



**Statement for the Record**

**American College of Physicians**

**Hearing before the House Ways and Means Health Subcommittee**

**On**

**Physician Organization Efforts to Promote High Quality Care**

**July 24, 2012**

The American College of Physicians (ACP) applauds Chairman Herger and Ranking Member Pete Stark for holding this hearing on how initiatives by ACP and other physician organizations to improve quality could contribute to a solution to Medicare’s physician payment system. We share your view that Medicare is in need of a new system that “brings more value to beneficiaries while remaining viable for physicians.” In that spirit, ACP’s statement will focus primarily on how Congress could build upon physician-led initiatives to transition to a new value-based payment and delivery system.<sup>1</sup> We will discuss delivery and payment reform models that we view as the most promising in any post-SGR environment, as well as noting the kinds of structural and reporting capabilities, payment incentives, and measurement systems needed for them to work.

My name is David L. Bronson. I am President of the American College of Physicians, the nation’s largest medical specialty organization, representing 133,000 internal medicine physicians who specialize in primary and comprehensive care of adolescents and adults, internal medicine subspecialists, and medical students who are considering a career in internal medicine. I reside in Cleveland, OH, and am board-certified in internal medicine and practice at the Cleveland

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<sup>1</sup> More detailed information on ACP’s activities and policy related to how Congress can work with ACP and others in the medical profession to advance comprehensive, patient-centered, and value-based payment and delivery system reforms can be found in our May 23, 2012 letter to The Honorable David Camp, Chairman of the House Committee on Ways and Means. This letter can be accessed at [http://www.acponline.org/advocacy/where we stand/medicare/srg\\_acp\\_response.pdf](http://www.acponline.org/advocacy/where_we_stand/medicare/srg_acp_response.pdf).

Clinic. I am also President of the Cleveland Clinic Regional Hospitals and a professor of medicine at the Cleveland Clinic Lerner College of Medicine of Case Western Reserve University.

Our testimony offers the following for the Subcommittee's consideration:

1. Discussion of why fundamental payment and delivery system reform is imperative.
2. Principles for transitioning to value-based payment and delivery system reforms, based on physician-led initiatives in the private and public sector to improve quality and lower costs.
3. Assessment of specific payment and delivery system reform models, in both the private and public sectors, which could be the basis for transitioning to fundamental reform.
4. Summary of ACP's many initiatives to develop evidence-based guidelines of care; to help physicians incorporate evidence-based, high value care into their practices; and to assist practices in moving toward value-based models.
5. Developing payment policies to support physician-led programs to promote high value care.
6. Leveraging and improving existing quality improvement/value-based payment programs.
7. Suggestions on a legislative framework to transition to better payment models.

## **WHY FUNDAMENTAL PAYMENT AND DELIVERY SYSTEM REFORM IS IMPERATIVE**

Fundamental reform of the Medicare payment system is long overdue, including repeal of Medicare's Sustainable Growth Rate (SGR). For more than a decade, the SGR has caused annual scheduled cuts in payments to physicians, endangering access to care, destabilizing the program, and creating barriers for physicians to develop the practice capabilities to improve clinical quality and effectiveness. Repeal of the SGR is essential, and we hope that it can be achieved this year.

But repeal of the SGR alone will not move Medicare to better ways to organize, deliver, and pay for care provided to Medicare enrollees. Accordingly, our testimony will focus on how to get from here to there, from a fundamentally broken physician payment system to one that is based on the value of services to patients, including immediate and longer-term steps that build upon successful physician-led initiatives in the private and public sectors.

## **PRINCIPLES TO CREATE A TRANSITIONAL VALUE-BASED PAYMENT INITIATIVE**

ACP believes that steps can be taken over the next 1-5 years, while providing physicians and patients with a necessary period of stable payments, to start more physicians on the road to better payment models, and reward “early adapters” who already have taken the leadership and risk of participating in new value-based payment and delivery models. During such a transitional period, we propose that physicians get higher updates for demonstrating that they have successfully participated in an approved transitional quality improvement (QI) or value-based payment (VBP) program. We begin by offering the following principles for developing a transitional QI/VBP program, and then we provide an assessment of specific physician-led models that could be incorporated into such a transitional QI/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 QI/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 QI/VBP initiative.
3. The transitional QI/VBP 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, these could include participation in the Patient Centered Medical Home (PCMH) and Patient-Centered Medical Home Neighborhood (PCMH-N) models, as determined by practices meeting designated standards through a deemed accreditation body and/or standards to be developed by the Secretary with input from the medical profession. Participation in 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 QI/VBP program. In addition, physicians who agree to incorporate programs, like ACP’s High Value, Cost-Conscious Care Initiative, into their clinical practice through shared decision-making with patients, might also qualify for a transitional QI/VBP payment. We discuss these initiatives in more detail later in our testimony.

4. Existing QI/VBP payment models—the Medicare Physician Quality Reporting System (PQRS), e-prescribing (e-RX), and meaningful use (MU) 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. Later in our testimony, we provide specific recommendations on leveraging and improving such programs.
5. 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, silo-ed fee-for-service system.
6. Performance-based payment updates should be in addition to a higher “floor” on payments for undervalued primary care/preventive/and coordinated care services, not limited by physician specialty, so that any physician who principally provides such undervalued services could qualify for the higher update. 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 QI/VBP initiative.
7. For a transitional QI/VBP program to be effective in improving quality, 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.

ACP welcomes the opportunity to work with the Subcommittee and other physician organizations to develop the details of a transitional QI/VBP initiative that builds upon the successful physician-run models, including PCMHs and PCMH-Ns, as discussed below.

## **SPECIFIC PAYMENT AND DELIVERY REFORMS THAT CAN SERVE AS THE BASIS FOR A TRANSITIONING TO FUNDAMENTAL REFORM**

### ***1. Patient-Centered Medical Home (PCMH)***

The PCMH is an approach to providing comprehensive primary care in a setting that focuses on the relationships between patients, their primary care physician, and other health professionals involved in their care. Key attributes of the PCMH promote health care delivery for all patients through all stages of life. It has its origins in the “Joint Principles of the Patient-Centered Medical Home” adopted by ACP, the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), and the American Osteopathic Association (AOA), and in the American Academy of Pediatrics’ (AAP) decades-long efforts to create medical homes for children with special health care needs.<sup>2</sup> Care through a PCMH is characterized by the following features: a personal physician for each patient; a physician-directed medical practice, where the personal physician leads a team of individuals trained to provide comprehensive care; whole person-orientation, where the treatment team directly assists the patient in meeting their specific health care needs; care coordinated across all elements of the complex health care system; quality and safety; and enhanced access to care. Several accreditation groups have developed accreditation or recognition programs that can be used in determining if a practice provides care that is consistent with these expected features. And an increasing number of payers and physicians are engaged in PCMH initiatives throughout the country, offering PCMHs to tens of millions of patients through thousands of physician-led PCMH practices.

#### **Scaling Up the PCMH Model**

ACP believes that the PCMH model has advanced enough that it could be scaled up for widespread implementation throughout Medicare in the immediate future. The growing amount of experience in both the public and private sectors on how to organize care around PCMHs, the thousands of physician practices that have already achieved certification or accreditation as a PCMH, and the growing amount of data on its effectiveness in improving care and lowering costs, makes it a logical model to scale up to the broader Medicare program. **This could be done, for instance, by providing higher Medicare payments to physician practices that have achieved recognition by a deemed private sector**

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<sup>2</sup> AAFP, AAP, ACP, and AOA. The Joint Principles of the Patient-Centered Medical Home. March 2007. Accessed at [http://www.acponline.org/advocacy/where we stand/medical\\_home/approve\\_jp.pdf?hp](http://www.acponline.org/advocacy/where_we_stand/medical_home/approve_jp.pdf?hp).

**accreditation body.** At a subsequent stage, PCMH performance metrics (now under development) could be added and incorporated into Medicare payment policies.

At the same time, ACP recognizes that there are challenges to the PCMH model. Some of these include:

- The need for care coordination across settings and the continuum of patient care.
- Related to the issue of care coordination is the lack of real- or near-time data being provided to practices on their patients, which makes it extremely challenging for them to provide proactive, patient-centered care. This is exacerbated by the lack of effective data and information sharing across sites of care.
- Finally, in many cases, practices are transforming to provide services to their patients in line with the PCMH model, but are only paid to do so for a subset of their patient population (e.g., Wellpoint and Aetna are paying them a per member per month payment for their beneficiaries, but they are not receiving payment from CMS for their Medicare patients). This issue is being addressed in some areas of the country, particularly those that will be selected to participate in the CMS Innovation Center’s Comprehensive Primary Care Initiative (CPCi), but many other practices across the country are not being “made whole” in terms of payment for the work they are doing.

## 2. *Patient-Centered Medical Home – Neighborhood*

The Patient-Centered Medical Home-Neighborhood (PCMH-N) concept was initially described by ACP in a position paper, developed by our Council of Subspecialty Societies.<sup>3</sup> The paper observes that the effectiveness of the PCMH care model is dependent on the contributions of the many subspecialists, specialists, and other health care entities (e.g., hospitals, nursing homes) involved in patient care. Specialty and subspecialty practices, hospitals, and other health care professionals and entities that provide treatment to the patient need to be recognized and provided with structural support—both non-financial and financial—for engaging in patient-centered practices that complement and support the efforts of the PCMH to provide high quality, efficient, coordinated care.

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<sup>3</sup> 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/](http://www.acponline.org/advocacy/where_we_stand/policy/)

The NCQA is in the process of developing 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. This decision was made following the conclusion of a comprehensive feasibility study in which this concept was strongly supported by multiple health care stakeholders. In addition, the American Board of Internal Medicine and the NCQA are now collaborating to align aspects of Maintenance of Certification and the new “medical neighbor” recognition process.

This new NCQA program, and similar efforts, can serve to encourage specialty/subspecialty practices and other “neighborhood” health care entities currently not involved within an integrated system—settings in which most care is currently being delivered—to implement these important processes. This is already happening in several areas of the country. For example:

- The Vermont Blueprint for Health program is implementing a program in which medical home and related, anchored subspecialty practices engaging in efficient, integrative processes will be sharing a monthly care coordination fee for the treatment of chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), diabetes, and asthma.
- The Texas Medical Home Initiative will require participating primary care practices to establish care coordination agreements with their most frequently referred to specialist and hospital settings.
- Programs in both the Denver and Grand Junction areas of Colorado are in the process of implementing “medical neighborhood” programs that promote increased integration among primary and specialty care practices.

Given the significant and rapid growth of activity to advance the PCMH neighbor concept, ACP believes that the PCMH-Neighborhood model will be ready to be scaled up for implementation throughout Medicare in the near future—and therefore could be incorporated into a transitional value-based payment approach.

## **DEVELOPING PAYMENT POLICIES TO SUPPORT PHYSICIAN-LED PROGRAMS TO PROMOTE HIGH VALUE CARE**

Medical specialty societies, including ACP, are taking a leading role in developing and implementing programs to improve the value of care provided to patients. These programs could also be considered for incorporation into a QI/VBP model.

ACP's High Value, Cost-Conscious Care Initiative (HVCCC), which includes clinical, public policy, and educational components, 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.<sup>4</sup>

For the clinical component of the HVCCC Initiative, ACP has released materials focused on three areas: low back pain, oral pharmacologic treatment of type 2 diabetes, and colorectal cancer. Furthermore, as part of this initiative, ACP convened a workgroup of physicians that identified, using a consensus-based process, 37 common clinical situations in which screening and diagnostic tests are used in ways that do not reflect high-value care.<sup>5</sup> Furthermore, on July 10, 2012, ACP and the Alliance for Academic Internal Medicine (AAIM) unveiled a high-value, cost-conscious care curriculum to help train internal medicine residents about how to avoid overuse and misuse of tests and treatments that do not improve outcomes and may cause harm. The free curriculum, available at [www.highvaluecarecurriculum.org](http://www.highvaluecarecurriculum.org), is designed to engage internal medicine residents and faculty in small group activities organized around actual patient cases that require careful analysis of the benefits, harms, costs, and use of evidence-based, shared decision making. The flexible curriculum consists of ten, one hour interactive sessions that can be incorporated into the existing conference structure of a program.

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<sup>4</sup> Additional information on ACP's High Value, Cost-Conscious Care Initiative (HVCCC) can be found at [http://www.acponline.org/clinical\\_information/resources/hvccc.htm](http://www.acponline.org/clinical_information/resources/hvccc.htm).

<sup>5</sup> Qaseem A, Alguire P. et al. Appropriate Use of Screening and Diagnostic Tests to Foster High-Value, Cost-Conscious Care. *Ann Intern Med.* 2012;156:147-149. Accessible at <http://www.annals.org/content/156/2/147.full.pdf+html?sid=10a2df33-7fa3-45c1-a01d-dc7ecd1b9f6c>

ACP has also joined other leading professional medical organizations in the Choosing Wisely campaign,<sup>6</sup> which complements our HVCCC Initiative. An initiative of the American Board of Internal Medicine (ABIM) Foundation, the goal of the Choosing Wisely campaign is to promote thoughtful discussions among physicians, patients, and other stakeholders about how to use health care resources to improve quality of care. In April 2012, ACP unveiled our list of "Five Things"<sup>7</sup> internists and patients should question in internal medicine.

On April 19, 2012, ACP and Consumer Reports announced a new collaborative effort to create a series of *High Value Care* resources to help patients understand the benefits, harms, and costs of tests and treatments for common clinical issues. The resources will be derived from ACP's evidence-based clinical practice recommendations published in *Annals of Internal Medicine*. The initial pieces of the *High Value Care* series will be two patient brochures about diagnostic imaging for low back pain and oral medications for type 2 diabetes. The *High Value Care* resources will be available on the websites of ACP ([ACPOnline.org](http://ACPOnline.org)), Consumer Reports ([ConsumerReports.org](http://ConsumerReports.org)), and *Annals of Internal Medicine* ([Annals.org](http://Annals.org)).<sup>8</sup>

Programs like ACP's HVCCC initiative could be supported by Medicare payment policies by: (1) reimbursing physicians appropriately for spending time with patients to engage them in shared decision-making based on the recommendations from those programs and similar efforts by other specialty societies and (2) developing a way to recognize, with higher payment updates, physicians who can demonstrate that they are incorporating such programs into their practices and engaging with their patients. For instance, under a transitional VBP program, physicians might qualify for higher updates if they can demonstrate that they have a plan to use evidence-based guidelines on high value care, developed by their own professional societies, to inform, educate, and engage patients in shared decision-making on clinical treatment options. The goal would be to provide ongoing structural payment support to such physicians and patients in shared decision-making based on the guidelines, not to link payment for any specific test or procedure to the clinical guidelines.

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<sup>6</sup> More information on the Choosing Wisely campaign can be found at: <http://choosingwisely.org/>.

<sup>7</sup> ACP's list of "Five Things" internists and patients should question in internal medicine can be found at: [http://choosingwisely.org/wp-content/uploads/2012/04/5things\\_12\\_factsheet\\_Amer\\_College\\_Phys.pdf](http://choosingwisely.org/wp-content/uploads/2012/04/5things_12_factsheet_Amer_College_Phys.pdf).

<sup>8</sup> More information on this effort can be found at: [http://www.acponline.org/pressroom/high\\_value\\_care\\_ed\\_materials.htm](http://www.acponline.org/pressroom/high_value_care_ed_materials.htm).

ACP also has a long and multi-faceted history of promoting patient-centered high quality care, through the publication of original scientific research, the provision of critical reviews and advice on performance measure development and use, the development of evidence-based guidelines, clinical decision aids, and quality improvement programs. These efforts serve to support comprehensive value-based approaches like the HVCCC Initiative that is described above.

### ***Original Scientific Research***

The *Annals of Internal Medicine* is ACP's flagship scientific publication and forms one of the most widely cited peer-reviewed medical journals in the world. The journal has been published for 80 years and accepts only 7 percent of the original research studies submitted for publication.

### ***Quality and Outcome Measures***

While ACP does not develop performance measures, the College is deeply involved in the critical review and provision of comments on performance measures developed by other organizations. The goal is to ensure that the measures are based on high quality clinical evidence. ACP also reviews performance measures that are currently under development or endorsement at national organizations like the NCQA, CMS, and the American Medical Association Physician Consortium on Performance Improvement. Furthermore, ACP reviews performance measures related to ACP's Clinical Guidelines, Guidance Statements, and Best Practice Advice papers.

In addition, ACP educates its membership on performance measurement initiatives through the development of policy papers and performance measurement commentaries in peer reviewed scientific journals. Most recently, ACP produced a policy paper on "The Role of Performance Assessment in a Reformed Health Care System".<sup>9</sup> This paper discusses in detail ACP's support for payment and delivery system reforms that promote high-value care, improved patient experiences, better population health, improved patient safety, and reduced per capita spending.

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<sup>9</sup> Available at: [http://www.acponline.org/advocacy/where\\_we\\_stand/policy/performance\\_assessment.pdf](http://www.acponline.org/advocacy/where_we_stand/policy/performance_assessment.pdf).

## *Evidence-Based Guidelines*

ACP has been producing evidence-based clinical practice guidelines since 1981 and is one of the oldest programs in the country.<sup>10</sup> ACP's goal is to provide clinicians with recommendations based on the best available evidence; to inform clinicians of when there is no evidence; and, to help clinicians deliver the best healthcare possible. Published guidelines are publically and freely available on ACP's website and are represented in databases such as the National Guideline Clearinghouse and the Guidelines International Network library.

## **LEVERAGING EXISTING QUALITY IMPROVEMENT/VALUE-BASED PAYMENT MODELS**

Physicians with a demonstrated commitment to quality and efficiency, who are not able to participate in the more comprehensive models during the transitional period and possibly in the longer term, could be offered the ability to receive incentives for their participation in existing programs, such as meaningful use (MU), the physician quality reporting system (PQRS), and e-prescribing (eRX), and by harmonizing such programs with specialty boards' practice improvement programs..

Major improvements in the MU, eRx, and PQRS programs are needed, though, if they are to be part of a transitional QI/VBP program. Currently, there is no true alignment among these programs in their measures, reporting requirements, and payment incentives. CMS has been unable to provide timely feedback to physicians regarding whether they are successfully satisfying program requirements, leading to frustration and distrust. ACP has been deeply involved in the national policy issues surrounding the use of health information technology to facilitate effective clinical data sharing—including the EHR Incentive Program as initiated with the HITECH Act. In our most recent comments on the notice of proposed rulemaking from both CMS<sup>11</sup> and ONC<sup>12</sup> on Stage 2 Meaningful Use, we highlighted our support of the government's vision to use EHRs and health IT to improve care, but believe that more needs to be done to align the measures across all of the initiatives currently underway including CMS' PQRS and e-prescribing programs. While CMS

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<sup>10</sup> Qaseem A, Snow V, Owens DK, Shekelle P; Clinical Guidelines Committee of the American College of Physicians. The development of clinical practice guidelines and guidance statements of the American College of Physicians: summary of methods. *Ann Intern Med.* 2010 Aug 3;153(3):194-9.

<sup>11</sup> ACP's comments on Stage 2 Meaningful Use to CMS can be found at: [http://www.acponline.org/advocacy/where\\_we\\_stand/health\\_information\\_technology/cms\\_nprm.pdf](http://www.acponline.org/advocacy/where_we_stand/health_information_technology/cms_nprm.pdf).

<sup>12</sup> ACP's comments on Stage 2 Meaningful Use to ONC can be found at: [http://www.acponline.org/advocacy/where\\_we\\_stand/health\\_information\\_technology/onc\\_nprm.pdf](http://www.acponline.org/advocacy/where_we_stand/health_information_technology/onc_nprm.pdf).

has made strides in aligning the measures at a high level, the technical requirements in each of the programs are different enough that dual processes must be undertaken. We are also concerned about the approach that CMS has taken when structuring the penalty phases of the EHR Incentive Programs, the eRx 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 and what is meaningful and actionable by the physicians.

In addition, ACP recommends that measures and measure strategies 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 ABIM, which is the largest of the certifying boards, includes in its MOC program a suite of quality measurements, and 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 PCMH-N Neighbor concept, described earlier in this testimony. 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.

ACP is attempting to help primary care clinicians, including those in small practices, apply the distilled scientific and clinical data to their every day practice through registries, practice improvement programs, and technologically advanced tools including tablet- and smart phone-based applications. Patient registries, which involve a systematized method for collecting patient-based data that are often used to help clinicians understand and improve their practice, are being developed and applied by ACP.

- In partnership with the New York-ACP Chapter and Dr. Ethan D. Fried, MD, MS, MACP (the Vice Chair for Education and Residency Training Program Director, in the Department of Internal Medicine at St. Luke's-Roosevelt Hospital and Associate Professor at Columbia University's College of Physicians and Surgeons), ACP's Center for Quality is being certified as a Patient Safety Organization (PSO), as it nationally expands a

registry of “near miss” events, by which physicians and their teams can examine instances in which patient safety was put at risk but averted, so as to understand the factors that contribute to and protect from risks.

- In partnership with the American College of Cardiology, ACP is piloting the PINNACLE Registry for primary care. The PINNACLE Registry not only interfaces with various EHR systems, but also has received the designation of EHR data submission vendor (DSV) permitting submission of PQRS data to CMS, linking quality improvement to pay-for-performance.
- ACP is piloting *MedConcert™*, the first multi-tenant cloud-based platform for QI, including registry, performance measure calculation, and secure communication capabilities. Multiple options for uploading registry data, including data from EHRs and administrative claims databases are permitted with *MedConcert™*. Educational and quality improvement resources are tagged to specific performance gaps on this platform.

Beyond registries, ACP’s newly formed Center for Quality is revitalizing its network of physician-quality improvement champions, known as ACPNet. Including nearly 2,000 internists nationwide, this practice-based research network (PBRN) is being surveyed about the methods by which quality improvement and research in the real-world environment can be more readily integrated into the busy practice environment, including the whole medical team. While PBRNs emerged as a tool for understanding real world practice, a still important goal, they are becoming a resource for identifying, testing, and rapidly spreading powerful quality improvement strategies. Accordingly, ACPNet will become the QI laboratory and trendsetter in internal medicine, guided by a national steering group of experts and grassroots leaders.

## **SUGGESTIONS FOR LEGISLATION TO TRANSITION TO A BETTER PAYMENT MODELS**

ACP understands that the Ways and Means Committee and other committees of jurisdiction, will need to consider a wide range of legislative options to move forward from the current broken payment system to one that achieves fundamental reform. We offer the following suggestions for the key components of such a framework for your consideration.

1. The framework should repeal the SGR, once and for all, or at the very least, create a pathway to full repeal.
2. It should halt the 27% SGR cut (29% cut with sequestration) scheduled on January 1, 2013.

3. It should replace scheduled SGR cuts in subsequent years with positive updates for all physicians, providing stable payments at least through 2017, and with higher payment updates for undervalued primary, preventive, and care coordination services.
4. It should begin the transition to new payment models by establishing a Transitional Quality Improvement/Value-Based Payment Initiative, as described in the principles offered earlier in this testimony, built upon physician-led efforts to improve payment and delivery systems (including PCMHs and PCMH-Ns) and to promote evidence-based, high-value care.
5. It should leverage and improve the existing MU, eRx, and PQRS programs, and harmonize them with specialty boards' practice improvement programs to the extent possible, as discussed earlier.
6. It should support further evaluation and testing of a wide variety of payment and delivery system reforms.
7. It should outline a process and timetable to achieve fundamental payment reforms.

ACP is encouraged that several legislative proposals have been developed that include many of the above elements, including the bipartisan Medicare Physician Payment Innovation Act, H.R. 5707, introduced by Reps. Allyson Schwartz and Joe Heck, and a proposal being developed by Rep. Tom Price, a member of this subcommittee, and Rep. Charles Boustany. ACP appreciates Drs. Price and Boustany's efforts to reach out to ACP and others by asking for our input on their draft legislative framework, and we have shared our suggestions with them. We look forward to continuing to work with this Subcommittee on Health and other committees of jurisdiction on legislation to transition from the current broken payment system to one that achieves fundamental reform, based on physician-led quality improvement initiatives.

## **SUMMARY AND CONCLUSION**

The College specifically recommends that:

1. Congress and the Medicare program should work with ACP and other physician organizations to develop a transitional QI/VBP initiative that would provide higher updates to physicians who successfully participate in a transitional QI/VBP initiative, consistent with the principles discussed above.

2. Congress should look to the PCMH as being one of the most promising models for improving outcomes and lowering costs; learning from the extensive and growing experience in the private sector and through the CMS Innovation Center, as well as from private sector recognition and accreditation programs. We are confident that the PCMH model, and the related PCMH-Neighborhood, 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.
3. Congress and CMS should work with the medical profession on reducing barriers to the PCMH model, including facilitating the coordination of care among physicians and across settings; facilitating the use of health IT in meaningful ways; aligning the multiple federal initiatives with the goal of health care transformation, including timely payment to those physicians that meet the requirements of these initiatives; recognizing existing professional quality reporting and improvement activities where applicable, and facilitating participation in these initiatives by all payers.
4. Medicare should adopt payment policies that support the efforts by ACP and other physician membership organizations to provide guidance to physicians on high-value, cost-conscious care, including payment policies to support shared decision-making strategies to engage patients in making decisions with their physician on their care, informed by evidence on value and effectiveness.
5. Congress should support continued evaluation of Accountable Care Organizations, Advanced Payment ACOs, Global and bundled payments, and other promising alternative payment models that could be offered to physicians, following a transition period, along with PCMHs.
6. Medicare should make improvements in the existing Medicare physician fee schedule to create incentives for care coordination.

The College appreciates the opportunity to share our observations, experiences, and recommendations on how Congress can work with ACP and others in the medical profession to advance comprehensive, patient-centered, and value-based payment and delivery system reforms that build upon successful physician-led quality improvement initiatives in the private and public sectors.