



February 25, 2013

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

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

Dear Chairmen Camp and Upton:

On behalf of the American College of Physicians (ACP), I appreciate this opportunity to respond to your request for comments on a discussion outline, as released on February 7th, to repeal the sustainable growth rate (SGR) and reform the Medicare physician payment system. We applaud you for your leadership in trying to address 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 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 recommendations for the Committees to consider as they further develop this proposal.

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

BRINGING MEDICARE REIMBURSEMENTS INTO THE 21ST CENTURY

The Discussion Outline

PHASE 1: Repeal SGR and provide a period of predictable, statutorily-defined payment rates

- While the duration and size of the payment rates to be set in statute are not yet determined, this phase will provide physicians time to transition to, and play a prominent role in, reforming the Medicare FFS physician payment system.

ACP Comments

ACP supports a phased approach, along the lines of what is outlined in the Energy and Commerce and Ways and Means Committees' proposal. ACP similarly has proposed a legislative framework that consists of two phases. During the first stage of ACP's proposal, Medicare would stabilize and improve payments under the current Medicare fee schedule for at least the next five years by eliminating the SGR as a factor in establishing annual updates and by ensuring higher payments and protection from budget neutrality cuts for undervalued primary care, preventive and care coordination services. During stage two, physicians would be given a set timetable to transition their practices to the models that Congress and the Department of Health & Human Services (HHS) have determined to be most effective based on

experience with the payment/delivery system models evaluated during stage one, leading to permanent replacements to the existing Medicare payment system.

ACP supports broad adoption of models including the patient-centered medical home (PCMH) and the patient-centered medical home neighborhood (PCMH-N), Accountable Care Organizations (ACOs), and other models that meet suggested criteria for value to patients. We recommend the development of different payment initiatives for different specialties and types of practice, rather than a “one-size-fits-all” model for all physicians.

Additionally, as you are aware, on February 6, 2013, Representative Allyson Schwartz (D-PA) along with Representative Joe Heck (R-NV), re-introduced bipartisan legislation to repeal and reform Medicare’s physician payment formula. The Medicare Physician Payment Innovation Act, H.R. 574, provides a viable and reasonable pathway to full SGR repeal and implementation of new value-based models of care that focus on quality of care, as opposed to volume of care, as occurs under the current payment system.

In brief, the Medicare Physician Payment Innovation Act of 2013 would:

- Repeal the Sustainable Growth Rate (SGR).
- Protect access to care for seniors, disabled persons, and military families, by eliminating all scheduled SGR cuts, including a nearly 30 percent cut in January, 2014.
- Stabilize payments with no cuts for the next six years and provide positive updates from 2015-2018.
- Provide a higher update for undervalued primary, preventive and coordinated care services, whether delivered by primary care physicians or by other specialists.
- Accelerate development, evaluation, and transition to new payment and delivery models, developed with input by the medical profession and with external validation.

ACP supports H.R. 574 and also recognizes that there will likely be variations on the framework proposed by H.R. 574 that could achieve the same goals of eliminating the SGR, stabilizing payments, recognizing the importance of improving payments for undervalued primary, preventive and coordinated care services, and establishing a clear pathway to patient-centered, value-based models. Therefore, we are interested in participating in ongoing discussions of how best to achieve a transition consistent with the above goals in a bipartisan way.

We note that the committees’ draft framework does not specify what the payment rates will be during the first phase, nor its duration. ACP recommends that during the first phase of your proposal (1) all physician services should receive a positive update and (2) undervalued evaluation and management services, whether delivered by primary care physicians or by other specialists, should receive an additional annual update above the baseline for all other services. We believe such incentives are critical to improving care coordination and addressing historical payment inequities that contribute to severe shortages in internal medicine, family medicine, internal medicine subspecialties, neurology, and other fields that principally provide evaluation and management services. We also recommend that this initial phase be no fewer than five years in duration. This overall sustained period of stability is needed to ensure access to care, while allowing time for Medicare to work with physicians to test, disseminate, and prepare for adoption of new patient-centered payment and delivery models.

We also recommend that physicians be able to qualify for higher updates during this phase if they successfully participate in a transitional value-based payment or approved quality improvement initiative. In our previous testimony before the Energy and Commerce Health Subcommittee on July 18,

2012—and reiterated in our statement for the record on February 14, 2013¹—we also outlined the following principles for developing a transitional quality improvement (QI)/value-based payment (VBP) program:

1. ACP supports in concept the idea of providing an opportunity for performance-based updates based on successful participation in an approved transitional VBP initiative that meets standards relating to the effectiveness of each program, building on successful models in the public and private sectors.
2. Transitional performance-based update programs should be incorporated into a broader legislative framework to stabilize payments and transition to new models. This is important so that physicians and the Medicare program have a clear “destination” and pathway to achieving it, even as physicians begin the journey through the transitional VBP initiative.
3. Any transitional performance-based payment updates should be in addition to a higher “floor” on payments for undervalued primary care/preventive/and coordinated care services, such as that specified by the Medicare Physician Payment Innovation Act, H.R. 574. This is important to address the continued under-valuation of these critically important services, even as payments also begin to reflect physician participation in the transitional VBP initiative.
4. The transitional performance-based payment program should include models for which extensive data and experience already exist, and that can more readily be scaled up for broader adoption by Medicare. Specifically, participation in the PCMH and PCMH-N models, as determined by practices meeting designated standards through an accreditation body and/or standards to be developed by the Secretary with input from the medical profession. Other established models that have demonstrated the potential to improve care coordination, such as Accountable Care Organizations (ACOs), bundled payments, and global primary care payments should also be considered for inclusion in a transitional VBP program. In addition, physicians who agree to incorporate programs, like ACP’s High Value, Cost-Conscious Care Initiative², into their clinical practice through shared decision-making with patients, might also qualify for a transitional VBP payment.
5. Existing QI/VBP payment models—the Medicare PQRS, e-RX, and meaningful use programs—if included in a transitional performance-based payment update program, should be improved to harmonize measures and reporting to the extent possible and to establish a consistent incentive program across all-elements. Efforts should also be made to align them with specialty boards’ maintenance of certification programs.
6. Transitional performance-based updates could be tiered so that programs that provide coordinated, integrated and patient-centered care get a higher performance update than less robust programs built on the current, siloed fee-for-service system.
7. CMS will need to improve its ability to provide “real time” data to participating physicians and practices. A method will need to be created to map practice-level participation in a transitional QI/VBP initiative to the individual physician updates under the Medicare Physician Fee Schedule.

¹ The full statement can be found at:

http://www.acponline.org/advocacy/where_we_stand/medicare/statement_for_the_record_ec_health_hearing_sgr_2013.pdf.

² Additional information can be found at: http://www.acponline.org/clinical_information/resources/hvccc.htm.

The Discussion Outline

PHASE 2: Reform Medicare's FFS payment system to better reflect the quality of care provided.

- Reform is needed to maintain a viable FFS system and an emphasis on value mirrors many private payer efforts.

ACP Comments

ACP agrees that reforms should be made in Medicare's FFS system to better reflect the quality of care provided

One immediate step that should be taken is for Medicare to begin paying for services relating to management of patients with complex chronic conditions. We support the development and recognition under Medicare fee-for-service payment polices of two new sets of CPT codes—(1) transition care following a facility-based discharge and (2) for chronic, complex care. 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 Patient Centered Medical Home (PCMH) model, which will be discussed further below. These new codes were developed by a CPT Panel workgroup and approved by the CPT Editorial Panel during their May 2012 CPT Meeting; they underwent the Relative Value Update Committee (RUC) survey process in order to be assigned recommended values; and the Centers for Medicare and Medicaid Services (CMS), in the 2013 fee schedule, assigned final valuations to the set of transition care codes and is now currently reimbursing physicians who meet the requirements of those codes. ACP is continuing to be actively engaged in this process in order to ensure that the complex, chronic care codes can also become part of the Medicare physician fee schedule in the near future.

ACP agrees with the Committees' proposal that reform efforts should take private payer efforts into account. As was outlined in our testimony before the Energy and Commerce Health Subcommittee on July 18, 2012—and in our statement for the record on February 14, 2013—**ACP strongly believes that the Patient-Centered Medical Home (PCMH) and Patient-Centered Medical Home Neighborhood 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.**

This readiness is reflected through the significant amount of private sector payer activity in the area of the PCMH, including test projects or roll-outs of the model in nearly all 50 states. For example:

- In Michigan, Blue Cross Blue Shield of Michigan's (BCBSM) Physician Group Incentive Program (PGIP) was established in 2004 as a collaborative partnership between BCBSM and physician organizations across the state, with the goal of optimizing patient care and transforming the state's health care delivery system. Then, in 2007, in the wake of the growing interest in the PCMH model, and in response to PGIP clinician requests for more direction and structure, BCBSM collaborated with clinicians to develop a set of 12 PCMH Initiatives.³
- In Genesee County, Michigan, the Genesee Health Plan, in collaboration with local physicians and hospitals, formed Genesys HealthWorks and has implemented a model built on a strong, redesigned primary care infrastructure and has demonstrated significant cost savings.⁴
- In the Hudson Valley area of New York, the THINC P4P-Medical Home project brings together multiple health plans that service the Hudson Valley region. Using standardized measures agreed

³ Share, David. From Partisanship to Partnership: The Payor-Provider Partnership Path to Practice Transformation. Testimony before the House Ways and Means Committee, Health Subcommittee. February 2012. Available at: http://waysandmeans.house.gov/UploadedFiles/Share_Testimony_FinalHE27.pdf.

⁴ Genesys HealthWorks Health Navigator in the Patient-Centered Medical Home. Available at: <http://www.pcpcc.net/content/genesys-healthworks-health-navigator-patient-centered-medical-home>.

upon by clinicians and payers, the project is providing performance incentives from multiple payers to the participating clinicians.⁵

- Colorado is the site of a multi-payer, multi-state PCMH pilot that includes multiple participants at both the local and national levels. The PCMH model is being tested in 16 family medicine and internal medicine practices selected from across the Colorado Front Range, as well as practices in Cincinnati, Ohio. The pilot is being evaluated by the Harvard School of Public Health to determine the effect on quality, cost trends, and satisfaction for patients and their health care team.⁶ ACP has been actively involved in this pilot, including serving on the steering committee.

In addition to these pilot programs, a number of large insurers have announced their intent to roll the PCMH model out more widely. For instance, in January 2012, Wellpoint, a private insurer covering 34 million Americans with a network of 100,000 primary care doctors, publicly announced its decision to invest in the medical home model across its entire network. Aetna, another large private health plan insuring more than 18 million Americans with a network of 55,000 primary care doctors, also recently announced a PCMH program roll-out in Connecticut and New Jersey, with expectations to expand the program nationally. And, building on a large medical home pilot project already underway, UnitedHealthcare, insuring 34 million Americans, announced in February 2012 an expansion of its value-based payment model, affecting between 50 percent and 70 percent of its customers. Numerous Blue Cross Blue Shield (BCBS) plans across the U.S. have been leaders in their respective marketplace, with over 4 million BCBS members in 39 states currently participating in some version of a PCMH initiative. For example, Care First, the BCBS affiliate in the Maryland/DC area, has implemented the PCMH model within over 75 percent of its participating primary care practices.

These private insurers have made the decision to roll the PCMH model out based on their experience to date with pilot programs, as well as the substantial evidence that health systems with a strong primary care foundation deliver higher-quality, lower-cost care overall and greater equity in health outcomes.⁷ Taking this a step further, research also shows that patient-centered primary care is best delivered in a medical home.⁸ Although peer-reviewed academic studies evaluating the medical home model in its full implementation are still limited,^{9,10,11} there is much to be learned from the numerous PCMH evaluations that have considered individual components of the PCMH model in specific settings, including a recent Institute of Medicine report that evaluated methods of care for those who are chronically ill.¹² One compelling indication of the value of PCMHs in improving outcomes and lowering costs is the simple fact that so many large, private sector payers have embraced the PCMH model, scaling it up to make PCMHs widely available to their subscribers, with many of them reporting substantial costs savings as a result.

⁵ Hudson Valley P4P-Medical Home Project. Available at: <http://www.pcpcc.net/content/hudson-valley-p4p-medical-home-project>.

⁶ The Colorado Multi-Payer, Multi-State Patient-Centered Medical Home Project. Available at:

<http://www.pcpcc.net/content/colorado-multi-payer-multi-state-patient-centered-medical-home-pilot>.

⁷ Johns Hopkins Bloomberg School of Public Health. Publications of the bureau of primary health care and primary care policy center. (2012). Available at: <http://www.jhsph.edu/pcpc/publications.html>.

⁸ Commonwealth Fund (2012, March 12). Patient-Centered Coordinated Care. Program Description.

http://www.commonwealthfund.org/~media/Files/Programs/2012/Program%20PDFs/2011_PatientCentered_Coord_Care_with_caption.pdf.

⁹ Peikes, D., Genevro, J., Scholle, S. H., Torda, P. (2011, Feb). The patient-centered medical home: Strategies to put patients at the center of primary care. Agency for Healthcare Research and Quality. AHRQ No. 11-0029. Rockville, MD. Retrieved from http://www.pcmh.ahrq.gov/portal/server.pt/community/pcmh_home/1483/pcmh_tools_resources_patient-centered_v2.

¹⁰ Jaén C. R., Ferrer R. L., Miller W. L., Palmer R. F., Wood R, Davila M, et al. (2010, May 1). Patient outcomes at 26 months in the patient-centered medical home national demonstration project. *Ann Fam Med*, 8(1 Suppl):S57–S67; S92.

¹¹ Reid, R. J., Coleman, K., Johnson, E. A, Fishman, P. A., Hsu, C., Soman, M. P., Trescott, C. E., et al. (2010, Mar) The group health medical home at year two: cost savings, higher patient satisfaction, and less burnout for providers. *Health Affairs*, 29(5):835–43.

¹² Institute of Medicine. (2012). *Living well with chronic illness: A public health call to action*. Washington, DC: National Academy Press.

The Discussion Outline

PHASE 2: Reform Medicare's FFS payment system to better reflect the quality of care provided. (cont.)

- After the period of stability, physician fee schedule payment updates will be based on performance on meaningful, physician-endorsed measures of care quality and participation in clinical improvement activities (e.g., reporting clinical data to a registry or employing shared-decision making tools).

ACP Comments

Overall, ACP supports payment and delivery system reforms that promote high-value care, improved patient experiences, better population health, improved patient safety, and reduced per capita spending. In 2012, ACP released a paper titled, *The Role of Performance Assessment in a Reformed Health Care System*,¹³ in which we laid out a series of policy statements focused on the evolving roles of performance assessment efforts within the realm of medical care, including programs linking payments to reporting and performance on specific quality measures. Therefore, we offer for the Committees consideration some key highlights of ACP's policy with regard to performance assessment efforts that are linked to payment.

First, ACP believes that payment and delivery system reform to promote high-value care should:

- Be integrated into innovative delivery system reforms such as the patient-centered medical home and other payment reform efforts that promote systems-based collaboration and health care delivery;
- Demonstrate improved quality patient care that is safer and more effective as the result of program implementation;
- Support an environment where all physicians—in both primary care and specialty practices—are supported in their efforts to perform better, continually raising the bar on quality;
- Develop, or link closely to, technical assistance efforts and learning collaboratives so that physicians and other health professionals are motivated and helped to improve their performance;
- Engage physicians in all aspects of program development including determination of standard measure sets, attribution methods, and incentive formulas; and
- Reflect national priorities for strengthened preventive health care, quality improvement, quality measurement, and reducing health disparities.

Second, measures of the quality and value of care should be evaluated through and collected in a consistent, reliable, feasible, and transparent manner; thoroughly tested prior to full implementation to the extent possible; and applied as part of overall payment and delivery system reform emphasizing collaborative system-based health care. To the extent that such reforms include linking payments to reporting and performance on specific quality measures, such incentives must take into consideration the conflicting evidence on the effectiveness of performance assessment-based payment programs and potential adverse consequences. For instance, some have concluded that while the data on performance-based incentives is generally positive, considerably more research needs to be conducted to ensure effectiveness of these incentives and their impact on patient and population health outcomes:

- A 2006 literature review by Petersen et al. concluded that 12 of 15 studies of physician and provider group-level P4P programs yielded partial or positive effects on quality measures.¹⁴

¹³ This paper can be accessed at:

http://www.acponline.org/advocacy/where_we_stand/policy/performance_assessment.pdf.

¹⁴ Petersen L. et al. Does Pay-for-Performance Improve Quality of Health Care? *Ann Intern Med*.

- A more recent literature review concluded that while results vary significantly based on measures and other program design factors, pay-for-performance efforts improve quality of care by about 5%.¹⁵
- Another review of performance assessment initiatives failed to find substantial evidence supporting or not supporting pay-for-performance effectiveness and expressed concern that such programs did little to address for selection bias. The authors suggested that quality improvement-based payment models should be carefully designed prior to implementation to ensure effectiveness.¹⁶¹⁷
- A study of a hypertension care performance program conducted in the United Kingdom found that even significant financial incentives did not lead to better quality. The study's authors speculated that most doctors may have already been delivering the recommended services, limiting the potential for large gains.¹⁸
- A review of physician cost-profiling initiatives in Massachusetts found that the measures produced inaccurate conclusions and that the average misclassification rate for internists was 25%.¹⁹
- Additionally, a comprehensive literature review found pay-for-performance connected improvement in the quality of diabetes care management but had little effect on acute care effectiveness.²⁰

However, a number of P4P programs have been shown to improve health outcomes:

- The HealthSpring/Sumner Medical Group pay-for-quality initiative centered on Medicare Advantage-enrolled patients and provided free nursing assistance to engage patients between office visits and facilitate disease management. Participating doctors who met quality targets were paid a 20% performance bonus. After the disease management and performance bonuses were provided, "patient outcomes improved across the board" and more preventive screenings were performed. Patient outcome improvements of at least 30% were achieved for diabetes control, prostate and breast cancer screenings, and cholesterol screenings.²¹²²

2006;145:262-272.

¹⁵ Van Herck P, De Smedt D, Annemans L, Remmen R, Rosenthal MB, Sermeus W. Systematic review: Effects, design choices, and context of pay-for-performance in health care. *BMC Health Serv Res*. 2010 August 23; 10: 247. Accessed at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2936378/?tool=pubmed> on June 9, 2011.

¹⁶ Lowes R. Little Evidence For or Against Pay-for-Performance Plans. *Medscape News*. September 7, 2011. Accessed at <http://www.medscape.com/viewarticle/749303> on October 11, 2011.

¹⁷ Scott A et al. The effect of financial incentives on the quality of health care provided by primary care physicians. *The Cochran Library*. September 7, 2011.

¹⁸ Abelson R. Financial Rewards for a Doctor's Care. *NY Times*. January 26, 2011. Accessed at <http://prescriptions.blogs.nytimes.com/2011/01/26/financial-rewards-for-a-doctors-care/> on May 4, 2011.

¹⁹ Adams JL, Mehrotra A, Thomas JW, McGlynn EA. Physician Cost Profiling-Reliability and risk of Misclassification. *NEJM*. 2010;362:1014-1021.

²⁰ Van Herck P, De Smedt D, Annemans L, Remmen R, Rosenthal MB, Sermeus W. Systematic review: Effects, design choices, and context of pay-for-performance in health care. *BMC Health Serv Res*. 2010 August 23; 10: 247. Accessed at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2936378/?tool=pubmed> on June 9, 2011.

²¹ Glendinning D. "Pay-for-quality" pilot project gets high marks. *American Medical News*. July 24/31, 2006. Accessed at <http://www.ama-assn.org/amednews/2006/07/24/gvsb0724.htm> on February 7, 2011.

²² Ward G. Managed-care company sees benefits of pay-for-performance. *The Tennessean*. February 27, 2008. Accessed at <http://library.corporate-ir.net/library/22/226/226354/items/324480/Tennessean2%20-%20P4Q%20results%20-%202.08.pdf> on February 7, 2011.

- Evidence also demonstrates that systems-based payment reforms can improve patient experience. A review of a California performance incentive program showed that adherence to physician communication, care coordination, access to care, and office staff interaction measures improved greatly, demonstrating that performance assessment-based payment may improve the patient-physician relationship.²³
- According to CMS, the number of physicians reporting on PQRs quality measures has expanded (although many physicians do remain frustrated with the program) and evidence indicates that recommended care is being delivered more frequently since the program's launch.²⁴ Among the reported quality improvements, CMS found that in 2009, 93% of physicians told diabetes patients about potential eye-related complications, an increase of 41% compared with 2007 reports.²⁵

Again, it is critical that programs linking payments to reporting and performance on specific quality measures take into consideration this conflicting evidence on the effectiveness of performance assessment-based payment programs and potential adverse consequences.

Third, to the extent that payment and delivery reforms include financial rewards and/or penalties linked to performance, the reward framework (i.e., type and magnitude of incentives) should be incorporated into systems-based payment reforms designed to permit and facilitate broad-scale positive behavior change and achievement of performance goals within targeted time periods. Potential rewards should be:

- Significant enough to drive desired behaviors and support continuous quality improvement;
- Reflective of the cost and other resources needed to participate in a performance assessment-based payment program, including the cost to measure and design improvements that will take, for example, system supports and program management;
- Balanced between rewarding high performance and rewarding substantial improvement over time;
- Graduated to create stronger incentives for physicians to participate in performance improvement programs and to ensure that a physician's level of commitment to quality improvement activities is recognized;
- Directed at positive rather than negative rewards;
- Timely and followed closely upon the achievement of performance;
- Designed to encourage physicians and health care systems to care for vulnerable patients with complex health care needs, reflect the level of care required, and avoid adverse, unintended consequences resulting from performance assessment-based payment program implementation; and
- Adjusted as the complexity of performance measure requirements change.

Fourth, 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, and report performance data internally and publicly. These processes should be transparent so that physicians, consumers, and payers know that methods,

²³ Rodriguez HP, Von Glahn T, Elliot MN, Rogers WH, Safran DG. The Effect of Performance-Based Financial Incentives on Improving Patient Care Experiences: A Statewide Evaluation. *J Gen Intern Med.* 2009;24(12):1281-1288. Accessed at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2787940/?tool=pubmed> on May 3, 2011.

²⁴ O'Kane M. The Acute Need for Delivery System Reform. NCQA. Power Point Presentation, March 9, 2009. Accessed at http://www.ehcca.com/presentations/pfpsummit4/okane_1.pdf on September 15, 2010.

²⁵ Centers for Medicare and Medicaid Services. Medicare News: CMS data show gains in key quality indicators through Physician Quality Reporting system and ePrescribing Incentive Program. CMS Office of Media Affairs press release. April 19, 2011.

expectations, rationale, and results are valid and reliable. Sponsors of programs that link payment to assessment of performance, including CMS, should collaborate with physicians who are potential participants regarding program implementation, educate physicians about the potential risks and rewards inherent in program participation, and immediately inform physicians of any changes in program requirements and evaluation methods and newly identified risks and rewards. CMS and other payers should inform patients at the time of enrollment of such efforts, potential risks, and physician participation.

Fifth, programs that link payment to assessment of performance should incorporate periodic, objective assessments of measurement, data collection, scoring, and incentive systems to evaluate their effects on achieving improvements in quality, including any unintended consequences. The programs and, where appropriate, their performance thresholds should be readjusted only when there is compelling evidence and a justifiable reason to do so.

Sixth, ACP supports a national strategy for quality improvement that will establish national goals, attend to high-leverage priority areas that will lead to significant gains in quality and value of care (such as care coordination), fill gaps where few performance measures exist, develop universal terminology for measurement developers, and harmonize measure sets to improve coordination and reduce duplication and confusion. Such a strategy should also lead to determination of a single core measure set to provide data for benchmarking and ongoing quality improvement. The strategy should be updated as performance measures and programs to link payments to assessments of performance evolve.

Seventh, analysis and reporting of physician and system performance should include the application of statistical methods that provide valid and reliable comparative assessments across populations.

- Data should be fully adjusted for case-mix composition (including factors of sample size, age/sex distribution, severity of illness, number of comorbid conditions, patient compliance, patient health insurance status, panel size/patient load, and other features of a physician's practice and patient population that may influence the results).
- To the extent possible, data analysis should accurately reflect all units of delivery that are accountable in whole or in part for the performance measured.

Eighth, health care professionals should have timely access to performance information prior to public reporting, and if this information is being tied to a payment incentive, there should be a timely, fair, and accurate appeals process available to examine potential inaccuracies.

Finally, it is crucial that any programs that link payments to performance assessment be subjected to ongoing research and monitoring to ensure that they support the patient-physician relationship, contribute positively to adoption of best practices, and do not unintentionally undermine patient care, such as by contributing to ethnic and racial disparities by penalizing or denying resources.

The Discussion Outline

PHASE 2: Reform Medicare's FFS payment system to better reflect the quality of care provided. (cont.)

- Medical specialty societies will develop meaningful quality measures and clinical improvement activities using a standard process.

In addition, in your request for feedback on this element, the following questions were posed:

- How should such a method account for local variances?
- What role do you envision state and local medical societies playing in the development of a standard development process to take into account local variances?

- How would such a structure, once established, account for changes or advancements in quality and improvement activities?
- Once established, what steps should be taken to help educate local physicians on the benefits of such quality measures and clinical improvement activities?

ACP Comments

As noted earlier, ACP 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, and report performance data internally and publicly. These processes should be transparent so that physicians, consumers, and payers know that methods, expectations, rationale, and results are valid and reliable. Sponsors of programs that link payment to assessment of performance, including CMS, should collaborate with physicians who are potential participants regarding program implementation, educate physicians about the potential risks and rewards inherent in program participation, and immediately inform physicians of any changes in program requirements and evaluation methods and newly identified risks and rewards. CMS and other payers should inform patients at the time of enrollment of such efforts, potential risks, and physician participation.

It is also important to note that physicians and practices that transition to the PCMH model should be measured by distinct measures that are focused on:

- Delivery of patient-centered care, which could be determined by recognition from a national “patient-centered medical home” program such as the Accreditation Association for Ambulatory Health (AAAHA), the Joint Commission, NCQA, URAC, or a state-based accreditation program; and/or by criteria developed by the Secretary of HHS that may pull from the national programs, current CMS Innovation Center Initiatives (e.g., the Comprehensive Primary Care Initiative), or other sources.
- Delivery of high quality and efficient care – potentially looking to the core measures recommended by the PCMH Evaluators’ Collaborative established by the Commonwealth Fund²⁶, which includes measures in the following domains: clinical quality (process and outcome), utilization, cost and patient experience of care.
- Delivery of coordinated care, which could be determined, in part, by recognition of non-primary care practices through the Specialty Practice Recognition program currently being developed by NCQA for release in spring, 2013. This program will assess a specialty/subspecialty practice’s ability to integrate/coordinate with primary care practices, and engage in processes to deliver patient centered care, improved patient access, improve care quality and implementation of “meaningful” health information technology.
 - In addition, the Agency for Healthcare Research and Quality (AHRQ) has available an atlas of care coordination measures;²⁷ 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.²⁸

²⁶ Rosenthal MB. Abrams MK. Biton A. et. al. Recommended core measures for evaluating the patient-centered medical home: Cost, utilization and clinical quality. Commonwealth Fund. May 2012. http://www.commonwealthfund.org/~media/Files/Publications/Data%20Brief/2012/1601_Rosenthal_recommended_core_measures_PCMH_v2.pdf

²⁷ Agency for Healthcare Research and Quality. Care Coordination and Measures Atlas. Accessed at <http://www.ahrq.gov/qual/careatlas/>

²⁸ NQF. Preferred practices and performance measures for measuring and reporting care coordination. 2010. Accessed at

In addition, measures and measure strategies should be thoughtfully aligned with – and where possible leverage – the regular practice assessment, reporting and quality improvement activities that individual physicians already are required to undertake as part of their specialty board Maintenance of Certification (MOC). For example, the American Board of Internal Medicine (ABIM), which is the largest of the certifying boards, includes in its MOC program a suite of quality measurements, reporting and improvement tools specifically focused on patient-centered primary care/specialist communication, and will soon introduce a care coordination module developed by several of the experts who also helped shape the Medical Neighbor concept, described below. Aligning PCMH/N practice accreditation standards with professional MOC assessment and improvement activities will send a powerful signal to physicians about the significance of the PCMH model, reduce redundant reporting requirements and facilitate participation by smaller practices. This alignment would also provide a means of accounting for changes or advancements in quality and improvement activities and of educating physicians on the benefits of such quality measures and clinical improvement activities.

The Discussion Outline

PHASE 2: Reform Medicare's FFS payment system to better reflect the quality of care provided. (cont.)

- Performance will be based on both risk-adjusted relative rankings amongst physician specialty peer groups and improvement on quality over time.

In addition, in your request for feedback on this element, the following questions were posed:

- Do you believe that some form of risk and reward system should be tied to performance? If so, what?
- How would you recommend addressing outliers once risk-adjusted relative rankings amongst physician specialty peer groups have been conducted?
- What other considerations should be taken into account with regards to medical professionals accessing and appealing such rankings?

ACP Comments

To the extent that such reforms include linking payments to reporting and performance on specific quality measures, such incentives must take into consideration the conflicting evidence on the effectiveness of performance assessment-based payment programs and potential adverse consequences. In addition, any rewards associated with such reforms should facilitate broad-scale positive behavior change and achievement of performance goals within targeted time periods. As noted above, potential rewards should be:

- Significant enough to drive desired behaviors and support continuous quality improvement;
- Reflective of the cost and other resources needed to participate in a performance assessment-based payment program, including the cost to measure and design improvements that will take, for example, system supports and program management;
- Balanced between rewarding high performance and rewarding substantial improvement over time;
- Graduated to create stronger incentives for physicians to participate in performance improvement programs and to ensure that a physician's level of commitment to quality improvement activities is recognized;
- Directed at positive rather than negative rewards;

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

- Timely and followed closely upon the achievement of performance;
- Designed to encourage physicians and health care systems to care for vulnerable patients with complex health care needs, reflect the level of care required, and avoid adverse, unintended consequences resulting from performance assessment-based payment program implementation; and
- Adjusted as the complexity of performance measure requirements change.

Additionally, ACP believes that it is critically important to assure that physicians are given the opportunity to comment on performance ratings that they believe are inaccurate, or that do not take into account the characteristics of the practice or patient population being treated prior to the release of ratings to the public or to their being tied to payment.²⁹ A fair reconsideration process helps to ensure the accuracy of the reported information, and thus, facilitates increased patient/consumer trust in the information, increases the willingness of clinicians to cooperate with the process and helps to minimize unintended consequences that may compromise the care of the patient.

The College also asks the Committees to consider the hardship exemptions from negative payment adjustments that are present in the Medicare Physician Payment Innovation Act, H.R. 574. Such exemptions may provide a lifeline for some struggling practices and help ensure ongoing access for the patient populations of those practices as they work to transition to value-based payment models.

The Discussion Outline

PHASE 2: Reform Medicare's FFS payment system to better reflect the quality of care provided. (cont.)

- Physicians will be provided with timely access to their quality performance score as well as with an appeals process to ensure accuracy.

ACP Comments

ACP is strongly supportive of health care professionals having timely access to performance information prior to public reporting and having the information tied to a payment incentive, and, as discussed above, of having a timely, fair, and accurate appeals process available to examine potential inaccuracies. In our recent report on the State of the Nation's Health Care³⁰, ACP made the following recommendation with regard to timely access to performance data:

Penalties should be instituted only if there is evidence that CMS has created programs and provided the necessary time, assistance and timely information needed for physicians to successfully participate in them. To, date, CMS has been unable to provide timely feedback to physicians regarding whether they are successfully satisfying program requirements, leading to frustration and distrust.

The College is pleased to see that the Committees' proposal includes language that reflects these views.

It is important to note that the Comprehensive Primary Care Initiative (CPCI), as well as other initiatives being conducted by the CMS Medicare-Medicaid Innovation Center (CMMI), do include a commitment by CMS and other participating payers to share data in a more frequent and consistent manner. These initiatives are discussed in more detail below. ACP is encouraged by this and hope that these projects will

²⁹ Detailed ACP policy with regard to fair appeals processes for performance data can be found in the following papers: (1) Developing a Fair Process through which Physicians Participating in Performance Measurement Programs Can Request a Reconsideration of Their Ratings. 2007. Accessible at: http://www.acponline.org/advocacy/where_we_stand/policy/appeals.pdf and (2) Healthcare Transparency—Focus on Price and Clinical Performance Information. 2010. Accessible at: http://www.acponline.org/advocacy/where_we_stand/policy/transparency.pdf.

³⁰ This report can be found at: http://www.acponline.org/advocacy/events/state_of_healthcare/snhcreport13.pdf.

provide an opportunity to learn the most efficient and effective means of regular data sharing with practices.

The Discussion Outline

PHASE 2: Reform Medicare's FFS payment system to better reflect the quality of care provided. (cont.)

- This proposal will reduce the reporting burden on physician practices, override the current ineffective CMS quality measurement programs, and align Medicare payment initiatives with private payer initiatives.

In addition, in your request for feedback on this element, the following questions were posed:

- What reporting requirements, among those your members must currently comply with, offer examples of how a more efficient reporting system might work?
- What current reporting requirements offer examples of how a more efficient reporting system should not work?
- How should such a system be designed to take into account improvements in current private payer initiatives or the introduction of new initiatives?

ACP Comments

ACP strongly believes that a specific goal of payment reform should be to reduce the time that physicians must spend in administrative tasks that do not improve patient care or outcomes; at a minimum, they should not add to the administrative burden.

As policymakers develop 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.

Fee-for-service and Relative Value Unit (RVU) payment models have appropriately been criticized for encouraging volume—seeing more patients per hour and providing more procedures to them—than creating incentives for physicians to spend time with patients. Yet the alternatives under consideration could further devalue clinical time if not designed carefully. Some forms of capitation, for instance, can create disincentives for physicians to see patients at all, since they would be paid the same amount per patient no matter how often the patient is seen or how much time is spent with the patient during each encounter. Fee-for-service at least has the virtue of generally requiring a face-to-face encounter for a visit to be reimbursed, even if the incentive is to see more patients per hour than necessarily is appropriate or desirable from a clinical standpoint.

The point is not that fee-for-service is preferable to capitation or other bundled payment models, only that any payment system will create incentives that can affect patient-physician relationships in ways that may be good as well as bad. The only way to ensure that payment models support the ability of physicians and patients to spend more appropriate clinical time together is to make this an explicit goal of payment reform. Accordingly, fee-for-service payment policies and relative value units should be revised to provide higher payments for more time-intensive clinical encounters, especially with patients with more complex diagnostic challenges and clinical conditions. Capitation and bundled payments must ensure that there is an incentive for physicians to spend appropriate clinical time with patients, such as by ensuring

that there is good risk-adjustment based on patients' health status, combining capitation with fee-for-service payments for specific encounters, and measures of patient experience with the care provided including time spent with the physician.

Similarly, payment systems can detract from patient-physician encounter time by requiring physicians to spend more time reporting on measures, requiring unnecessary documentation of the services provided, and submitting paperwork to justify their clinical decision-making, at the expense of time with patients. There are, after all, only a set number of hours in a day, and an hour spent on paperwork is an hour that is not available for meaningful patient care. A specific goal of payment reform should be to reduce the time that physicians must spend in administrative tasks that do not improve patient care or outcomes; at a minimum, they should not add to the administrative burden.

As indicated earlier in our discussion of a transitional value-based payment approach, ACP supports the use of existing QI programs such as Medicare PQRS, e-RX, and meaningful use 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 report³¹, 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.

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 CMS³² and ONC³³ 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.

It is important to note though that CMS has expressed interest in continuing 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 is soliciting 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. ACP encourages the Committees to take these efforts into account, and perhaps consider encouraging and facilitating these improvements before creating an alternative quality reporting program.

ACP encourages the Committees to consider the initiatives of the CMS Innovation Center, which is working to align federal, state, and private payer payment and deliver system reform efforts. In its first

³¹ This report can be found at: http://www.acponline.org/advocacy/events/state_of_healthcare/snhcreport13.pdf.

³² These comments can be found at: http://www.acponline.org/advocacy/where_we_stand/health_information_technology/cms_nprm.pdf.

³³ These comments can be found at: http://www.acponline.org/advocacy/where_we_stand/health_information_technology/onc_nprm.pdf.

year CMMI has introduced initiatives involving over 50,000 health care clinicians and 1 million Medicare, Medicaid, and CHIP beneficiaries. CMMI's efforts fall into a number of categories:

- Primary Care Transformation
- Accountable Care Organizations (ACOs)
- Bundled Payments for Care Improvement
- Initiatives Focused on the Medicaid and CHIP Population
- Initiatives Focused on Medicare-Medicaid Enrollees
- Initiatives to Speed the Adoption of Best Practices
- Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models

One critical program of the CMMI is the Comprehensive Primary Care Initiative (CPCi), which is a collaboration between private and public payers and primary care practices to support patient centered primary care. The CPCi is modeled on the PCMH and PCMH–Neighborhood concepts, championed by ACP and other national membership organizations representing physicians and other clinicians and supported by thousands of business, consumer, and payer groups represented in the Patient-Centered Primary Care Collaborative (PCPCC). In this initiative, primary care practices are receiving new, public and private funding for primary care functions not included in the fee-for-service payments and will have the opportunity to share net savings generated through the program. Forty-four commercial and State insurers are joining with Medicare to support comprehensive primary care, provided that selected practices demonstrate capabilities aligned with the PCMH model. If successful, CMS has the authority to expand the program throughout Medicare, potentially leading to a sustainable new payment and delivery model for primary care.

Finally, as the United States transitions to models where physicians will be held more accountable for the outcomes of care, not the processes they follow to get there, the quid pro quo should be a dramatic reduction in clinical “micro-management” by third-party payers and government. If physicians can show that they can achieve high-quality and cost-effective outcomes and positive patient experiences with the care provided, based on good and readily reportable composite measures, there is little or no justification for pre-authorization requirements, detailed documentation of each code and encounter, and post-payment second-guessing of clinical decision-making.

The Discussion Outline

PHASE 2: Reform Medicare's FFS payment system to better reflect the quality of care provided. (cont.)

- Physicians who are participating in certain alternative reimbursement models under Medicare may opt out of this modified FFS payment system.

ACP Comments

As has been noted above, **ACP strongly believes that the PCMH model, as one potential alternative reimbursement model, will be ready to be a part of a new, value-based health care payment and delivery system.** In addition, as discussed in our previous testimony and statement, the importance of involvement of the “medical neighborhood” to the ultimate success of the PCMH model to fully achieve its quality and efficiency goals has been highlighted by recent policy papers by ACP³⁴ and the Agency for Healthcare Quality and Research (AHRQ).³⁵ The NCQA, acknowledging the importance of the

³⁴ American College of Physicians. The patient centered medical home neighbor: The interface of the patient centered medical home with specialty/subspecialty practice. 2010. Accessed at http://www.acponline.org/advocacy/where_we_stand/policy/.

³⁵ Agency for Healthcare Research and Quality (AHRQ). Coordinating care in the medical neighborhood: Critical components and available mechanisms. 2011. Available at http://pcmh.ahrq.gov/portal/server.pt/community/pcmh_home/1483/what_is_pcmh.

involvement of the “medical neighborhood” in support of PCMH (primary) care, is in the process of finalizing a “medical neighbor” recognition process that identifies specialty and subspecialty practices that engage in activities supportive of the PCMH model—with particular emphasis on care coordination and integration. Several areas of the country are also 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.

ACO development is also rapidly occurring throughout the country with the implementation of the Pioneer (32 approved programs) and Medicare Shared Savings Programs (220 approved programs) within the public sector, and the report of over 220 ACOs being developed across 45 states and the District of Columbia within the private sector – an increase of 38 percent in the private sector within only the past 6 months.³⁶ The selected ACOs operate in a wide range of areas of the country and almost half are physician-driven organizations serving fewer than 10,000 beneficiaries, demonstrating that smaller organizations are interested in operating as ACOs. One example of these private sector programs is the Alternative Quality Contract offered through BCBS of Massachusetts, which has shown both improved quality and a downward bending of the cost growth curve after only one year of implementation.³⁷ The growth of the ACO model has led NCQA (released) and URAC (in process) to develop an ACO recognition process that helps ensure that these organizations engage in processes that promote patient centered, high quality, efficient integrative care.

In addition to the programs noted above, ACP’s High Value Care Initiative (HVC), which includes clinical, public policy, and educational components,³⁸ was designed to help physicians and patients understand the benefits, harms, and costs of an intervention and whether it provides good value, as well as to slow the unsustainable rate of health care cost increases while preserving high-value, high-quality care.

ACP recognizes that a one-size fits all approach is not ideal and therefore believes that moving toward alternative delivery system and payment models can be done in parallel with reforming a post-SGR fee-for-service system to incentivize improved care coordination and better reflect the quality of care provided, particularly for those physicians and specialties for which FFS is better suited.

The Discussion Outline

PHASE 3 and BEYOND: Further reform Medicare’s FFS payment system to also account for the efficiency of care provided; provide information for Congress to further modify the payment system

- After several years of risk-adjusted quality-based payments, physicians who perform well on quality measurement will be afforded the opportunity to earn additional payments based on the efficiency of care.
- Physicians will be provided with timely access to their efficiency performance score as well as with an appeals process to ensure accuracy.
- This proposal will reduce the reporting burden on physician practices and align Medicare payment initiatives with private payer initiatives.
- Physicians who are participating in alternative reimbursement models under Medicare may opt out of this modified FFS payment system.
- An assessment of the reformed FFS payment system and Medicare and private alternative delivery model tests will help to ensure that physicians can select from payment system options.

³⁶ Muhlestein D et. al. Growth and Dispersion of Accountable Care Organizations: June 2012 Update. Leavitt Partners. Accessed at <http://leavittpartners.com/wp-content/uploads/2012/06/Growth-and-Dispersion-of-ACOs-June-2012-Update2.pdf>

³⁷ Song B, Safran D, et. al. Health Care Spending and Quality in Year 1 of the Alternative Quality Contract. N Engl J Med 2011; 365:909-918 September 2011. Accessed at <http://www.nejm.org/doi/full/10.1056/NEJMsal101416#t=articleTop>.

³⁸ Additional information can be found at: http://www.acponline.org/clinical_information/resources/high_value_care/.

- Congress would solicit recommendations from physician societies and other relevant stakeholders on how to further reform and improve the Medicare physician payment system.

ACP Comments

Our earlier comments on phase 2 of the Committees’ proposal address the major elements of phase 3— including, the implementation of risk-adjusted, quality based payments; the need for timely access to quality and efficiency data; support for decreasing the reporting burden; and the readiness of the PCMH model as one potential alternative reimbursement model.

ACP is strongly supportive of incorporating an ongoing evaluation of a reformed Medicare fee-for-service system. In fact, the College calls for all programs that link payment to assessment of performance to incorporate periodic, objective assessments of measurement, data collection, scoring, and incentive systems to evaluate their effects on achieving improvements in quality, including any unintended consequences. The programs and, where appropriate, their performance thresholds should be readjusted only when there is compelling evidence and a justifiable reason to do so. Additionally, ACP is supportive of physicians and other stakeholders having a key role in these evaluations and appreciates the inclusion of this element in the Committees’ proposal.

The Discussion Outline

OTHER ISSUES FOR CONSIDERATION: Developing complimentary reforms to improve the practice environment.

- Medical liability reform.
- Private contracting/balance billing in Medicare without penalty to providers or patients to ensure patient choice and access.

ACP Comments

With regard to medical liability reform, ACP continues to urge Congress to enact proven reforms that will reduce the costs of medical liability insurance and defensive medicine, including enactment of caps on non-economic damages, which would in no way limit the amount of money that an injured plaintiff could receive to cover his or her hospital costs, doctor bills, other medical expenses, lost wages, or future damages.

In addition to continuing to advocate for caps on non-economic damages, ACP has developed a framework for legislation that authorizes a national pilot on health courts. ACP believes that health courts, also known as “medical courts or health care tribunals” are a highly promising alternative to the existing tort system for adjudicating medical liability claims. Health courts would offer patients access to a specialized “no fault” administrative process where judges, experienced in medicine and guided by independent experts, determine contested cases of medical negligence without the unpredictability and unfairness of jury trials. Under today’s judicial system, judges and juries decide medical malpractice cases with little or no medical training. The majority of medical liability cases involve very complicated issues of fact, and these untrained individuals must subjectively decide whether a particular physician deviated from the appropriate standard of care.

A national pilot of health courts would allow for evaluation of an alternative resolution process for medical malpractice claims. Health courts utilize an administrative process and specialized judges, experienced in medicine and guided by independent experts, to determine cases of medical negligence without juries. Health courts would provide fair compensation for injuries caused by medical care, reduce costly and time-consuming litigation, reduce medical liability costs, provide guidance on standards of care, reduce the practice of defensive medicine, and improve patient safety.

Health courts have received bipartisan support from Congress, interest groups, and physician membership organizations. President Obama included funding for demonstration projects for health courts in his Fiscal Year 2012 budget and former Massachusetts Governor Mitt Romney supports funding for states to adopt the health court model. In 2005, Senators Max Baucus (D-MT) and Mike Enzi (R-WY) as well as Jim Cooper (D-TN) and Mac Thornberry (R-GA) introduced legislation that would provide grants to states to administer health courts. The American Medical Association, the American Congress of Obstetricians and Gynecologists, and the Common Good have also endorsed the use of health courts.

With regard to private contracting under Medicare, the College has long-standing policy that supports the primacy of the relationship between a patient and his/her physician, and the right of those parties to privately contract for care, without risk of penalty beyond that relationship. ACP policy goes on to state that certain patient protections are essential under any Medicare private contracting agreement. From an ethical standpoint, ACP believes that the physician's first and primary duty is to the patient. Physicians should be cognizant of their professional obligation to care for the poor and of medicine's commitment to serving all classes of patients who are in need of medical care.

There are several important elements that ACP would suggest be included as part of any private contracting agreement: (1) a requirement that physicians disclose their specific fee for professional services covered by the private contract in advance of rendering such services, with beneficiaries being held harmless for any subsequent charge per service in excess of the agreed upon amount; (2) a prohibition on private contracting for dual Medicare-Medicaid eligible patients; (3) a requirement that private contracts cannot be entered into at a time when the Medicare beneficiary is facing an emergency medical condition or urgent health care situation; (4) a prohibition on private contracting in cases where a physician is the "sole community provider" for those professional services that would be covered by a private contract; (5) a prohibition on private contracts in other cases where the patient is not able to exercise free choice of physician; (6) that private contracting arrangements should not apply at a time when emergency or urgent care is being rendered, even if the treating physician and patient had previously entered into a private contract.

CONCLUSION AND SUMMARY OF RECOMMENDATIONS

Based upon the feedback provided above, the College specifically recommends:

1. Congress should enact legislation to eliminate the SGR and transition to new value-based quality improvement and payment/delivery system models, using a phased approach as proposed by the committees' draft framework and also by the Medicare Physician Payment Innovation Act of 2013.
2. During the first phase (1) all physician services should receive positive update and (2) undervalued evaluation and management services, whether delivered by primary care physicians or by other specialists, should receive an additional annual update above the baseline for all other services.
3. Congress and the Medicare program should work with ACP and other physician organizations to develop a transitional value-based payment initiative, which would provide higher updates to physicians who successfully participate in a designated VBP initiative, consistent with the principles discussed above.
4. Congress should look to the PCMH as being one of the most promising models for improving outcomes and lowering costs—and therefore, as one potential alternative reimbursement model available for physicians to opt into during phase 2. The extensive and growing experience in the

private sector and from the new CPCi and Advanced Primary Care Initiatives in CMS as well as from private sector recognition and accreditation programs should help inform the scaling up of this model. We are confident that the PCMH model, the related PCMH-Neighborhood, and ACOs—in conjunction with efforts by ACP and other physician membership organizations to provide guidance to physicians on high-value, cost-conscious care—can be scaled up in the more immediate future, as part of a transition to better payment and delivery systems to replace the SGR and pure fee-for-service.

5. A specific goal of payment reform should be to reduce the time that physicians must spend in administrative tasks that do not improve patient care or outcomes; at a minimum, reforms should not add to the administrative burden.
6. Medicare should make improvements in the existing Medicare physician fee schedule to create incentives for care coordination and improved quality and to allow physicians to spend more appropriate clinical time with patients.
7. CMS will need to improve its ability to provide “real time” data to participating physicians and practices. A method will need to be created to map practice-level participation in a transitional QI/VBP initiative to the individual physician updates under the Medicare Physician Fee Schedule.
8. Congress should require that measures of the quality and value of care used by Medicare and potentially other payers in a reformed delivery and payment system be evaluated through and collected in a consistent, reliable, feasible, and transparent manner; thoroughly tested prior to full implementation to the extent possible; and applied as part of overall payment and delivery system reform emphasizing collaborative system-based health care. Additionally, to the extent that such reforms include linking payments to reporting and performance on specific quality measures, such incentives must take into consideration the conflicting evidence on the effectiveness of performance assessment-based payment programs and potential adverse consequences.
9. Measures and measure strategies should be thoughtfully aligned with – and where possible leverage – the regular practice assessment, reporting and quality improvement activities that individual physicians already are required to undertake as part of their specialty board Maintenance of Certification (MOC).
10. Physicians must be given the opportunity to comment on performance ratings that they believe are inaccurate, or that do not take into account the characteristics of the practice or patient population being treated prior to the release of ratings to the public or to their being tied to payment.³⁹ A fair reconsideration process helps to ensure the accuracy of the reported information, and thus, facilitates increased patient/consumer trust in the information, increases the willingness of clinicians to cooperate with the process and helps to minimize unintended consequences that may compromise the care of the patient. The College also asks the Committees to consider the hardship exemptions from negative payment adjustments that are present in the Medicare Physician Payment Innovation Act, H.R. 574.

³⁹ Detailed ACP policy with regard to fair appeals processes for performance data can be found in the following papers: (1) Developing a Fair Process through which Physicians Participating in Performance Measurement Programs Can Request a Reconsideration of Their Ratings. 2007. Accessible at: http://www.acponline.org/advocacy/where_we_stand/policy/appeals.pdf and (2) Healthcare Transparency—Focus on Price and Clinical Performance Information. 2010. Accessible at: http://www.acponline.org/advocacy/where_we_stand/policy/transparency.pdf.

The College appreciates this opportunity to share its recommendations on the discussion outline, as released on February 7th, to repeal the sustainable growth rate (SGR) and reform the Medicare physician payment system and looks forward to working with you to address these critical issues. We provide this feedback to you in the interest of being constructive and appreciate your willingness to consider our recommendations. Please contact Richard Trachtman at rtrachtman@acponline.org or 202-261-4538 if you have any questions or would like additional information.

Sincerely,

A handwritten signature in black ink that reads "David Bronson". The signature is written in a cursive style with a large initial "D" and a long horizontal flourish at the end.

David L. Bronson, MD, FACP
President, American College of Physicians