



Statement for the Record

American College of Physicians

Hearing before the House Energy & Commerce Subcommittee on Health

“Using Innovation to Reform Medicare Physician Payment”

July 18, 2012

The American College of Physicians (ACP) applauds Chairman Pitts and Ranking Member Pallone for holding this hearing and for the committee’s bipartisan efforts in trying to develop a solution to Medicare’s physician payment system, which has been a burden on physician practices for over a decade. We share your view that Medicare is in need of a new system that “reduces spending, pays physicians fairly, and pays for services according to their value to the beneficiary.” In that spirit, ACP’s statement will focus primarily on new value-based payment and delivery system models that we envision as the most promising in any post-SGR environment, and the kinds of structural and reporting capabilities, payment incentives, and measurement systems needed for them to work. We likewise will outline what we see as the preferred legislative pathway to these new models.

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 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. We explain why it is imperative that the SGR be repealed and replaced with a framework to align payment incentives with the value of care provided to beneficiaries.
2. We explain why a payment system that recognizes the value of well-delivered primary care is essential to improving outcomes and lowering the costs of care.
3. We identify specific payment and delivery models that we believe have progressed enough that they can be scaled up into the broader Medicare program in the near-term future, as well as other promising models that should be evaluated on a broader scale and if shown to be effective, broadly implemented throughout the Medicare program as part of a permanent alternative to the SGR.
4. We propose improvements that can be made in the existing Medicare fee schedule to create incentives for coordinated, patient-centered care.
5. We offer our preferred legislative framework to eliminate the SGR and advance to better payment and delivery models.
6. We offer a set of specific principles to develop a transitional program to create incentives for physicians to begin incorporating value-based payment (VBP) initiatives into their practices, as a step toward full implementation of new payment and delivery models.

REFORMING THE SUSTAINABLE GROWTH RATE (SGR)

Medicare's SGR formula is fatally flawed and should be replaced with a framework that creates stable and positive updates for all physician services; provides incentives for primary, preventive and coordinated care; accelerates development and testing of new models developed with physicians input; and establishes a transition to the most effective new payment models.

The unworkable SGR formula determines the annual payment updates to physicians for the services they provide under the Medicare and TRICARE programs. (TRICARE, the health insurance program for military families, uses the same flawed SGR formula as Medicare.) Every year since 2001, the SGR has resulted in annual scheduled

payment cuts that jeopardize access to care for our nation’s Medicare beneficiaries and military families. The scheduled cuts also act as a barrier to physicians investing in health information systems and in acquiring other practice capabilities to improve the value of care provided to patients. While Congress typically enacts short-term “patches” to avert payment reductions, its repeated inability to agree on a permanent solution has resulted in a ballooning of the budget cost of SGR repeal – from \$40 billion only a few years ago to almost \$300 billion today to an estimated \$600 billion by 2016. If Congress does not intervene, the estimated cut scheduled for Jan. 1, 2013 is nearly 30 percent.

Congress should eliminate the physician payment cuts scheduled for Jan. 1; the SGR should be repealed this year and physician payments should be transformed from a system that incentivizes volume to one that preserves and promotes the patient-physician relationship and rewards high-quality and efficient care. It should also recognize and address the on-going undervaluation of primary care, preventive and care coordination services – which have led to a projected shortage of 44,000 primary care physicians for adults by the end of this decade.

THE VALUE OF PRIMARY AND COORDINATED CARE

Research both in this country and globally reflects that the foundation of an effective and efficient health care system is a robust primary care work. Care delivered in areas in which there is a sufficient number of primary care physicians and other related health care professionals is of higher quality and lower cost. The need to ensure a sufficient primary care workforce becomes more important with recognition of our rapidly aging population characterized by multiple chronic conditions.

The demand for primary care in the United States is expected to grow at a rapid rate while the nation’s supply of primary care physicians for adults is dwindling and interest by U.S. medical school graduates in pursuing careers in primary care specialties is steadily declining. Primary care physicians provide 52 percent of all ambulatory care visits, 80 percent of patient visits for hypertension, and 69 percent of visits for both chronic obstructive pulmonary disease and diabetes, yet they comprise only one-third of the U.S. physician workforce, and if current

trends continue, fewer than one out of five physicians will be in an adult primary care specialty. There are **over 100 studies that show primary care is associated with better outcomes and lower costs of care** ([http://www.acponline.org/advocacy/where we stand/policy/primary shortage.pdf](http://www.acponline.org/advocacy/where_we_stand/policy/primary_shortage.pdf)).

Medicare and delivery system reform should have as explicit goals increasing recognition of the value of primary care in improving outcomes and lowering costs; creating incentives for well-organized, team-based, coordinated, accountable and patient-centered primary care (Patient-Centered Medical Homes); and creating incentives for more physicians to go into internal medicine and other primary care disciplines.

Congress should also recognize that internal medicine subspecialists provide a substantial amount of primary and principal care in the United States as well as being key members of the team in providing coordinated care to patients, working hand-in-glove with the patient's primary care specialists. Their contributions should be recognized in any new payment system, and specifically, Medicare should improve payments for undervalued evaluation and management and care coordination services, whether provided by a primary care specialist or an internal medicine subspecialist physician within their range of expertise. And, as discussed later in this testimony, incentives should be created for medical specialists to link seamlessly with Patient-Centered Medical Home practices—a concept called the Patient-Centered Medical Home Neighborhood (PCMH-N).

SPECIFIC PAYMENT AND DELIVERY REFORMS THAT CAN SERVE AS THE BASIS FOR A NEW MEDICARE PAYMENT SYSTEM

1. Patient-Centered Medical Home (PCMH)

ACP has joined with other physician organizations in advancing new models of payment and delivery that are centered on patients' needs, including working with the Centers for Medicare and Medicaid Services (CMS),

private payers, business, and consumer groups to broadly test the PCMH model, which already is showing success in improving outcomes and reducing costs.

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. This care 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.

PCMH in the Public Sector

In its first year the CMS Innovation Center (CMMI), established by the Affordable Care Act (ACA), has introduced 16 initiatives, involving over 50,000 health care clinicians. CMMI's initial efforts have focused on improving patient safety, promoting care coordination, investing in primary care transformation, creating bundled payment models, and addressing the needs of dual-eligibles. 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 will receive 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.

On April 11, 2012 CMS announced the first seven market areas—and on June 6, 2012, CMS named the 45 commercial, federal and State insurers in those seven markets that have committed to work with CMS on this project. These include:

- Arkansas: Statewide (4 payers)
- Colorado: Statewide (9 payers)
- New Jersey: Statewide (5 payers)
- New York: Capital District-Hudson Valley Region (6 payers)
- Ohio and Kentucky: Cincinnati-Dayton Region (10 payers)
- Oklahoma: Greater Tulsa Region (3 payers)
- Oregon: Statewide (7 payers)

ACP has reached out to all of our Chapters in these states and regions to help spread the word about the importance of this initiative and encourage our members to apply by the July 20, 2012 deadline.

PCMH in the Private Sector

There has also been a significant amount of private sector payer activity in 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.¹
- 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.**²
- 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 upon by clinicians and payers, the project is providing performance incentives from multiple payers to the participating clinicians.³
- 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.⁴ 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

¹ 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.

² 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>.

³ Hudson Valley P4P-Medical Home Project. Available at: <http://www.pcpcc.net/content/hudson-valley-p4p-medical-home-project>.

⁴ 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>.

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 in 2012. 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.⁵ Taking this a step further, research also shows that patient-centered primary care is best delivered in a medical home.⁶ Although peer-reviewed academic studies evaluating the medical home model in its full implementation are still limited^{7,8,9} 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.¹⁰ 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,

⁵ 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/pccp/publications.html>.

⁶ 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.

⁷ 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.

⁸ 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.

⁹ 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.

¹⁰ Institute of Medicine. (2012). *Living well with chronic illness: A public health call to action*. Washington, DC: National Academy Press.

scaling it up to make PCMHs widely available to their subscribers, with many of them are reporting substantial costs savings as a result.

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 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 accreditation body.** At a subsequent stage, PCMH performance metric 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. ACP has taken a leadership role in helping to address this challenge through our work on the development of the PCMH-Neighborhood model, which is discussed below.
- 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. 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

CMS¹¹ and ONC¹² 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 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, e-Prescribing Incentive Program, and Physician Quality Reporting System (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. More about ACP's effort to facilitate the adoption of health IT will be addressed below.

- Practices that are trying to transform and that are actively engaging in or pursuing PCMH recognition/accreditation, meaningful use for their electronic health records, e-prescribing, etc. also struggle when they do not receive timely payments from their payers for these activities.
- 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 were selected to participate in the CPCi, discussed above, but many other practices across the country are not being "made whole" in terms of payment for the work they are doing.

The Role of the PCMH in a Post-SGR Environment

Given all of the federal, state, and private sector activity described above, as well as ongoing efforts to address the challenges that have been discussed, it is reasonable to expect that the PCMH model will be ready to be a part of a

¹¹ These comments can be found at: http://www.acponline.org/advocacy/where_we_stand/health_information_technology/cms_nprm.pdf.

¹² These comments can be found at: http://www.acponline.org/advocacy/where_we_stand/health_information_technology/onc_nprm.pdf.

new, value-based health care payment and delivery system. Under this model, practices that provide comprehensive primary care to their patients will be:

- Paid differently, including:
 - A periodic (e.g., monthly, quarterly) care management fee to allow them to strengthen their capacity to provide comprehensive, patient-centered care. This fee could go toward additional staffing, infrastructure, health information technology, and/or otherwise uncompensated physician and staff time.
 - A potentially revised, improved, and/or expanded set of fee-for-service evaluation and management codes that better incorporate physician and staff non-face-to-face time when providing care management and care coordination services.
 - Shared savings based upon improved quality of care and better patient outcomes.
- Organized differently, in order to:
 - Deliver proactive, timely preventive care to their patients.
 - Provide 24/7 access to their patients through online interactive tools, data, and information.
 - Actively engage patients, their families, and their caregivers in their health care.
 - Provide comprehensive care management services to their patients, particularly those with high health care needs (e.g., multiple chronic conditions).
 - Coordinate care across their patients' medical neighborhoods by acting as the first point of contact and working collaboratively with the team of clinicians involved in their patients' care.
- Measured differently, via 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 Fund¹³, 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;¹⁴ and
 - The National Quality Forum (NQF) has established a platform for the development of care coordination measures consisting of a set of domains, principles and preferred practices.¹⁵

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

¹³ 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

¹⁴ Agency for Healthcare Research and Quality. Care Coordination and Measures Atlas. Accessed at <http://www.ahrq.gov/qual/careatlas/>

¹⁵ NQF. Preferred practices and performance measures for measuring and reporting care coordination. 2010. Accessed at http://www.qualityforum.org/Publications/2010/10/Preferred_Practices_and_Performance_Measures_for_Measuring_and_Reporting_Care_Coordination.aspx

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.

2. Patient-Centered Medical Home – Neighborhood

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 ACP¹⁶ and the Agency for Healthcare Quality and Research (AHRQ).¹⁷ 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 incentives—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. The above cited College policy paper outlines a model using care coordination agreements to promote a functioning PCMH-Neighborhood. Reciprocal recognition of professional MOC standards and activities that focus on these same skills and systems, including implementation of such agreements, is a potent lever.

The NCQA, acknowledging the importance of the involvement of the “medical neighborhood” in support of PCMH (primary) care, 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—including physician groups, employers, health plans, state and federal payers, and patient

¹⁶ 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/.

¹⁷ 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.

advocates. In addition, the American Board of Internal Medicine and the NCQA are, collaborating to align aspects of Maintenance of Certification and the new “medical neighbor” recognition process.

Efforts to promote processes to coordinate care between primary care practices and the other physicians and health care professionals providing treatment to the patient have been an integral part of both private and public integrated care systems (e.g. Kaiser, Department of Veterans Affairs) and are an important component of the developing Accountable Care Organization (ACO) models. 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 COPD, 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.

3. Accountable Care Organizations (ACOs)

The ACA instructed the Secretary of Health and Human Services (HHS) to implement, no later than January 1, 2012, a voluntary shared savings program that promotes accountability for services delivered to a defined Medicare fee-for-service (FFS) patient population with the goals of increasing the quality and efficiency of services delivered.

Eligible participants consist of groups of clinicians and other providers, referred to as Accountable Care Organizations (ACOs), which have established a mechanism for shared governance and take joint responsibility for the quality and efficiency of the services delivered to a defined population. These groups can consist of physician group practice arrangements, networks of individual practices, partnerships and joint-ventures between hospitals and other providers, hospitals employing physicians and other professionals, and other arrangements determined appropriate by the Secretary of HHS.

The Role of ACOs in a Post-SGR Environment

The ACO model, either using a shared savings or alternative “capitated payment” model, facilitates a “sea change” regarding care delivery. Rather than care being delivered in clinical silos and focused on the production of volume, care will be aligned with measures of quality, efficiency and clinical coordination. Value will be rewarded rather than volume. Substantial evidence toward ACO development throughout the country is already occurring with the implementation of the Pioneer (32 approved programs) and Medicare Shared Savings Programs (132 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 month.¹⁸ 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.¹⁹ The growth of the ACO model has led NCQA (released) and URAC (in process) to develop an ACO recognition process that helps

¹⁸ 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>

¹⁹ 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/NEJMsa1101416#t=articleTop>.

ensure that these organizations engage in processes that promote patient centered, high quality, efficient integrative care.

OTHER PROMISING PAYMENT MODELS

***4. Comprehensive Global Payment Model*²⁰**

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

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

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

²⁰ Goroll AH, Berenson RB, Schoenbaum SC, Gardner LA. Fundamental reform of payment for adult primary care: comprehensive payment for comprehensive care. *J Gen Intern Med.* 2007;22:410-415. Summary available at http://www.commonwealthfund.org/~media/Files/Publications/In%20the%20Literature/2007/Mar/Fundamental%20Reform%20of%20Payment%20for%20Adult%20Primary%20Care%20Comprehensive%20Payment%20for%20Comprehensive%20Care/Goroll_fundamentalfundamentadulprimarycare_1014_itl%20pdf.pdf.

Eligibility for this payment would be limited to those practices that demonstrated having the infrastructure and general capability to deliver the requisite services, as assessed by an organization such as NCQA or URAC. The care provided would be documented by an annual random sample of practices. The documentation typically required for each visit would be significantly reduced and payment would be heavily risk- and needs- adjusted to match each patient's burden of care. This payment model is currently being piloted within the Capital District Health Plan in Albany, New York. Initial data reflects decreased costs and improved care quality compared to a cohort control.²¹

5. **"Prometheus" Evidence-informed Case Rate (ECR) Model**

This payment model, developed by the non-profit PROMETHEUS Payment Inc. establishes case rates for the treatment of specific conditions based on the cost of all services, pharmaceuticals, tests, equipment, etc. needed to treat the condition following agreed upon evidence-based clinical practice guidelines. The case rate is triggered by a diagnosis and, for chronic conditions, takes the form of a yearly rate. The amount of the payment to the practice also depends upon its performance on a quality scorecard and the efficiency of care provided by the other physicians and health care professions throughout the system providing care to the patient for the defined condition. Pilot demonstrations are being implemented in Rockford, Illinois and Minneapolis, Minnesota with a third site in Utah.²² PROMETHEUS Payment Inc. has also outlined how this model can be used for the payment of primary care services, including the provision of funds to transform primary care practices into medical homes.²³

INCORPORATING HIGH VALUE CARE INTO PAYMENT POLICIES

²¹ Feder J. A health plan spurs transformation of primary care practices into better-paid medical homes. *Health Affairs* 2011 30 (3): 397-399.

²² Prometheus Newsletter 2. Accessed at <http://www.prometheuspayment.org/news-events/newsletters/2009/PPInewsletter09issue2.pdf>.

²³ Prometheus Payment Incorporated. Sustaining the Medical Home: How Prometheus Payment Can Revitalize Primary Care. 2009. Accessed at <http://www.prometheuspayment.org/publications/pdf/STMH%20Full%20with%20Apps.pdf>.

Medical specialty societies, including ACP, are taking a leading role in developing and implementing programs to improve the value of care provided to patients.

ACP's High Value, Cost-Conscious Care Initiative (HVCCC), which includes clinical, public policy, and educational components,²⁴ 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.

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.²⁵ Furthermore, on July 10, 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, 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.

ACP has also joined other leading professional medical organizations in the Choosing Wisely campaign,²⁶ which complements our HVCCC Initiative. An initiative of the ABIM Foundation, the goal of the Choosing Wisely campaign is to promote thoughtful discussions among physicians, patients, and other stakeholders about how to

²⁴ Additional information can be found at: http://www.acponline.org/clinical_information/resources/hvccc.htm.

²⁵ 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>

²⁶ More information on this initiative can be found at: <http://choosingwisely.org/>.

use health care resources to improve quality of care. In April 2012, ACP unveiled our list of "Five Things"²⁷ internists and patients should question in internal medicine.

On April 19, 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), Consumer Reports (ConsumerReports.org), and *Annals of Internal Medicine* (Annals.org).²⁸

Finally, the educational component of the program involves elements for both physicians and patients. The next edition of ACP's Medical Knowledge Self Assessment Program (MKSAP) will have a focus on optimal diagnostic and treatment strategies, based upon considerations of value, effectiveness, and avoidance of overuse and misuse.

Programs like ACP's HVCCC initiative and *Choosing Wisely*® could be incorporated into 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 payments, physicians who can demonstrate that they are incorporating such programs into their practices and engagement with their patients.

IMPROVING MEDICARE FEE-FOR-SERVICE TO SUPPORT CARE COORDINATION

²⁷ This document can be found at: http://choosingwisely.org/wp-content/uploads/2012/04/5things_12_factsheet_Amer_College_Phys.pdf.

²⁸ More information on this effort can be found at: http://www.acponline.org/pressroom/high_value_care_ed_materials.htm.

Even as new models of payment are being evaluated, and some like the PCMH scaled up more broadly through the program in the near-term, Medicare fee-for-service (FFS) will continue to be the principal way that most doctors will be reimbursed for at least the next several years. In addition, FFS is an element of other payment and delivery models, including PCMHs and ACOs. Consequently, it is important to make FFS improvements to recognize and support the value of coordinated care.

Specifically, ACP support the development and recognition under Medicare fee-for-service payment polices of two new CPT codes—(1) for chronic, complex care and (2) transition care following a facility-based discharge. These new codes have been developed by a CPT Panel workgroup and approved by the CPT Editorial Panel during their May 2012 CPT Meeting. These codes are currently undergoing a survey process in order to be assigned recommended values by the Relative Value Update Committee (RUC), and then receive a final valuation by the Centers for Medicare and Medicaid Services (CMS). These codes 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 was discussed above. The College is also encouraged by the inclusion of a similar new transition of care code applicable to post-hospital discharge situations in the recently released Medicare 2013 Physician Fee Schedule proposed rule.

A LEGISLATIVE FRAMEWORK TO REPEAL THE SGR AND PROGRESS TO BETTER MODELS

Today's testimony demonstrates that enough progress is being made to develop, implement and evaluate new payment and delivery models to serve as the basis for replacing the SGR. Getting from here to there, though, will require that Congress enact a legislative framework to eliminate the SGR, stabilize payments during a transition phase, evaluate and implement new models, and specify a pathway and timetable to such models.

Specifically, ACP envisions two phases in the SGR reform process. During the first stage, 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. This 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.

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 full testing of models including the patient-centered medical home and the patient-centered medical home neighborhood, Accountable Care Organizations, 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.

The Physician Payment Innovation Act of 2012, H.R. 5707: Reps. Allyson Schwartz (D-PA) and Joe Heck (R-NV) recently introduced legislation, consistent with ACP’s core principles above, outlines the 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.

H.R 5707 achieves five key policy goals:

1. Repeals the Sustainable Growth Rate (SGR).
2. Protects access to care for seniors, disabled persons, and military families, by eliminating all scheduled SGR cuts, including a nearly 30 percent cut on January 1, 2013. Patients need the certainty of knowing that the government will not impose cuts that could force many doctors out of the Medicare and TRICARE programs. (TRICARE updates are set by the Medicare SGR formula, so military families are

at the same risk of losing access to doctors as persons enrolled in Medicare because of the scheduled cuts.)

3. Stabilizes payments through 2018, with no cuts for the next six years and positive updates to all physicians during 2014-2017. The Medicare Physician Payment Innovation Act would continue current Medicare rates through 2013; provide modest positive updates of 0.5 percent to all physicians in calendar years 2014-2017, and then extend the 2017 rates through December 31, 2018. This 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.
4. Provides a higher update for undervalued primary, preventive and coordinated care services, whether delivered by primary care physicians or by other specialists. The bill provides a 2.5 percent annual update in calendar years 2014-2017 for designated primary care, coordinated care, and preventive services codes when provided by physicians for whom 60 percent of Medicare allowable charges come from these designated codes. 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.
5. Accelerates development, evaluation, and transition to new payment and delivery models, developed with input by the medical profession and with external validation. The six-and-a-half years established by the bill for CMS to develop, evaluate, and then adopt at least five new models, including an alternative fee-for-service option for physicians who participate in designated quality improvement programs, will help ensure sufficient time for CMS and Congress to “get it right.”

ACP recognizes that there may be variations on the framework proposed by H.R. 5707 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. We are open to discussion of how best to achieve a transition consistent with the above goals, while recognizing that H.R. 5707 is the first and only bipartisan bill that we are aware of that translates the above critical policy goals into a practical legislative framework.

PRINCIPLES TO CREATE A TRANSITIONAL VALUE-BASED PAYMENT INITIATIVE

Finally, ACP believes that additional steps could be taken, during a period of stable payments such as proposed in H.R. 5707, 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 models like PCMHs and ACOs. During this transitional period, physicians would get higher updates for demonstrating that they have successfully participated in an approved transitional value-based payment program (VBP). We offer the following principles for developing a transitional 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.
2. Transitional performance based update programs should be incorporated into a broader legislative framework to stabilize payments and transition to new models, such as that proposed in H.R. 5707. This is important so that physician 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 H.R. 5707. 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 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 Initiative, 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 build on the current, silo-ed 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.

ACP welcomes the opportunity to work with the Subcommittee and other physician organizations to develop the details of a transitional VBP initiative, as part of a broader legislative framework to repeal the SGR, stabilize

payments, provide higher updates for under-valued primary, preventive and coordinated care services, and transition to better payment and delivery models by a defined date.

SUMMARY AND CONCLUSION

Based upon our above responses, the College specifically recommends that:

1. 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 from the new CPCi and Advanced Primary Care Initiatives in CMS 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.
2. 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.
3. Congress should support continued evaluation of Accountable Care Organizations, Advanced Payment ACOs, Prometheus, and other promising alternative payment models that could be offered to physicians, following a transition period, along with PCMHs.
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. Medicare should make improvements in the existing Medicare physician fee schedule to create incentives for care coordination.

6. The Energy & Commerce Committee should report legislation to repeal the SGR, provide for stability in payments for all physicians, higher updates for undervalued care coordination, preventive, and primary care services, and transition to new payments and delivery models, working from the bipartisan Medicare Physician Payment Innovation Act, H.R. 5707.

7. Congress and the Medicare program should work 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 transitional VBP initiative, consistent with the principles discussed above.

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.