf, <http://content.healthaffairs.org/content/31/9/2002.full.html>, and <http://content.healthaffairs.org/content/31/9/2010.full.html>.

¹⁹ Agency for Healthcare Research and Quality. Care Coordination and Measures Atlas. Accessed at <http://www.ahrq.gov/qual/careatlas/>.

²⁰ NQF. Preferred practices and performance measures for measuring and reporting care coordination. 2010. Accessed at

http://www.qualityforum.org/Publications/2010/10/Preferred_Practices_and_Performance_Measures_for_Measuring_and_Reporting_Care_Coordination.aspx

(NCQA) Patient-Centered Medical Home Recognition Program (2011)²¹, URAC's Patient-Centered Health Care Home's Accreditation Program²², and The Joint Commission's Primary Care Medical Home Option.²³ ACP supports the idea of CMS basing its determination of accreditation as a PCMH through a national accreditation organization (via a deeming approach for the purposes of Medicare payment, discussed further below). The standards included in each of these programs are already well known and widely used and, while not identical, do include very similar concepts.

Additionally, NCQA has recently released a Patient-Centered Specialty Practice Recognition Program²⁴, which now creates a pathway for non-primary care practices to be formally acknowledged and incorporated into a new, value-based health care payment and delivery system based on the PCMH-N concept. Several areas of the country are already involved in testing and implementing the PCMH neighborhood concept, including: the Vermont Blueprint for Health program, the Texas Medical Home Initiative, and programs in both the Denver and Grand Junction areas of Colorado. It is likely other accreditation programs will follow suit and also start to develop programs that are relevant for non-primary care practices.

Also, ACO development is rapidly occurring throughout the country in both the public and private sector. The Medicare shared savings program has contracted with dozens of physician practices and hospitals, including ACO practices that involve ACP members. Although the financial model for each ACO varies depending on the type of ACO program in which it is participating, all are paid under the usual Medicare FFS basis with the opportunity to share in savings to the program from more effective management of the Medicare patients attributed to them. Variations of the shared savings programs involve more or less financial risk and reward for the participating practices. Therefore, while not discussed in detail in this testimony, ACOs should also be considered part of a new VBP and delivery system.

Deeming of VBP programs and Validation of Performance Measures

The Department of Health and Human Services has a long history and tradition of deeming non-profit private sector accreditation organizations to satisfy compliance with federal regulations in a way that relies on the accreditation organization's expertise, while still ensuring that the process meets federal standards relating to transparency. We believe that CMS can learn from those relationships and work with the accreditation organizations and national specialty societies, including ACP, to design a deeming program for PCMH and PCMH-N recognition that appropriately balances the interests of the non-profit, private sector accreditation organizations and CMS' responsibility to establish and maintain transparency in its decision-making processes. CMS could deem a program as meeting the standards to qualify for a graduated VBP update allowance as long it can demonstrate that it includes one or more of the core elements associated with effective programs, as described previously in our testimony. Such deemed programs could include:

- PCMH and PCMH-N practices as recognized or accredited by a nationally recognized accreditation organization.

²¹ More information on NCQA's PCMH Recognition program is available at: <http://www.ncqa.org/tabid/631/Default.aspx>.

²² More information on URAC's PCHCH Accreditation program is available at: https://www.urac.org/healthcare/prog_accred_pchch_toolkit.aspx.

²³ More information on the Joint Commission's Primary Care Medical Home Option is available at: <http://www.jointcommission.org/accreditation/pchi.aspx>.

²⁴ Additional information on the NCQA Patient-Centered Specialty Practice Recognition Program can be found at: <http://www.ncqa.org/Programs/Recognition/PatientCenteredSpecialtyPracticeRecognition.aspx>.

- PCMH and PCMH-N practices as recognized and offered to enrollees of one or more private health insurance programs, and/or as recognized by state government programs including Medicaid.
- Programs developed by national specialty societies, state medical societies, county medical societies, community-based physician groups, or other entities that would apply directly to CMS to be deemed as an approved initiative.

Robust and aligned performance measurement approaches and a stable infrastructure to develop, test, validate, and integrate performance measures into practice are essential. Although ACP agrees with the goal of encouraging the development of performance measures applicable to all specialties, it is essential that this not result in specialty specific—siloes efforts, but rather part of a national strategy for quality improvement. The development, validation, selection, refinement, and integration of performance measures should be a multilevel process that takes advantage of the most recent scientific evidence on quality measurement and have broad inclusiveness and consensus among stakeholders and in the medical and professional communities. This entire process should be transparent to the medical community. Measures should be field-tested to the extent possible prior to adoption. All measures, whether developed by a specialty society or other experts, accordingly should go through a multi-stakeholder evaluation process, a role that is performed by the National Quality Forum (NQF) as a trusted evaluator of measures. ACP encourages the committees to ensure that there is stable and sustainable financing for the NQF. Deeming of private sector specialty programs, such as patient registry programs, might be considered as another way of qualifying specialty society quality improvement programs, although the clinical performance measures used by such programs should go through the NQF validation program. Additionally, it is important to note, that while CMS has made strides in aligning measures across their programs (i.e., PQRS, VBP program, MU)—and the College is encouraged by the recent release of a timeline for alignment of quality reporting programs within Medicare²⁵—at a high level the technical requirements in each of the programs are still different enough that dual processes must be undertaken.

In addition, in order to maximize physician engagement and promote quality, the SGR repeal and Medicare physician payment reform proposal should explicitly acknowledge the role of the physician specialty certification community. The American Board of Medical Specialties (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. In this regard, the SGR proposal should include participation in ABMS MOC as a quality metric, include ABMS MOC as a reporting pathway, and allow physicians choice in reporting so that they can align their quality improvement activities in ways that are relevant to their practices.

Other Payment System Models for Consideration

It is important to note that comprehensive reforms to the payment system must provide flexibility and multiple options with various levels of risk and integration to ensure maximum participation and successful implementation of new payment models in diverse practice settings and geographic regions. Therefore, ACP is also supportive of testing a number of models, including the following.

“Prometheus” Evidence-informed Case Rate (ECR) Model

This payment model, developed by the non-profit PROMETHEUS Payment Inc. establishes case rates for the treatment of specific conditions based on the cost of all services, pharmaceuticals, tests, equipment, etc. needed to treat the condition following agreed upon evidence-based clinical practice guidelines. The case rate is triggered by a diagnosis and, for chronic conditions, takes the form of a yearly rate. The amount of the payment to the practice also depends upon its performance on a quality scorecard and the

²⁵ More information on CMS’ quality reporting alignment timeline is accessible at: http://www.cms.gov/eHealth/ListServ_LearnMoreaboutTimingofQMA.html

efficiency of care provided by the other physicians and healthcare professions throughout the system providing care to the patient for the defined condition. Pilot demonstrations are being implemented in Rockford, Illinois and Minneapolis, Minnesota with a third site in Utah.²⁶ PROMETHEUS Payment Inc. has also outlined how this model can be used for the payment of primary care services, including the provision of funds to transform primary care practices into medical homes.²⁷

*Comprehensive Global Payment Model*²⁸

This model proposes a comprehensive payment structure consisting of a global payment for primary care (coordinated, comprehensive, continuous, personalized care) to replace visit-based compensation paid to the practice. The global fee is linked to the number of patients in the practice and covers the cost of all necessary staff and technology to the practice, as well as a respectable income for the physicians. The global payment would cover:

1. All care and coordination provided by the primary clinician
2. All services rendered by other professional and administrative staff on the treatment team (e.g. follow-up nurses, social workers, nutritionists)
3. Essential practice infrastructure and systems – particularly an interoperable EHR with clinical decision support

This global payment model maintains population risk with the payer, while practices accept technical risk for providing the required ambulatory care in a manner that minimizes waste and inefficiency and facilitates adherence to professional standards of care and referral. The model also includes a meaningful component of payment (15-25 percent) that is outcome-based and linked to validated measures of patient satisfaction clinical performance, and efficiency.

Eligibility for this payment would be limited to those practices that demonstrated having the infrastructure and general capability to deliver the requisite services, as assessed by an organization such as NCQA. The care provided would be documented by an annual random sample of practices. The documentation typically required for each visit would be significantly reduced and payment would be heavily risk- and needs- adjusted to match each patient's burden of care. This payment model is currently being piloted within the Capital District Health Plan in Albany, New York. Initial data reflects decreased costs and improved care quality compared to a cohort control.²⁹

ACP recommends that Congress authorize the Secretary to test these models as optional, alternative payment systems—practices could remain under traditional FFS or opt for either the “Prometheus” Evidence-informed Case Rate (ECR) Model, where available, or the Comprehensive Global Payment Model. These approaches could then be studied closely by HHS to determine their overall success in increasing quality and reducing cost, improving physician and patient satisfaction, as well as their ability to potentially reduce or eliminate many administrative hassles faced by physicians that operate exclusively—or even partially—within the FFS system.

²⁶ Prometheus Newsletter 2. Accessed at <http://www.rwjf.org/en/research-publications/find-rwjf-research/2009/03/prometheus-payment-reform-quarterly-newsletter-issue-2.html>

²⁷ Prometheus Payment Incorporated. Sustaining the Medical Home: How Prometheus Payment Can Revitalize Primary Care. 2009. Accessed at <http://www.hci3.org/content/sustaining-medical-home>

²⁸ Goroll AH, Berenson RB, Schoenbaum SC, Gardner LA. Fundamental reform of payment for adult primary care: comprehensive payment for comprehensive care. *J Gen Intern Med.* 2007;22:410-415. Summary available at http://www.commonwealthfund.org/~media/Files/Publications/In%20the%20Literature/2007/Mar/Fundamental%20Reform%20of%20Payment%20for%20Adult%20Primary%20Care%20%20Comprehensive%20Payment%20for%20Comprehensive%20Care/Goroll_fundamentalreformpaymentadultprimarycare_1014_itl%20pdf.pdf.

²⁹ Feder J. A health plan spurs transformation of primary care practices into better-paid medical homes. *Health Affairs* 2011 30 (3): 397-399.

Expanded Use of Bundled Payments

The Congressional Budget Office recently released a review of “lessons learned” as a result of Medicare disease management, care coordination and value-based purchasing demonstrations.³⁰ The Medicare Participating Heart Bypass Center Demonstration provided bundled payments to cover all inpatient hospital and physicians’ services for coronary artery bypass graft surgeries conducted at seven participating hospitals. It was the only VBP demonstration that yielded significant savings for the Medicare program. Bundled payments reduced Medicare’s expenditures for heart bypass surgeries by about 10 percent, and there were no apparent adverse effects on patients’ outcomes. Medicare has a long history of using bundling of services to stabilize expenditures without decreasing quality—these efforts include the establishment of diagnosis-related groupings (DRGs) for acute inpatient hospital care and the bundling of physician fees and services within the Medicare End Stage Renal Disease (ESRD) program. The CMMI in August of 2011 released the Medicare “Bundled Payments for Care Improvement Initiative.” This initiative tests four models of bundling payment for services that patients receive across a single episode of care, such as heart bypass surgery or a hip replacement. All models include an inpatient acute care phase and these CMMI-tested models can be rapidly implemented and expanded throughout the Medicare system if deemed successful through the expanded authority granted to the Secretary through the Affordable Care Act.

Additionally, the Bipartisan Policy Center (BPC) recently made the following recommendation:

Expand payment bundles to increase coordination of care and facilitate the adoption of broader payment and delivery system reform. Bundles—including inpatient, physician, post-acute care, and any readmissions within 90 days—should be established nationwide no later than 2018 for certain diagnosis-related groups (DRGs).³¹

The BPC goes on to note that this approach could save Medicare \$8.2 billion between FY 2014-2023. **Therefore, ACP supports the concept of expanding payment bundles to increase coordination of care and facilitate the adoption of broader payment and delivery system reform—and Congress could call on the Secretary to conduct this expansion, likely via a broadening of the bundled payment effort already underway within the CMMI.**

The College appreciates this opportunity to share its recommendations with the Senate Finance Committee for how to improve the Medicare physician fee schedule and the FFS system overall to provide stability for physician reimbursement and lay the necessary foundation for a performance-based payment system following the repeal of the SGR. Please contact Brian Buckley at bbuckley@acponline.org or 202-261-4543 if you have any questions or would like additional information.

Sincerely,



Molly Cooke, MD, FACP
President, American College of Physicians

³⁰ The complete CBO report can be accessed at: <http://www.cbo.gov/publication/42860>.

³¹ The complete Bipartisan Policy Center report can be accessed at: <http://bipartisanpolicy.org/sites/default/files/BPC%20Health%20Care%20Cost%20Containment%20Report%20Executive%20Summary.pdf>.