



Statement for the Record

American College of Physicians

Hearing before the House Energy & Commerce Subcommittee on Health

“A Permanent Solution to the SGR: The Time Is Now”

January 21-22, 2015

The American College of Physicians (ACP) applauds Chairman Pitts and Ranking Member Green for holding this hearing and for the committee’s continued bipartisan efforts to develop a solution to Medicare’s physician payment system. ACP is the largest medical specialty organization and the second largest physician group in the United States, representing 141,000 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.

ACP agrees with the Energy and Commerce Subcommittee on Health that it is imperative to permanently eliminate the fatally flawed Sustainable Growth Rate (SGR) formula and implement reforms that will eliminate the uncertainty that has threatened seniors’ access to their physicians for over 13 years. Therefore, ACP would like to express our strong support for the bipartisan agreement reached last year by the House Energy & Commerce, Ways & Means, and Senate Finance Committees on comprehensive legislation to repeal Medicare’s flawed Sustainable Growth Rate (SGR) formula. This legislation, the SGR Repeal and Medicare Provider Payment Modernization Act of 2014, represented years of policy development toward a new physician payment system that brings better value to

patients and to the entire health care system. We urge you to reintroduce and expedite this legislation to the floor for a vote and work with your colleagues to enact it before the current SGR patch expires at the end of March 2015.

In this statement we:

- Outline the numerous reasons why the SGR Repeal and Medicare Provider Payment Modernization Act of 2014 should be reintroduced and quickly enacted rather than continuing with the SGR and more patches.
- Urge caution about any major changes in the 2014 legislation that would upset the consensus that was established when drafting this bill. In particular, ACP feels strongly that any changes that would weaken the incentives for Alternative Payment Models (APMs), Patient Centered Medical Homes (PCMHs) in particular, would be problematic.
- Highlight a number of tools and resources that ACP provides to help physicians make the transition to a value-based payment and delivery system, whether via the proposed Merit-Based Incentive Payment System (MIPS), as outlined in the SGR Repeal and Medicare Provider Payment Modernization Act or as an APM.
- Recommend that the reintroduced legislation also include a reauthorization of the Medicare Primary Care Incentive program.

SUPPORT OF THE SGR REPEAL AND MEDICARE PROVIDER PAYMENT MODERNIZATION ACT OF 2014

SGR Repeal and Base Payment Updates

First and foremost, after more than 13 years, 17 patches, and billions wasted—it is truly time to pass SGR-repeal now! If not repealed by the end of March 2015, then the 18th patch will be needed in order to avert a 21 percent cut to physician payments, which will continue the damaging cycle of uncertainty

faced by physicians and their patients. The SGR Repeal and Medicare Provider Payment Modernization Act of 2014 also would allow for stable positive updates of 0.5 percent for the first 5 years. This not only provides the necessary stability, but also allows physicians time to transition to a truly value-based payment system focused on quality of care and care coordination and to actively participate in alternative payment models, especially PCMHs, a model that the College has espoused for over a decade. Physicians will also be eligible for additional updates through the new MIPS, which is discussed further below. Then, in later years, professionals participating in APMs that meet certain criteria would receive annual updates of one percent, while all other professionals would receive annual updates of 0.5 percent. As is outlined in greater detail below, ACP is strongly supportive of incentivizing movement toward APMs, as well as providing a clear pathway and deliverables for physicians so that they know what to expect, and when, and can plan accordingly.

Establishment of the Merit-Based Incentive Payment System (MIPS)

While alignment has been increasing over the past several years, the existing Medicare quality reporting/incentive programs, Physician Quality Reporting System (PQRS), the Value-Based Modifier (VBM) program, and Meaningful Use (MU) still have significant variation in terms of measures, data submission and review options, and payment timelines—which results in significant confusion and hassles for physicians. The new MIPS program, as outlined in the 2014 legislation, would unify these programs. The College strongly supports alignment across the various CMS reporting programs to reduce the reporting burden on physicians—and believes that this alignment will create the opportunity to further harmonize with private sector measurement and payment programs. Additionally, this legislation keeps the money from physician quality incentive program penalties in the Medicare physician payment pool; therefore, significantly increasing the total funds available to pay physicians. This money would be lost if the current system remains in place.

The new MIPS program also would use a composite score, across four categories—quality, resource use, EHR Meaningful Use, and clinical practice improvement activities—to assess the performance of physicians. This approach empowers physicians to set their own individual conversion factor, rather than having it determined by a flawed formula or other external approach. Physicians will be able to proactively review their data in order to set their performance goals. The current Medicare reporting programs are not at all clear, transparent, or fully aligned in terms of performance thresholds that must be met. Additionally, in the current Medicare reporting/incentive programs, physicians receive little to no incentive payment for engaging in clinical improvement activities. And current programs do not offer physicians the opportunity to get credit for transforming to a PCMH.

The MIPS program would change that and give credit for overall improvement from year to year, as well as for engaging in specific clinical improvement activities. ACP is particularly supportive of the inclusion of PCMH models as an approach that would receive the highest score for the clinical practice improvement category.

If current law is allowed to stand, in 2018 physicians would be faced with:

- 2 percent penalty for failure to report PQRS quality measures;
- 4 percent (increasing to 5 percent in 2019) penalty for failure to meet EHR MU requirements;
- and
- Additional potential negative adjustments under the VBM program of 2 or 4 percent and growing.

All of these could add up to 6-8 percent cuts as early as 2018 and 7-10 percent cuts in 2019. Therefore, ACP is strongly supportive of the new MIPS program in that it aligns all of those incentive payments and

caps them at more reasonable limits in the early years, which gradually increase over time. This is a much more logical, aligned, and transparent approach that will allow physicians to better understand what incentives they can expect (and strive for) and when. Additionally, the 2014 legislation states that physicians' payment adjustment in one year will have no impact on their payment adjustment in a future year, which ensures that physicians are not penalized if they continuously perform at a high level. However, physicians will also receive credit for improvement from one year to the next in the determination of their scores in the quality and resource use performance categories and may receive credit for improvement in clinical practice improvement activities—which encourages improvement over time and will help cut down on inappropriate competition among physicians and other eligible professionals (EPs).

Also of note in the 2014 legislation is that on top of the base positive incentive payments that high performing physicians would receive individually via the MIPS program, they can also receive additional payment. In aggregate, this additional payment would be up to \$500 million per year for several years. This new money does not exist within the current Medicare reporting/incentive programs. ACP believes that this additional incentive will enable the higher performing physicians to receive incentive payments even if all professionals perform above the threshold (which would make the budget neutral payment pool very limited in its ability to provide rewards).

Technical Assistance for Small Practices

The 2014 legislation specifically allocates additional new money (\$40 million) to help small practices. ACP strongly supports assistance and funding to help small practices improve their MIPS performance or transition to alternative payment models. There is currently no funding assistance available to assist small practices in the Medicare reporting programs and very limited assistance is available for APM

transition. (Currently this is primarily limited to practices participating in CMS Innovation Center projects).

Alternative Payment Models (APMs)

The SGR Repeal and Medicare Provider Payment Modernization Act of 2014 would allow those physicians participating in APMs to receive a 5 percent bonus—this is entirely new funding and is on top of any current payment structures that are part of their APM (e.g., prospective care coordination fees, shared savings, etc.). APMs are defined in the bill as:

- Those that involve risk of financial loss and a quality measure component, e.g., the Medicare Shared Savings Program—also referred to as the Medicare Accountable Care Organization (ACO) program.
- PCMHs that have been proven to work with the Medicare population—PCMH APMs are exempt from the financial risk requirement.

ACP has been strongly supportive of both ACOs and PCMHs—and views these models as a solid base and starting point for the development of additional evidence-based alternative delivery and payment system models that reward value over volume. ACP is particularly pleased that the 2014 legislation would allow for a more rapid and robust expansion of the PCMH and PCMH specialty practices, without financial risk, as well as other evidence-based models throughout all of Medicare. This will enable physicians to transition their practices to offer Medicare beneficiaries greater access to medical homes—thus building on the testing of the PCMH model within Medicare that has taken place under current law. The College is also supportive of expanding the list of APMs to ensure that all specialties and practice sizes have the opportunity to participate—an approach that is taken in the 2014 legislation. Also of note in the 2014 legislation is that APMs are excluded from the MIPS and most Meaningful Use requirements—this will not only encourage APM participation, but it also will eliminate the need for

these practices to meet largely duplicative quality reporting requirements, i.e., for the APM and for the MIPS, that would add undue burden onto these high performing APM practices. This is a particularly important component of the bill as this is an action that CMS currently does not have the statutory authority to implement.

Measure Development

The 2014 legislation would provide \$15 million in funding annually over 4 years for quality measure development. This is an extremely important component of the legislation as there is no source of direct federal funding currently available for quality measure development. Yet a number of gaps in and improvements to the current measure sets need to be addressed to ensure that the measures used in the MIPS and APM programs are relevant, appropriate, accurately assessed, applicable across all specialties, meaningful to both clinicians and their patients, and lead to improvement over time. ACP is strongly supportive of filling gaps in quality measurement and obtaining stakeholder input into the measure development process. The College advocates for focusing on outcome measures, patient and family experience measures, care coordination measures, and measures of population health and prevention. ACP also appreciates that the legislation continues to encourage electronic specification of the measures—by identifying it as one of the top considerations for filling measure gaps.

IMPROVEMENTS TO THE SGR REPEAL AND MEDICARE PROVIDER PAYMENT MODERNIZATION ACT OF 2014

Throughout the development of the SGR Repeal and Medicare Provider Payment Modernization Act of 2014, ACP, other medical societies, and numerous other stakeholders provided a number of recommendations for improvements in the legislation. The final language of the 2014 legislation took into account many of these comments and is reflective of a true consensus across the house of

medicine. Therefore, ACP urges caution about making any major changes in the 2014 legislation that would upset this consensus. In particular, ACP feels strongly that any changes that would weaken the incentives for APMs, PCMHs, and PCMH specialty practices, in particular, would be problematic. However, given the momentum that this legislation would foster toward a truly value-based delivery and payment system and the funding that the legislation would provide for measure development, ACP is seeking greater clarity in the role that the National Quality Forum (NQF) will play in this new, post-SGR system. The College continues to recommend that all measures, regardless of source, go through a multi-stakeholder evaluation process—a role that is performed by the National Quality Forum (NQF) as a trusted evaluator of measures.

Additionally, the 2014 legislation included setting an annual target for identifying misvalued services of 0.5 percent of the estimated amount of fee schedule expenditures. If that target, which would remain in effect for several years, is met, that amount would be redistributed in a budget-neutral manner within the physician fee schedule. Alternatively, if the target is not met, fee schedule payments for the year would be reduced by the difference between the target and the amount of misvalued services identified in a given year. This provision ultimately was included in the most recent SGR patch, Protecting Access to Medicare Act, with a plan to initiate a 0.5 percent target starting in 2017. However, the Achieving a Better Life Experience (ABLE) Act, passed in December 2014, doubles the amount of that target, and therefore the amount at risk of being cut, to 1 percent on all Medicare reimbursements, starting in 2016. Therefore, it is important to note that this provision for potential RVU reductions should not be included when re-drafting the SGR repeal legislation as it is no longer a viable source of savings.

ACP'S ROLE IN HELPING PHYSICIANS TRANSITION TO A VALUE-BASED DELIVERY AND PAYMENT SYSTEM

As is outlined above, ACP strongly 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. Therefore, the College has a long history of providing support to physicians transforming their practices to provide value based care. For instance, in 2009 ACP developed a web based product, Medical Home Builder, to guide practices on their transformation to PCMHs. This product has been refined and expanded to become ACP Practice AdvisorSM. The modules within Practice Advisor educate and guide physicians that are transforming their practices to improve their ability to provide high quality, safe, efficient, effective, and timely patient centered care. The components of the modules consist of 1) evidence based background information, 2) case studies that provide examples of how to implement these approaches in the practice setting, 3) ACP Practice Biopsy, an assessment of how the practice is doing, and 4) resources and tools to support implementation. The Case Study and Practice Biopsy focus on the processes that need to be implemented/enhanced to accomplish the transformation from volume based to value driven healthcare. Additionally, selected Practice Advisor Modules have been further developed to provide Maintenance of Certification (MOC) credit to physicians for assessing how well a practice is performing with regard to specific clinical quality measures.

As is indicated above, ACP supports the unification of existing Medicare quality reporting programs, including PQRS, VBM, and MU, as is outlined in the 2014 legislation, as well as aligning these programs with private payer initiatives and with specialty boards' maintenance of certification programs. The College has been actively supporting our members in a variety of ways to help ensure their successful

participation in these Medicare reporting programs, as well as their successful engagement in new opportunities offered by CMS within fee-for-service.

These programs to provide support and assistance to ACP members include:

- The Physician & Practice TimelineSM: Professional Requirements and Opportunities (http://www.acponline.org/running_practice/physician_practice_timeline/)—This online tool provides a helpful at-a-glance summary of upcoming important dates related to a variety of regulatory, payment, and delivery system changes and requirements, including PQRS, VBM, MU, ICD-10, Open Payments Program, transitional care management (TCM) codes, and the chronic care management (CCM) code. The Timeline then links users to practical tools and resources to help them with successful participation.
- PQRS Wizard (<https://acp.pqrswizard.com/>): A cloud-based registry for PQRS reporting with a 99.5 percent success rate for participants.
- Genesis Registry: A CMS-approved qualified clinical data registry (QCDR) for use with PQRS. As a QCDR, the Genesis Registry can include data from multiple payers, allow for continuous exchange of EHR data and benchmarking, help physicians meet the requirements of Stage 2 meaningful use, and provide meaningful feedback reports to clinicians. This registry currently includes 24 eMeasures across 3 National Quality Strategy (NQS) domains and will soon be increasing to 40 eMeasures across 6 NQS domains. The Genesis Registry is also linked to ACP's growing area of clinical quality improvement programs, described briefly below.
- Clinical Quality Improvement Programs: ACP's Center for Quality leads a nationwide quality improvement network of ACP chapters, physicians, their health care teams, residency programs, and other health and quality systems. ACP Quality Connect, as it is called, currently focuses on diabetes, adult immunization, and chronic pain management. The peer network of nearly 1000

physicians and their teams improve management of chronic conditions while linking to multiple performance reporting requirements, including professional requirements for certification and payer-linked programs such as the PQRS and Bridges to Excellence, as well as Meaningful Use stage II requirements. This program is also linked to ACP registries including the Genesis QCDR, described above, and the Diabetes Collaborative Registry.

- Transitional Care Management (TCM) codes: ACP provides a set of instructional videos and articles, as well as a sample documentation and flow sheet.
- Chronic Care Management (CCM) code: The ACP Toolkit for implementation of the CCM code in physician practices includes background information for clinicians and staff, a step-by-step implementation guide, and a sample patient agreement.

Additionally, the College is involved in ongoing advocacy with the relevant regulatory agencies, including CMS and ONC, to improve the existing Medicare quality reporting programs and new opportunities within both the CMS Innovation Center and traditional Medicare fee-for-service. Recent relevant letters to the agencies include:

- ACP Letter to CMS providing feedback on the 2015 final physician fee schedule rule:
http://www.acponline.org/acp_policy/letters/mpfs_final_rule_comment_letter_2015.pdf.
- Joint Letter from ACP, the Institute for Patient- and Family-Centered Care, and National Partnership for Women and Families to CMS on advanced care planning codes:
http://www.acponline.org/acp_policy/letters/joint_letter_advanced_care_planning_rule_2014.pdf.
- Joint Letter from ACP and several other specialty societies to CMS on advanced care planning codes:

http://www.acponline.org/acp_policy/letters/joint_comment_letter_advance_care_planning_codes_2015_fee_schedule_2015.pdf.

- ACP Letter to ONC on EHR Certification Criteria:
http://www.acponline.org/acp_policy/letters/acp_comments_on_onc_proposed_2015_cehrt_criteria_2014.pdf.
- Joint ACP letter with several internal medicine subspecialty societies on the implementation of the Meaningful Use program:
http://www.acponline.org/acp_policy/letters/css_mu_letter_2014.pdf.
- ACP letter to ONC on the agency's 10-year interoperability roadmap:
http://www.acponline.org/acp_policy/letters/final_acp_letter_onc_10_year_interop_plan_2014.pdf.

REAUTHORIZATION OF THE MEDICARE PRIMARY CARE INCENTIVE PROGRAM

Another element to Medicare payment reform that is essential if we are to ensure access to primary care services is continuation of the Medicare Primary Care Incentive Program. This program, which began on January 1, 2011, pays internal medicine specialists, family physicians, and geriatricians a 10 percent bonus on designated office visits and other primary care services, will sunset at the end of 2015. It represents a modest but essential step to address the long-standing under-valuation of primary care, which Republicans and Democrats alike, and independent experts like the Medicare Payment Advisory Commission, have long agreed contributes to fewer physicians entering and remaining in primary care. As a consequence, our nation is experiencing a growing primary care physician shortage, reduced patient access, and long waits for appointments in many communities. We also know from hundreds of studies that the availability of primary care in a community is positively associated with better outcomes and lower costs. While additional policy reforms are needed to support primary care, many of which

have been included in the Medicare SGR Repeal and Medicare Provider Payment Modernization Act, continuing the current law Medicare Primary Care Incentive program past its scheduled expiration at the end of this year is essential. Without it, primary care physicians will face deep Medicare payment cuts for their already-undervalued services, creating yet another disincentive for physicians to enter and remain in primary care, further undermining patient access. We note that the Medicare Payment Advisory Commission is in agreement that the primary care incentive program should be continued, but allocated to the eligible physician specialties for each Medicare patient they see, rather than as a bonus on the evaluation and management codes billed by the physician. ACP is analyzing the impact of this proposed modification and will share its recommendations with the committee in the near future. Unlike MedPAC, we also believe that the Medicare Primary Care Incentive Program should continue to be funded directly by the program, rather than being funded through a budget-neutral reduction in payments for other physicians' services. Such budget-neutral funding would undermine support within the medical profession for continuing the program, and may result in RVU reductions for some services that are currently valued appropriately.

In order to provide primary care physicians the stability of knowing that the Medicare Primary Care Incentive Program will not be allowed to sunset at the end of 2015, we urge the committee to include reauthorization of this vital program in reporting comprehensive physician payment reform legislation that also includes the SGR Repeal and Medicare Provider Payment Modernization Act as reintroduced for the 114th Congress.

SUMMARY AND CONCLUSION

As outlined in the above statement, the College urges you to reintroduce and work with your colleagues to expedite floor consideration of the SGR Repeal and Medicare Provider Payment Modernization Act of 2014 so the measure can be voted on and enacted before the current SGR patch expires at the end of March 2015. This legislation represents years of policy development toward a new physician payment system that brings better value to patients and to the entire health care system.

Additionally, the College urges caution about making any major changes to the 2014 legislation that would upset the consensus that was established when drafting this bill. In particular, ACP feels strongly that any changes that would weaken the incentives for Alternative Payment Models (APMs), Patient Centered Medical Homes (PCMHs) in particular, would be problematic.

This statement also serves to highlight a number of tools and resources that ACP provides to help physicians make the transition to a value-based payment and delivery system, whether via the proposed Merit-Based Incentive Payment System (MIPS), as outlined in the SGR Repeal and Medicare Provider Payment Modernization Act, or as an APM.

Finally, ACP strongly recommends that the reintroduced legislation also include a reauthorization of the Medicare Primary Care Incentive program.