



June 10, 2013

The Honorable Fred Upton
Chairman, Energy and Commerce Committee
U.S. House of Representatives
Washington, DC 20515

The Honorable Henry A. Waxman
Ranking Member, Energy and Commerce Committee
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Upton and Ranking Member Waxman:

On behalf of the American College of Physicians (ACP), I appreciate the opportunity to respond to draft legislative language released on May 28, 2013 by the Energy and Commerce Committee to repeal the current Sustainable Growth Rate (SGR) system and replace it with a fair and stable system of physician payment in the Medicare program. 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. Overall, the College supports the intent of your legislative proposal to move toward a more stable, effective and efficient physician payment system, something we agree is absolutely necessary. However, ACP would like to provide some feedback on the specific questions you have raised and recommendations for the Committee to consider as you further develop this legislation.

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.

Committee Questions for Comment on Phase I

1. *What is an appropriate period of payment stability in order to develop and vet measures and build the necessary quality infrastructure?*

The College recommends that Congress 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 (VBP) models. While some specialties do have a strong set of existing performance measures that have been well tested, for other specialties measures are completely lacking or there are only a few available measures ready for use. Therefore, this five year period of stability is critical to ensuring that performance measures, to be used in transitional value-based payment programs, are able to go through a transparent, multi-stakeholder review and validation process, regardless of the source of the measure.

We specifically recommend that the Committee consider including language to establish a period of stable and positive payments, during which new models of payment and delivery would be evaluated, as proposed by the Medicare Physician Payment Innovation Act, H.R. 574, which ACP has endorsed. We also urge the Committee to include the language from H.R. 574 to establish positive baseline updates for all physicians, plus an additional baseline update for undervalued evaluation and management services, during this period of stability.

2. *Considering the different levels of provider readiness, how do we balance the need for a stable period enabling providers to build and test the necessary quality infrastructure, while still incentivizing early innovators to move to Phase II, with opportunities for quality-based payment updates?*

The College believes that the groundwork is already in place for Congress to begin to facilitate a broad transition to value-based delivery and payment approaches, including the Patient-Centered Medical Home (PCMH), PCMH-Neighbor specialty practices, and other models as discussed in more detail later in this letter, 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. Therefore ACP is appreciative that the Committee has included mention of the PCMH concept in their draft legislation. We request, however, that the bill state that the Secretary “shall” include PCMHs as one of the Alternative Payment Models, rather than “may” include as proposed in the current draft. And, as noted later in this letter, we believe that physicians who are in a recognized PCMH or PCMH-Neighborhood specialty practice should begin to qualify for graduated, incentive based updates beginning in 2014.

As you indicate, 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 VBPs and delivery models. We believe that the Committee must develop an approach that: (1) allows sufficient time for physicians to develop the capabilities to participate in VBP models while at the same time (2) ensures that the transition period provides higher (graduated) incentive updates to physician who are further along in moving away from pure Fee-for-Service (FFS) to value-based alternative models; and (3) allows immediate opportunities for physicians in approved/deemed alternative models, including PCMH, PCMH-N, ACO and bundled payments, to qualify for higher, graduated incentive payments during the transition period.

Specifically, 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 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/approved program has demonstrated core capabilities/competencies to achieve better clinical outcomes, with more effective use of resources. **Studies demonstrate 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, with particular emphasis on measures that improve clinical outcomes and patient experience with the care provided at an organizational/system level, rather than process measures at the individual physician level**
- **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 Initiative¹, described later in this letter and the *Choosing Wisely* effort² organized by the American Board of Internal Medicine.**

¹ Additional information on ACP’s High Value Care Initiative can be accessed at: <http://hvc.acponline.org/>.

² Additional information on the Choosing Wisely effort can be accessed at: <http://www.choosingwisely.org/>.

- **Informed and pro-active clinical care management team and empowered patients, as described in the Chronic Care Model (CCM),³ within a practice or across a group of practices. The CCM has proven itself over the past decade as a meaningful framework for practice redesign that leads to improved patient care and better health outcomes.⁴**
- **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 letter.**

Although many of the above elements may be found in integrated delivery models, they can also be incorporated into independent physician practices in a fee-for-service (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/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 those who participate 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, achievement at each level could be considered additive or could each be done independently. 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 note about these tiers is that they should allow for every physician/specialist 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	Reporting on a more robust set of performance measures,	Reporting on a more robust set of performance measures	Reporting on a more robust set of performance measures,

³ Additional information on the Chronic Care Model can be accessed at:

http://www.improvingchroniccare.org/index.php?p=The_Chronic_Care_Model&s=2.

⁴ 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*
on processes at the individual physician level; and showing improvement in those measures over time	including a mix of process and outcome measures (either within a PCMH program or independently) and patient experience measures at both the individual and organizational levels; and showing improvement in those measures over time	that are more focused on outcomes and patient experience measures (either within a PCMH program or independently) and organizational performance; and showing improvement and/or consistently high quality in those measures over time	focused on outcomes, (either within a PCMH program or independently) that includes composite, population, outcomes, patient experience and cost measures; and showing improvement and/or consistently high quality in those measures over time, at the organizational level.
			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 PCMHs around the country recognized by accreditation bodies and/or private payers and 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.

3. *What does a meaningful, timely feedback process look like for providers? What are adequate performance feedback intervals?*

ACP is strongly supportive of health care professionals having timely access to performance information, particularly prior to having the information tied to a payment incentive or to public reporting. The appropriate time period may vary depending on the measure—in some cases reviewing performance quarterly or every 6 months may be most effective, whereas for other quality measures, such as cancer screenings, colonoscopy rates, and incidence of stroke in patients with atrial fibrillation (i.e., those with abnormal heart beats) for example, a 1 year review of the data will be more informative. Physicians should have a key role in helping to determine the appropriate timeframes for review of performance information—and the decision-making process should be transparent so that physicians, consumers, and payers are fully aware of the data sharing expectations.

It is important to note that the Comprehensive Primary Care Initiative (CPCI), as well as other initiatives being conducted by the Center for Medicare and Medicaid Innovation (CMMI), do include a commitment by CMS and other participating payers to share data in a more frequent and consistent manner. ACP is encouraged by these efforts and hopes that these projects will provide an opportunity to learn the most efficient and effective means of regular data sharing with practices.

We also agree with a recommendation in a new paper published by the Robert Wood Johnson Foundation (RWJF) by Berenson, Pronovost, and Krumholz to “use measurement to promote the concept of the rapid-learning health care system.”⁵ The dissemination of quality measure data should be viewed as one prong in a multi-pronged strategy to improve health care quality. Accompanying strategies should include offering technical assistance to strengthen providers’ capacity to improve care and creating formal accountability systems. “In addition, collaborative activities among institutions can produce insights that may elude them individually. Measures can help identify top performers, and detailed analysis can then identify what distinguishes those who excel.”

⁵ Berenson, Pronovost, and Krumholz. “Achieving the Potential of Health Care Performance Measures: Timely Analysis of Immediate Health Policy Issues.” May 2013. Published by The Robert Wood Johnson Foundation and the Urban Institute. Accessed at: <http://www.urban.org/publications/412823.html>.

Additionally, it is important to note that clinicians should have a timely, fair, and accurate appeals process available to examine potential inaccuracies—particularly before measurement data are tied to payment incentives.

4. *How should Peer Provider Cohorts be defined in order to ensure adequate specificity while preserving adequate comparison group size and ability to develop appropriate measurement sets? For example, is using the American Board of Medical Specialties (ABMS) list adequate?*

The concept of using peer provider cohorts for the purposes of measurement is one that ACP would be interested in seeing tested—and could be tied in with our proposed graduated payment approach to value-based payment, described previously in this letter. Specifically, depending on the robustness of the competencies and related measure set for a given cohort—or the availability of alternative approaches, such as the use of evidence-based practice guidelines like those included in ACP’s High Value Care Initiative, the PCMH model, the PCMH-N specialty practice model, etc.—then that cohort could qualify for a certain percentage VBP update above the baseline. **Overall, ACP strongly recommends that the use of peer provider cohorts for the purpose of measurement be used as a bridge to transition fully to alternative models—that is, cohorts should begin to move physicians and their practices in the direction of adopting *organizational/system* level approaches to improve quality and patient experience with the care provided. Also, any competency-based update incentive program should provide higher graduated incentive payments to physicians who successfully participate in cohorts that include the core competencies and capabilities needed to improve outcomes within their organizations and systems of care.**

Accordingly, we believe that:

- Cohorts that include competencies and related measures to *achieving better patient outcomes and experience with the care provided*, as opposed to process measures, should have more weight (and qualify physicians who are participating in such cohorts for higher competency-based incentive payments) than physicians who are participating in cohorts that involve reporting only on individual *physician-level process measures*.
- Cohorts that evaluate performance *at the level of the organization or system* in which the physician is delivering care and are focused on achieving better outcomes and patient experience with the care provided, should carry more weight than cohorts that evaluate the performance of the individual physician acting on his or her own.

We agree with Berenson, Pronovost, and Krumholz that:

Public reporting and rewards for outcomes rather than processes of care should cause provider organizations to engage in broader approaches to quality improvement activities, ideally relying on rapid-learning through root cause analysis and teamwork rather than taking on a few conveniently available process measures that are actionable but often explain little of the variation in outcomes that exemplifies U.S. health care.

The College also agrees with their observation that, “the notion that an individual health professional can be held accountable for the outcomes of patients in isolation from other health professionals... is becoming an outdated perspective. Systems-based care is emerging as a key value within health care and vital component of high quality care.” The authors go on to note that other issues with attributing performance measure data to individual clinicians are more technical—many individual clinicians lack sufficient volumes of certain types of patients to permit valid statistical inferences about their performance on a given measure. To circumvent these difficulties, performance can be measured at the

organizational or departmental level, allowing measures to assess and promote team-based care, while addressing many of the technical issues that can undermine measurement efforts.

Finally, we agree with their emphasis on the importance of measuring patient experience with the care provided within the organization:

Measure patient experience with care and patient-reported outcomes as ends in themselves. Given the inevitable gaps in both process and outcome measures for specific areas of clinical care, it is important to realize that patient experience is ubiquitous and can be drawn upon to measure a broad range of performance. With the growing array of scientifically rigorous surveys of patient experiences with care, we now have the capacity to incorporate standardized assessments of that experience into the measurement enterprise.

The authors go on to note that this is especially important since there is marked heterogeneity in patient experience ratings, and the quality of providers' attention to patients' needs can influence health outcomes.

In terms of how these peer provider cohorts would be defined, ACP agrees that using the ABMS list is a good place to start. We believe that a "primary care" cohort may be too broad—that there should be peer cohorts for internal medicine specialists who provide comprehensive and primary care to adults (general internal medicine cohorts) and cohorts for internal medicine subspecialties, like cardiology or rheumatology.

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 Committee's SGR repeal proposal 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.

Geographic variations should also be considered when initiating the cohorts. For example, a clinician cohort in San Francisco may vary significantly from cohorts in Texas or West Virginia based on the local make-up of the health care system. Cohorts that are formed at a community level—that is, physicians working together within their own communities to improve outcomes and patient experience with the care provided, likely will be more effective in driving quality and efficiency gains than a national cohort for a given specialty, procedure, or disease condition.

Additional considerations should include the need to risk adjust based on differing patient populations across specialties and geography and a differentiation of clinicians that primarily provide outpatient care from those that largely provide inpatient care. The cohort data should be regularly reviewed during the years of stability—and payments tied to them should be fairly modest during this time (along the lines of what the College proposes in its graduated payment approach)—to determine if they are effective and if more or less differentiation may be necessary. If it becomes clear that cross-specialty cohorts may be appropriate, like a cohort for primary care that would include internal medicine, family medicine, and pediatrics, then additional differentiation considerations may need to come into play—specifying adult vs. pediatric primary care, for instance. Additionally, it is important to note that physicians should have a key role in determining methods used to develop and select measures (including the measurement evidence and any evidence grading methods used) for their cohorts, in collecting and aggregating the data on the measures used within their cohort, and in advising on changes that may need to be made to their cohort based on the data review (e.g., additional differentiation, development of a cross specialty cohort).

5. *Should the list of Peer Provider Cohorts also include patient, procedural, or disease-specific cohorts in addition to the traditionally-defined specialty groupings?*

As noted above, the College does believe that the performance measures used for any given peer provider cohort should be risk adjusted based on the patient population being served, particularly when outcome measures are being used. In terms of procedural or disease-specific cohorts, in most cases all physicians, regardless of their specialty, should be held to one standard and use the same measures. However, it may be useful to test disease-specific cohorts for disease states where there are robust and validated measure sets available, the opportunity for clinical improvement may be the greatest, and/or the savings potential from providing improved care is significant. In these cases, disease-specific cohorts will likely need to cut across specialties in order to facilitate care coordination, team-based care, and shared accountability.

And, as noted above, cohorts should be created to measure performance at the level of an organization in addition to cohorts designed around competencies relating to individual physician performance.

6. *Under the proposed revision of SGR which emphasizes best quality practices, non-physician providers who are currently paid under the Medicare payment system are also expected to be rated on quality measures. Do these non-physician providers need unique measurement sets compared to physician providers?*

As stated earlier, in most cases, all physicians, regardless of their specialty, should be held to one standard and use the same measures. Therefore, it seems appropriate that non-physician clinicians should also be held to the same standards when caring for patients. The goal should be to move toward truly coordinated, interdisciplinary, team-based care using “best practices” to overcome the current fragmentation within the health care system.

Committee Questions for Comment on Phase II

1. *Understanding that the proposed payment system relies on reporting, how should existing programs such as, but not limited to PQRS, EHR/Meaningful Use, VBM be transitioned into the new system? Are there aspects of the current systems that should be retained, modified, or discarded?*

ACP supports the use of existing QI programs such as Medicare PQRS, e-RX, EHR Incentive/Meaningful Use, and Value-Based Payment Modifier (VBPM) programs. However, we do share the significant concerns expressed by many organizations that these programs are burdensome and currently not well-aligned with one another, with private payer initiatives, or with specialty boards’ maintenance of certification programs. In our recent State of the Nation’s Health Care report⁶, the College recommended that Congress and CMS work with physicians to encourage participation in quality reporting programs by reducing administrative barriers, improving bonuses to incentivize ongoing quality improvements for all physicians, and broadening hardship exemptions. If necessary, Congress and CMS should 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. This report also called for CMS to harmonize (and reduce to the extent possible) the measures used in the different reporting programs, working toward overall composite outcomes measures rather than a laundry-list of process measures.

⁶ This report can be found at: http://www.acponline.org/advocacy/events/state_of_healthcare/snhcreport13.pdf.

While CMS has made strides in aligning the measures, at a high level, the technical requirements within each of the programs are different enough that dual processes must be undertaken. In the College's recent comments on the notice of proposed rulemaking from both CMS⁷ and ONC⁸ on Stage 2 Meaningful Use, we also noted our concern about the approach that CMS has taken when structuring the penalty phases of the EHR Incentive Programs, e-Prescribing Incentive Program, and PQRS by requiring that the activity to avoid the penalty must be completed in the prior year or even two years in advance of the legislated deadline. As a result, CMS has effectively moved up the legislated deadline beyond what the market can bear.

However, it is important to note though that CMS is taking action to better align their programs through the feedback they have sought via the 2013 physician fee schedule proposed rule and a recent request for information (RFI), which solicited ways in which physicians might use the clinical quality measures (CQM) data reported to their specialty boards, specialty societies, regional health care quality organizations or other non-federal reporting programs to also report under PQRS, as well as the Electronic Health Record (EHR) Incentive Program. CMS also recently released a timeline for alignment of their quality reporting programs, which is extremely encouraging.⁹ ACP encourages the Committee to take these efforts into account, and perhaps consider encouraging and facilitating these improvements before potentially discarding the existing programs and creating an alternative quality reporting program.

ACP also encourages the Committee to consider the initiatives of the CMS Innovation Center, which is working to align federal, state, and private payer payment and delivery system reform efforts. In addition to the organizers of these projects, the practices and physicians that are participating in them, who are also subject to the broader CMS reporting efforts, will likely have some insights to share as to how those programs might be better aligned and incorporated into a new set of alternative payment models over time.

Finally, ACP believes that it would be appropriate to consider sunseting the existing PQRS and e-RX programs, and potentially the VBPM and EHR Incentive programs, if a new quality incentive program is created that achieves the same objectives but in a more consistent way with consistent and harmonized measures, and fewer administrative burdens on physicians and practices. However, the infrastructure that has been built for these programs should be leveraged to the extent possible and not recreated from scratch.

- 2. How do we align and integrate quality measurement and reporting with existing and developing specialty registries? How can registries support provider feedback and streamline provider reporting burden?*

The College is supportive of using existing specialty registries as a means to achieve value-based payments. Specifically, ACP recommends that Congress direct the Secretary to establish a process of deeming of private sector specialty programs, such as patient registry programs, as means of participating in a graduated, VBP approach. The clinical performance measures used by such programs should go through the National Quality Forum (NQF) endorsement process, as this will ensure that the measures are evaluated by a multi-stakeholder process.

⁷ These comments can be found at:

http://www.acponline.org/advocacy/where_we_stand/health_information_technology/cms_nprm.pdf.

⁸ These comments can be found at:

http://www.acponline.org/advocacy/where_we_stand/health_information_technology/onc_nprm.pdf.

⁹ The CMS Timeline of Quality Reporting Alignment can be accessed at:

http://www.cms.gov/eHealth/ListServ_LearnMoreaboutTimingofQMA.html.

More broadly, the College recommends that Congress direct the Secretary to establish a deeming process for a number of different types of programs that meet certain standards, in order to qualify participants for a graduated VBP update allowance. These programs must be able to demonstrate that they include one or more of the core elements associated with effective programs, as described previously in our letter. Such deemed programs could include:

- PCMH and PCMH-N practices as recognized or accredited by a nationally recognized accreditation organization.
- 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 (e.g., registries), 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.

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.

With regard to physician reporting burden, all reporting on quality measures, including the use of registries for this purpose, should be automated, able to use and repurpose existing data as needed, and able to be integrated into the physician and practice's workflow.

Additionally, as the Committee considers new payment and delivery models aligned with "value" to the patient, they must recognize that among the values that patients hold dearest is having enough clinical time with their physicians and among the values physicians hold dearest is being able to spend appropriate clinical time with their patients. Indeed, allowing physicians to spend appropriate clinical time with their patients—time spent learning about them and their families and home life, listening to them, uncovering the reasons for their symptoms, explaining the clinical issues, developing an appropriate treatment plan, and engaging their patients in shared decision-making—is at the very essence of the patient-physician relationship. Yet discussion of new and improved payment models often appears at best to be indifferent to how their incentives might support or devalue physicians' and patients' clinical time together. Therefore, any approaches to performance measurement and reporting that detract from patient-physician encounter time should be avoided. If, as more experience is gained by physicians with registries (perhaps via a deeming program as discussed above), it is determined that registry use does provide a more streamlined approach to measurement that is more aligned with a physician practice's workflow—and therefore does not negatively impact physician-patient encounter time—then more widespread use of them should be encouraged.

3. *What Clinical Improvement Activities best promote high quality clinical care and should those activities be required as an integral part of a quality-based payment system?*

As was discussed earlier, studies indicate that the most effective quality improvement 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, with particular emphasis on measures that improve clinical outcomes and patient experience with the care provided at an organizational/system level, rather than process measures at the individual physician level.
- 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, described later in this letter 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), within a practice or across a group of practices. The CCM has proven itself over the past decade as a meaningful framework for practice redesign that leads to improved patient care and better health outcomes.
- 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.

Therefore, ACP recommends that programs containing one or more of these elements be recognized by the Secretary via a deeming process. Then, physicians could choose to participate in the program or programs that are most relevant to their specialty and practice type.

Additionally, 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 Emanuel¹⁰ 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.
- 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.

¹⁰ 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>.

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 Initiative¹¹ and the *Choosing Wisely* Campaign¹², 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.

4. *What process or processes could be enacted that would ensure quality measures/measurement sets maintain currency and relevance with regard to the latest evidence-based clinical practices and care delivery systems? How would these processes ensure that quality measures evolve with data accumulation and advancement in measure development science, and appropriately account for the relative value of measures as they relate to best possible patient care?*

Robust and aligned performance measurement approaches and a stable infrastructure to develop, test, validate, update, and integrate performance measures into practice are essential. 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 has 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. In addition, ACP recommends the measurement targets 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. 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. Therefore, ACP encourages the Committee to ensure that there is stable and sustainable financing for the NQF, as well as for the measure development and maintenance processes that feed into NQF's endorsement process.

¹¹ Additional information on ACP's High Value Care Initiative can be accessed at: <http://hvc.acponline.org/>

¹² Additional information on the Choosing Wisely effort can be accessed at: <http://www.choosingwisely.org/>.

We also support the recommendation from the RWJF report referenced earlier on the need to “invest in the “basic science” of measurement development.” The authors observe that: “there is no body of expertise with responsibility for addressing the science of performance measurement. NQF comes closest, and while it addresses some scientific issues when deciding whether to endorse a proposed measure, NQF is not mandated to explore broader issues to advance the science of measure development.”

The authors further state that an infrastructure is needed to gain national consensus on: what to measure, how to collect the data needed to calculate measures, the accuracy of EHR data for use in performance measurement, how to determine the cost-effectiveness of particular measures, how to reduce the costs of data collection, what thresholds to use to ensure measure accuracy, and how to prioritize which measures to collect. Establishing general standards for performance measures could help move the policy discussion from whether measures are good enough to use despite their flaws to a more fundamental discussion of how to design good measures, how to assess current measures, and whether the costs of producing better measures are worth the benefits.

5. *Quality measures are categorized into process, structural, and outcome measures. Should these measures be differentially weighted in a quality scoring system? If so, how?*

As noted earlier, the report from Berenson, Pronovost, and Krumholz includes an in depth discussion of structure, process, and outcomes measures, outlining the pros and cons of each type. The researchers conclude that the best approach is to “decisively move from measuring processes to outcomes.” ACP agrees with this conclusion and therefore, in our recommendation to implement a graduated VBP approach, the College calls for a higher percentage update above the baseline for physicians and practices that are reporting on a more robust set of performance measures, either within a PCMH program or independently, that includes composite, population, outcomes, and cost measures, particularly for those participants that are showing improvement and/or consistently high quality in those measures over time. During the period of stability, these payment updates should remain fairly modest in order to allow for the development of the quality measurement infrastructure to support these efforts and for the understanding and implementation of these measurement and reporting approaches by physicians and practices to grow.

6. *From a variety of backgrounds, providers newly enter (or re-enter) the Medicare system throughout the year. Since these providers have no reference baseline with regard to quality reporting in the Medicare system, how should the system account for their payment during their “observation” year?*

Individual physicians and other clinicians that enter or re-enter the Medicare system should have an opportunity to establish reference baseline performance data. This timeframe should be for at least 6-12 months. However, early opt in to a peer provider cohort should be an option for physicians entering Medicare that are already familiar and actively involved with performance measurement and reporting for other payers.

Additionally, if physicians join a practice or group that is already participating at the group level, the Committee could consider adopting the approach Medicare is currently using for PQRS and the VBPM program—where those physicians are immediately included in the measurement reporting and payment program that is applicable for that group. In other words, measurement data and payment determinations are reviewed and made at the TIN (tax identification number) level for a given time period, regardless of the NPI’s that make up the TIN.

7. *Should public and multi-stakeholder input be used during the measure development and selection processes? If so, are there current CMS or non-CMS mechanisms that could be applied?*

As discussed earlier, the College recommends that 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. Therefore, ACP encourages the Committee to ensure that there is stable and sustainable financing for the NQF, as well as for the measure development and maintenance processes.

Additionally, ACP also believes that physicians should have a key role in determining methods used to:

- Develop and select measures (including the measurement evidence and any evidence grading methods used),
- Collect data from physicians,
- Aggregate and score performance,
- Report performance data internally and publicly, and
- Tie payment updates to performance data.

Also, as noted earlier, ACP believes that there is an urgent need to invest in the basic science of measure development.

8. *In the interest of transparency, a public comment opportunity is vital to the quality measure development and approval process. Are there current mechanisms that are both substantive and nimble enough to meet the policy framework in the discussion draft of the legislative language?*

The NQF process does involve input from multiple stakeholders, including consumers. Providing adequate funding for NQF and the measure development and maintenance processes that feed into NQF's endorsement process would help with improving and streamlining the measure pipeline—allowing it to indeed be substantive and nimble enough to meet the Committee's policy framework. We also support the concept of allowing for a public comment period on measures that will be linked to Medicare incentive payments, but caution that such a comment period should not result in measures being altered, adopted, or rejected in response to public comments that are not supported by evidence.

9. *Methods linking quality performance to payment incentives must be fair to providers and faithful to the goals of a value-based payment system. Many strategies have been proposed; examples include comparing providers to each other versus to benchmarks. Please suggest method(s) of quality-based payment which meet the goals of fairness and fidelity, and one that promotes provider collaboration and sharing of best practices to achieve a learning healthcare system.*

The Committee could consider modeling their approach after that being used within the Medicare shared savings (ACO) program.

- First, select measures in multiple domains for each peer provider cohort. These domains could be weighted differentially or equally (with physicians being actively involved in the selection and weighting decisions) and each domain will have a certain number of measures. For example the Medicare Shared Savings program selected the following domains:
 - Patient/care-giver experience
 - Care coordination/patient safety

- Preventive health
- At risk population
- Then, based on the overall performance of members on each element within the domain:
 - Determine an absolute minimal threshold that a participant (which could be an individual physician or an organization) will have to achieve in order to receive any credit for that measure. The participant can receive increased credit the higher they perform above this threshold for each measure. This approach serves to require some level of minimal achievement, but also a means of rewarding improvement over time.
 - Measure scores within each domain are aggregated, and domain scores are then aggregated (weighted or not weighted) to obtain an overall score, which would then determine the specific payment update.

Additional points of note are that, like the current CMS quality reporting programs, physicians should be able to choose whether they want to be evaluated as an individual clinician or at the practice (group/organization) level

The College also strongly recommends that physicians or practices be able to opt out into an alternative payment and delivery model, like the PCMH, PCMH-N, etc. at any time. However, as discussed earlier, during the graduated approach to transitioning to alternative models, the Medicare FFS payments should continue to provide positive incentives to these physicians by allowing them to qualify for the higher levels of graduated VBP FFS updates

Additional Comments and Recommendations from ACP

Alternative Payment Models

The College encourages the Committee to incorporate language from the Medicare Physician Payment Innovation Act of 2013 (H.R. 574) that directs the Secretary to evaluate and then make recommendations for adoption of different models of payment and delivery systems on a defined timeline. While we support the concept of also creating an incentive based update program as new models are being developed and evaluated, and to allow physicians to qualify for higher incentive payments within fee-for-service as soon as next year if they are participating in approved (or deemed) models, we also believe that it is important to establish that the goal is to move as many physicians as possible away from traditional FFS to new payment and delivery models aligned with value, by a defined timeline and following a rigorous evaluation process.

We believe that the following alternative payment models should be considered for incorporation into a Medicare value-based payment system following SGR repeal.

Patient-Centered Medical Home (PCMH)/ PCMH Neighborhood

As stated previously, 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.¹³ Therefore we are appreciative that the Committee

¹³ A sampling of recent data on the effectiveness of PCMH programs can be accessed at: <http://www.pcpc.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.

has included mention of the PCMH concept in their draft legislation, but recommend that the bill *require* the Secretary to create a process to recognize PCMH and PCMH-N practices for higher Medicare payments as early as 2014.

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 assessed by validated 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.¹⁴ 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.¹⁵

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 (NCQA) Patient-Centered Medical Home Recognition Program (2011)¹⁶, URAC's Patient-Centered Health Care Home's Accreditation Program¹⁷, and The Joint Commission's Primary Care Medical Home Option.¹⁸ 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,

<http://content.healthaffairs.org/content/31/9/2002.full.html>, and

<http://content.healthaffairs.org/content/31/9/2010.full.html>.

¹⁴ Agency for Healthcare Research and Quality. Care Coordination and Measures Atlas. Accessed at

<http://www.ahrq.gov/qual/careatlas/>.

¹⁵ 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

¹⁶ More information on NCQA's PCMH Recognition program is available at:

<http://www.ncqa.org/tabid/631/Default.aspx>.

¹⁷ More information on URAC's PCHCH Accreditation program is available at:

https://www.urac.org/healthcare/prog_accred_pchch_toolkit.aspx.

¹⁸ More information on the Joint Commission's Primary Care Medical Home Option is available at:

<http://www.jointcommission.org/accreditation/pchi.aspx>.

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 Program¹⁹, 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 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.

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 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.²⁰ 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.²¹

¹⁹ Additional information on the NCQA Patient-Centered Specialty Practice Recognition Program can be found at: <http://www.ncqa.org/Programs/Recognition/PatientCenteredSpecialtyPracticeRecognition.aspx>.

²⁰ 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>

²¹ 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>

*Comprehensive Global Payment Model*²²

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.²³

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.

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.²⁴ 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

²² 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.

²³ Feder J. A health plan spurs transformation of primary care practices into better-paid medical homes. *Health Affairs* 2011 30 (3): 397-399.

²⁴ The complete CBO report can be accessed at: <http://www.cbo.gov/publication/42860>.

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).²⁵

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.**

Hardship Exemptions

ACP believes that it is appropriate to establish a clear but realistic timeline for physicians to transition to new payment and delivery models, with positive incentives during the transition, as described earlier in this letter. We also believe that it may be appropriate to provide reduced FFS updates for physicians who *choose* to remain in a pure FFS system at the end of such a transition period, if alternative payment and delivery models are available that are suitable for their specialty, patient population, and type of practice. However, we believe that hardship exemptions need to be available for physicians who cannot make such a transition through no fault of their own. We encourage the committee to consider incorporating language from the Medicare Physician Payment Innovation Act of 2013 (H.R. 547) to establish such a timeline and hardship exemption process.

Summary

The College appreciates this opportunity to share its recommendations with the House Energy & Commerce Committee on your legislative proposal to repeal the SGR, 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 and alternative payment systems. We support the intent of your proposal, and hope that our responses to the questions you posed will be of help to you in continuing the development of a proposal that would:

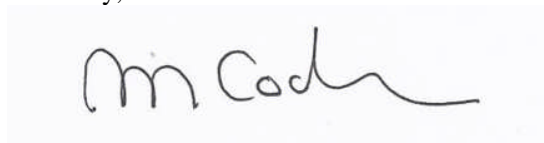
- Eliminate the SGR;

²⁵ 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>.

- Provide positive and stable payments to all physicians, with higher baseline updates for evaluation and management services, for at least five years;
- Create a process for physicians to qualify for graduated incentive-based payments during this period of stability for participating in programs to improve quality and the effectiveness of care;
- Put greater emphasis on programs that would move away from reporting on process measures at the individual physician level to programs that measure improvements in outcomes and patient experience with care at the organizational and system level;
- Create a process to “deem” programs that would qualify for graduated incentive based payments;
- Create a clearer “bridge” between the proposed FFS competency-based incentive program and new payment models, by creating incentives within the competency-based update program for physicians who are developing the competencies needed, within their practices and organizations, to successfully make the transition to new payment and delivery models aligned with value;
- Create incentives for physicians to develop and participate in “peer cohorts” that have the greatest potential to improve outcomes, patient experience, and effectiveness of the care provided, at both an individual and organizational level and within their own communities;
- Allow physicians in recognized PCMH practices to qualify for higher FFS payments as early as next year; and
- Create a timeline and process for HHS to evaluate, propose, and designate approved new payment and delivery models, with hardship exemptions.

Please contact Jonni McCrann at jmccrann@acponline.org or 202-261-4541 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, American College of Physicians