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A System in Need of Change: Restructuring Payment Policies to Support Patient-Centered Care

American College of Physicians
A Position Paper

A System in Need of Change: Restructuring Payment Policies to Support Patient-Centered Care

A Position Paper of the
American College of Physicians

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EXECUTIVE SUMMARY

This policy paper builds on an analysis of problems currently affecting the U.S. health care delivery and payment system and recent American College of Physician (ACP) policy statements to propose a new physician payment structure that fosters the delivery of care that is patient-centered, longitudinal, and coordinated. More specifically, this paper, which focuses on the Medicare system but is applicable to all health care payers, proposes a multi-component, bundled payment structure that facilitates more effective and efficient care delivery for all patients through the Advanced Medical Home (AMH). The AMH, which is a care delivery model that contains principles jointly supported by the American Academy of Family Physicians and the ACP, offers the benefits of a personal physician with a whole-person orientation who accepts overall responsibility for the care of the patient and leads a team that provides enhanced access to care, improved coordinated and integrated care, and increased efforts to ensure safety and quality. This position paper further proposes the establishment of a recognition process that assesses and documents a practice's structural capability to fulfill the services required under the AMH and that would qualify the practice for a new risk-adjusted payment structure that would consist of the following components:

- **A prospective, bundled structural practice component** that covers the practice overhead costs linked to providing AMH services that are not currently paid under the present system.
- **A prospective, bundled care coordination component** that recognizes the work value of physician and nonphysician clinical and administrative care coordination activities that take place outside of face-to-face visits and that are not currently paid under the present system.
- **A visit-based fee-for-service component that** recognizes visit-based services that are currently paid under the present system.
- **A performance-based component that** recognizes achievement of quality and efficiency goals.

The ACP also recommends in this policy paper the addition of separate payments for specific care coordination services for those practices that do not meet all the requirements of an AMH practice, as well as changes in the current payment system to promote improved service valuation and to promote the implementation of health information technology (HIT) and performance reporting through the provision of incentives.

Finally, the paper calls for the elimination of the Medicare Sustainable Growth Rate (SGR) formula for annual physician fee updates and suggests to Congress a transitional pathway to accomplish this goal that culminates in a stable and predictable methodology for updating physician payments, while addressing the need to deliver high-quality, cost-effective care. The proposed methodology for establishing annual Medicare fee schedule payment updates relies on annual Medical Payment Advisory Commission (MedPAC) recommendations and includes the following components:

- **A stable and positive percentage update in the conversion factor recommended for all services that takes into account the costs of delivering care, beneficiary access to services, workforce, and other data on trends that may affect access and quality.**
- **An additional percentage amount recommended, above Medicare baseline spending on physician services, to fund a physicians' quality improvement pool.**

- **Additional optional targeted "add-ons" to payments for certain categories of services to achieve desired policy objectives.**

This paper contains the following 9 position statements:

Position 1: The College recommends that Medicare and other health care payers implement changes to support a new model of service delivery with related risk-adjusted prospective payments for ambulatory care that uses systems that promote patient-centered, longitudinal, coordinated care. This new model would apply to physicians in practices that have demonstrated key attributes necessary to manage care consistent with this approach, and would take into account the increased work and resources associated with providing this model of care.

Position 2: The College recommends that this new payment and delivery model be based on the principles of the Advanced Medical Home (AMH), which offers the benefits of a personal physician with a whole-person orientation and provides enhanced access to care, coordinated and integrated care, and increased efforts to ensure safety and quality. This model would improve the care for all patients and address current unmet needs of the chronically ill.

Position 3: The College recommends that a multi-component, bundled payment structure be implemented that results in a substantial increase in payments to primary and principal care physicians who accept responsibility for care management and coordination in recognized AMH practices. The payment structure should have a prospective component and be risk adjusted to reflect differences in the case mix of patients being treated. The increased reimbursement resulting from this payment structure must be sufficient to support the initial and sustained practice redesign and clinical work associated with effective management of patients in a variety of practice settings; particularly in smaller practices that provide the majority of care to Medicare beneficiaries. The payment model should specifically include a:

- **Prospective, bundled structural practice component that covers practice expenses linked to the delivery of services under the AMH model not covered by the Medicare Resource-Based Relative Value Scale (RBRVS) system.**
- **Prospective, bundled care coordination component to cover physician and non-physician clinical and administrative staff work linked to the delivery of services under the AMH model not covered by the Medicare RBRVS system.**
- **Visit-based fee component for services delivered as part of a face-to-face visit and already recognized by the Medicare RBRVS system.**
- **Performance-based component based on the achievement of defined quality and cost-effectiveness goals as reflected on evidence-based quality, cost of care, and patient experience measures.**

Position 4: The College recommends that Congress enact legislation to direct the Secretary of the Department of Health and Human Services (HHS) to implement a large-scale Medicare pilot project of the AMH model. The pilot would include a bundled payment structure that supports practices, including smaller practices, that are recognized as AMHs; authority to institute incentives, such as reduced deductibles

and co-insurance, for beneficiaries to select a physician within a recognized AMH as their personal physician; and non-financial incentives, such as reductions in documentation requirements, for practices that qualify as AMHs. The proposed pilot should also include representation from practices of varying sizes (with substantial representation from small practice settings), in different geographic settings and of varying levels of professional maturity. Upon completion of the pilot program, the Secretary should be authorized to implement changes in Medicare payment policies, including changes that will allow physicians in an AMH to share in program-wide savings attributable to them, to provide sustained and ongoing support to practices nationwide that meet the qualifications as an AMH.

Position 5: The College recommends that Centers for Medicare and Medicaid Services (CMS) provide separate Medicare payments under the RBRVS system for services that facilitate patient-centered, longitudinal, coordinated care to be used by physicians in practices that cannot provide all of the attributes necessary to qualify as an Advanced Medical Home in order to encourage improved and more efficient delivery of services.

Position 6: The College recommends that CMS implement procedures within the RBRVS system that:

- **Improve the accuracy of work and practice expense relative values,**
- **Provide an incentive for the adoption of health information technology linked to quality improvement efforts,**
- **Provide incentives for physicians to participate in programs to continuously improve, measure and report on the quality and cost of the care provided.**

Position 7: The College strongly supports the MedPAC recommendation to eliminate the flawed SGR formula and further recommends that it be replaced with a methodology that provides positive, stable, and predictable updates to physician payments.

Position 8: The College recommends that alternative volume or budget controls be considered by Congress only as a backup mechanism and only to the extent that other reforms in payment methodologies to improve quality and introduce greater efficiency are found to be insufficient. These other reforms include aligning Medicare payments with quality improvement, promoting adoption of HIT in support of quality improvement, promoting physician-guided care management and the Advanced Medical Home, encouraging evidence-based medicine, supporting the value of primary care, and addressing mispricing of services.

Position 9: The College recommends that Congress establish a pathway toward eliminating the SGR and creating a more stable and predictable method for updating payments to physicians that would combine annual updates reflecting increases in practice expenses, performance based payments, and additional optional payment increases to achieve specific policy objectives. This pathway should include a specified legislative timeframe—no later than five years—for sunsetting the flawed SGR formula. Such legislation should establish a transition period that will result in positive, stable, and predictable annual percentage updates to all physicians and increased payments for participating in a voluntary pay-for-reporting program.

At the end of this transition period, a new approach to establishing annual Medicare fee schedule payment updates to physicians should be established. This new approach should include the following components:

- **A stable and positive percentage update in the conversion factor for all services that takes into account the costs of delivering care, beneficiary access to services, workforce, and other data on trends that may affect access and quality.**
- **An additional percentage amount, above Medicare baseline spending on physician services, to fund a physicians' quality improvement pool. This pool will provide a dedicated source of funding for physician-led programs that the Secretary has determined can achieve program-wide quality improvements and cost efficiencies, such as programs to address regional variations in quality and cost of care, programs to improve care of patients with chronic diseases, and surgical outcome and measurement programs. Funds dedicated to the pool would include shared savings from program-wide improvements rather than being limited to Part B funding.**
- **Optional targeted "add-ons" to payments for certain categories of services to achieve desired policy objectives such as increasing the supply of primary care physicians.**

A SYSTEM IN NEED OF CHANGE

The American College of Physicians (ACP) is the nation's largest medical specialty society representing over 120,000 internal medicine physicians and medical students. In a recent policy paper,[1] ACP described significant problems in the U.S. health care system, which include the following:

- Health care costs are growing faster than the economy[2] and the cost of care is becoming difficult for employers, government, and individuals to meet. Employers are cutting back on worker and retiree benefits, premiums are increasing for both public and private sector payees, and the number of the uninsured has reached over 45 million and is projected to continue to rise.[3,4]
- There are significant gaps in the quality of health care that Americans receive.[5] Health care outcomes in the United States contrast poorly with those of other industrial countries, despite the highest level of spending.[6]
- Patients are reporting dissatisfaction with the care received; are dissatisfied with the extent their physicians are providing whole-person, integrated care; and do not feel that their primary care physicians know much about them – despite having sustained relationships over years.[7]
- Primary care physicians are dissatisfied with the practice of medicine due to the financial, administrative, and increasingly technical demands under the current care system.[8 9]

The current health care payment and delivery system is particularly poor at providing care for the chronically ill. This is a critical shortcoming of the system; it is estimated that approximately 45 percent of all Americans have a chronic health condition, and the percentage within the Medicare population is much higher—78 percent of Medicare beneficiaries have one or more chronic conditions.[10] Furthermore, 20 percent have at least five chronic conditions; this group accounts for two-thirds of all Medicare spending.[11] The population of chronically ill patients, who tend to see multiple physicians and are on multiple medications, frequently receive inadequate care. The current health care system does not support or encourage adequate care coordination among providers or across sites of service.[12] One result of the absence of coordination of care is that patients with chronic conditions receive evidence-based recommended care only 56 percent of the time.[13] Further, a recent Medicare Payment and Advisory Commission (MedPAC) analysis of claims-sbased ambulatory measures of patients predominately with chronic conditions indicated that only two-thirds of beneficiaries in 2004 received necessary care for 20 of 32 indicators.[14]

Compounding the current health care system's difficulties is the looming collapse of primary care in the United States. The availability of primary care physicians – those physicians with the specialized training to provide patient-centered, longitudinal, coordinated care[15] – is projected to rapidly decline in the near future. The number of new students entering into primary care is decreasing[16] and physicians who have chosen the field are leaving in disproportionate numbers compared with other specialties.[17] This is in contrast to a projected need for an expanded primary care workforce to meet the needs of the aging "baby boomers" cohort.[18] This impending shortage of primary care physicians will result in further fragmentation of care and lead to poorer quality, more inefficiencies, and higher healthcare costs.[19,20]

This position paper proposes a new physician payment and delivery model that builds upon and extends existing ACP policy to address the core deficiencies of the current payment and delivery system. The model promotes the provision

of patient-centered, longitudinal, coordinated care that has been related to improved quality and cost efficiencies for the general patient population and specifically addresses the current unmet needs of the chronically ill. This position paper also specifies additional changes to the current Medicare payment and delivery system to improve its accuracy in valuing services and the quality and effectiveness of the care provided. ACP believes that the combined effect of these proposals will stimulate the development of robust clinical systems to provide the type of care patients want to receive and physicians want to deliver.

Before introducing these new proposals, it is important to understand the specific problems with the current system that make it inadequate to meet the health care needs of our nation.

SPECIFIC PROBLEMS WITH THE CURRENT HEALTHCARE PAYMENT AND DELIVERY SYSTEM

The Medicare program is the largest single purchaser of health care in the United States and is the standard for health plan payment policies in the private sector. Thus, our analysis of specific problems in the current payment and delivery system will focus on Medicare. Medicare has established payment for ambulatory care providers through a Resource Based Relative Value Scale (RBRVS) Physician Fee Schedule (PFS) system since 1992.[21] Under this system, payments for each of the thousands of procedures recognized by Medicare are determined by the relative work, practice expense (PE) and practice liability insurance (PLI) resource costs required to provide the service expressed as relative value units (RVUs). The combined relative value for a service, adjusted for geographic differences through Geographic Practice Cost Indices (GPCIs), is then multiplied by a standard conversion factor (expressed in dollars) that is established yearly by the Centers for Medicare and Medicaid Services (CMS) and that determines the actual payment for the service under Medicare for that year.

The payment formula is[1]:

Payment Amount = [(Work RVU * Work GPCI) + (PE RVU * PE GPCI) + (PLI RVU * PLI GPCI)] * Conversion Factor

In a recent policy paper, "Reform of the Dysfunctional Payment and Delivery System,"[22] the ACP specified in detail several limitations and problems with the current Medicare payment system. These include:

- Undervaluing the evaluation and management (E/M) clinical services that are the procedures predominately provided by primary care physicians.
- Using methodologies that lead to inaccurate relative values for work (particularly overvaluation of newly introduced, high technology-oriented procedures), and practice expense.
- Not paying for those services required to allow the primary care physician to provide patient-focused, longitudinal, coordinated care.
- Using a yearly fee update formula – the sustainable growth rate (SGR) – that projects annual cuts in physician fees of approximately 5 percent at least through 2011 and has a disproportionately adverse impact on primary care physicians.
- Providing incentives for volume of services without regard to the quality or cost of the clinical service provided.

[1] A more complete description of the payment system is included in Appendix A.

Viewed broadly, the primary problems of the current Medicare payment and delivery system are:

1. **The system is based on a payment model that encourages the delivery of fragmented, high volume, high cost care.**

The Medicare RBRVS PFS payment system is based on a "piece work," fee-for-service model that pays providers based solely on the volume of procedures done multiplied by the resource value of the procedure and the conversion factor. The economic literature reflects that this model, while increasing accessibility to services, provides substantial incentive to increase service volume.[23,24] It further encourages the provision of unnecessary care, high cost care and an overly broad scope of practice. Finally, it provides no incentive to physicians to collaborate with other physicians treating the patient since each provider is paid only for the specific procedures performed. This results in uncoordinated, non-integrated care that is particularly deleterious to individuals with chronic illnesses. The current fee-for-service payment system encourages fragmented, high volume, high cost care.

Table 1 provides a general overview of the effects of the major payment approaches in health care on physician behavior. The characteristic of the fee-for-service payment model has been highlighted above, including how it contributes to the current problems in meeting the needs of the chronically ill. Salary approaches, which adequately address the high volume issue, are not aligned with the autonomy desired by most physicians, and are only practical in closed care systems such as the Veteran's Affairs (VA) system or managed networks of care (e.g. Kaiser Permanente, Mayo Clinic). Full capitation models, which contain both insurance and technical risk (see definitions in Table 1) , are not feasible within the small practice setting given the high financial risk. Furthermore, this model has the potential to increase patient health risk since there are incentives to reduce services and defer care beyond the prepayment period.[25] The bundled payment or noninsurance risk capitation models (e.g. case rates, global rates), which provide incentives for efficient and effective performance while removing any insurance risk, appear very promising vehicles for an improved Medicare physician payment structure—provided that the payments are adequate. Goodson et. al. point out that all forms of capitation place the provider at some form of additional financial or liability risk and this risk must be recognized and addressed.[26] Medicare has been gradually converting payment structures in many areas to prospective payment, bundled rates. These include prospective payment for acute inpatient care (Diagnosis Related Groups), post acute inpatient care, and outpatient hospital care (Ambulatory Payment Classifications). MedPAC reports that within the acute inpatient setting this payment structure has been associated with decreased cost with no decrease in quality.[27]

Table 1. Effects of Different Payment Approaches on Behavior*

PAYMENT APPROACH	ADVANTAGES	DISADVANTAGES
Fee For Service (FFS)	• Rewards physicians directly based on the amount of work done. • Increases accessibility for those who can afford the care — model focused on attracting "buyers" of the service. • Protects provider from cost care, and an overly insurance risk.** • Protects provider from a significant amount of technical risk*** — since current FFS is based on the resource use of a typical, rather than an efficient provider. • Increases physician autonomy.	• Provides incentive for increased volume and intensity. • Reduces concerns regarding cost to payer. • Provides an incentive for the provision of unnecessary care, high broad scope of practice. • Minimal incentive for cooperation, integration among providers to promote efficient, effective provision of care.
Capitation (full)	• Provides incentive to decrease volume and intensity of care. • Provides incentive to control unnecessary and high cost care. • Encourages cooperation among providers to promote efficient, effective provision of care.	• Provides incentive to treat least complex patients who require minimal care. • Provides incentive to deny appropriate services. • Places provider under insurance risk. • Places provider under technical risk. • Tends to minimize accessibility.
Bundled, Global, or Case Rate models (Non-insurance capitation)	• Provides an incentive for the efficient use of resources. • Eliminates incentive to increase volume of components of the bundle. • Rewards physicians based on combination of amount of work done (e.g. number of cases treated) and the efficiency and effectiveness of the care provided. • Removes insurance risk.	• Can provide incentive to treat "most profitable" cases.**** • Provider maintains technical risk.
Salary	• Increases methods of cost-control available to payer. • Minimizes incentive to over-service. • Minimizes incentive to limit patients to least complex or most profitable.	• Can undermine productivity. • Decreases physician autonomy.

* These models can also be used in combination.

** Insurance risk – also called population or probability risk, refers to the risk of the excessive utilization and cost of a service that is beyond the control or responsibility of the physician. e.g. Unexpectedly high use of a service within the defined population.

*** Technical risk – refers to risk of the excessive utilization and cost of a service that are under the physician's control – excessive cost due to the delivery of ineffective and inefficient care.

****This disadvantage is minimized with adequate case-mix and severity of illness adjustments

Table abstracted primarily from the following sources:

Robinson JC Theory and practice in the design of physician payment incentives. Milbank Quarterly 2001;79(2):149-177

Monrad Aas IH 1995 Health Policy 34: 205-220

2. The system does not adequately recognize the value of the primary care physician and the unique services they provide.

The field of modern day primary care developed in the 1960's in reaction to a U.S. health care system that lacked coordination, continuity, and comprehensiveness.[28] Delivery of primary care has been related to improved health care quality at lower cost:

- States with a higher ratio of primary care physicians to population have better health outcomes, including lower mortality rates from cancer, heart disease or stroke.[29,30]
- Areas with more specialists have higher per capita Medicare spending,[31] and an increase in primary care physicians is associated with a significant increase in quality of health services, as well as a reduction in costs.[32]
- Studies of ambulatory care–sensitive conditions have shown that hospitalization rates and expenditures are higher in areas with fewer primary care physicians and limited access to primary care.[33]
- Cross-national comparisons indicate that countries with stronger primary care infrastructures have lower rates of premature births, deaths from treatable conditions, and postneonatal mortality.[34–36]

Unfortunately, E/M services, which are at the core of the primary care practice, are undervalued relative to more procedural and technologically-driven activities. The average income for primary care physicians is at least 40 percent lower than most other medical specialties[37] and many of the activities that are historically part of primary care receive little or no payment (e.g. care coordination activities). This lack of adequate payment and recognition of these services is directly related to the projected decline in the primary care workforce[38] and contributes to the limited amount of care coordination being provided to Medicare beneficiaries.[39] CMS recently announced[40] increases to the relative value of E/M services under Medicare. These changes will partially help to address the erosion of E/M relative values that have occurred since the inception of the RBRVS system due to a combination of a review process that does not do a good job identifying overvalued procedures and the slower volume growth of E/M services relative to other services.[41] These changes will increase the revenue that internists and other physicians receive from Medicare for providing E/M services. However, this projected increase in reimbursement will, at best, only serve to partially offset the 10.2 percent decline in real income primary care physicians lost between 1995 and 2003 and doesn't fully correct the service valuation problem.[42]

3. The system does not adequately recognize the value of providing effective care to the chronically ill.

Despite a large chronically ill patient population under Medicare and in the general population, the current fee-for-service system reflects healthcare's historic orientation towards responding to acute illness and injury[43] and fails to support the current principles of quality chronic care.

> "Provider reimbursement is based on encounters of short duration, which discourages the provision of time-consuming but critical activities such as patient education, counseling, and care coordination. Medicare's failure to reimburse services not provided by a physician impedes the operation of multidisciplinary teams and the use of nonphysician professionals who may be capable of meeting aspects of patient care more appropriately and less expensively. The program currently lacks incentives for providers to adopt information technology such as electronic medical records, patient registries, or other systems to enhance communication among providers and manage patients proactively and longitudinally."[44]

Current models of chronic care, generally based on the work of Ed Wagner, MD, FACP, and his colleagues,[45,46] contain the following elements, which are not supported by the current health care payment and delivery system:

- The provision of coordinated care, both within a given practice and between consultants, ancillary providers, and community resources.
- The provision of information, tools, and encouragement to patients to facilitate the self-management of their illness.
- The adoption and use of health information technology (HIT) such as electronic medical records and clinical decision support to facilitate patient education and care coordination, to establish patient registries, and to improve quality.
- The adoption and use of enhanced communication access such as secure e-mail, telephone consultation, and remote monitoring of clinical data.
- The routine evaluation of the quality and effectiveness of clinical activities provided.

The literature reflects improvement in the quality of care received using various combinations of these activities for a variety of chronic illnesses including hypertension,[47] diabetes,[48] asthma,[49] congestive heart failure (CHF),[50] coronary artery disease,[51] and depression.[52] In addition, there is also promising research support for the cost effectiveness (return on investment) of many of the activities. Goetzel et. al. reviewed the disease management literature and found strong evidence for the cost effectiveness of chronic care interventions addressing CHF and individuals with multiple comorbidities; some positive data was also reported for asthma and diabetes.[53] Other studies have shown that improved care coordination following hospitalization significantly reduces readmissions.[54,55] Further, both MedPAC[56] and the Commonwealth Fund[57] conclude that there is evidence that high-quality ambulatory care can avoid hospitalizations for a number of chronic conditions including CHF, chronic obstructive pulmonary disease (COPD)/asthma, diabetes, and hypertension.

The importance of providing effective care to the chronically ill is further highlighted by a recent analysis of Medicare expenditures between 1987 and 2002, which indicated that virtually all of the growth in spending can be traced

to the significant increase in the medical management of beneficiaries with multiple chronic conditions. The researchers who conducted this analysis further observed that the current fee-for-service payment model does not adequately support chronic care treatment and they call for the development of more effective models and standards of care.[58]

4. **The system does not consider any evidence-based quality, cost of care,[2] or patient experience data in determining provider reimbursement.**

The literature is replete with evidence of significant quality gaps within the present health care payment and delivery system, despite significantly high expenditures in this sector.[59] The current Medicare payment policy contributes to this problem by failing to provide incentives for physicians to engage in performance improvement efforts. All physicians are provided the same standard payment for a procedure regardless of the quality of performance.

There has been substantial progress made in the past several years in developing evidence-based clinical quality measures. Primarily through the efforts of the National Committee for Quality Assurance (NCQA), the American Medical Association/Physician Consortium for Performance Improvement (AMA/PCPI), AQA, and the National Quality Forum (NQF), clinical measures have been developed for many specialties.

There is also substantial interest in the development of cost-of-care or resource-use measures.[60] Many private plans use these measures, often along with quality measures, to provide confidential feedback to providers and establish tiered panels of providers with related financial incentives to the provider and/or the plan member. Particular interest has been evidenced in the use of "episode groupers", which use claims data to establish the cost of care for clinically distinct episodes of care adjusted for severity.[61]

A series of standardized patient experience-of-care measures are currently being developed and implemented as part of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) project of the federal Agency for Healthcare Research and Quality (AHRQ).[62]

The CMS initiated a Physician Voluntary Reporting Program (PVRP)[63] in 2006 that will expand into a voluntary pay-for-reporting program as a result of legislation enacted by the 109th Congress.[64] This follows an increasing trend in the private sector of linking provider payments to performance.[65]

The above outlined problems with the current RBRVS payment and delivery system directly contribute to the inadequacies found in health care currently being delivered throughout the nation. The previously cited ACP health care policy paper on our dysfunctional payment and delivery system[66] ended with

> "….The College believes that changes to the current Medicare payment and delivery system that include ensuring the accurate valuation of physician services, providing separate payments that facilitate accessible and coordinated care, and adding a quality component will improve the system and help mitigate the predicted collapse of primary care. The College further believes that these modest changes alone will not be sufficient to permanently maintain and foster a thriving primary care workforce… entire new payment and delivery models need to be developed and studied, such as the Advanced Medical Home, that more effectively meet the needs of our patients, and the physicians that serve them."

[2] The AQA provides a discussion of principles regarding efficiency, cost of care and value measures available at http://www.aqaalliance.org/files/PrinciplesofEfficiencyMeasurementApril2006.doc

A PROPOSED NEW PHYSICIAN PAYMENT AND DELIVERY MODEL

The ACP has articulated in recent policy papers the specific changes required in the RBRVS system to improve overall health quality and effectiveness and provide more equitable payments to providers, such as the importance of patient-centered, longitudinal, coordinated care for all Americans – particularly the chronically ill[67,68]—and the importance of linking Medicare payments to effective quality measurement.[69] The College, based on an analysis of the current RBRVS PFS system, and employing and expanding on the guidance provided by these policy papers, proposes specific changes to improve the current RBRVS-based model and an entirely new physician payment and delivery system for practices that are recognized as having the structural attributes to provide consistent patient-centered, longitudinal, coordinated care to all patients. The implementation of these changes would result in:

- Improved accuracy in the valuation of physician services.
- Recognition of the value of patient-centered, longitudinal, coordinated care services and the cost of providing these services.
- Recognition of the value of critical elements of chronic care delivery (e.g. disease self-management and follow-up) and the cost of providing these services.
- Recognition of the value of quality improvement and performance measurement, including the assessment of evidence-based quality, cost efficiency, and patient experience of care, and recognizing the cost of obtaining this data.
- Transition from the current procedure-oriented payment structure to a broader unit of care payment.

Position 1: The College recommends that Medicare and other health care payers implement changes to support a new model of service delivery with related risk-adjusted prospective payments for ambulatory care that uses systems that promote patient-centered, longitudinal, coordinated care. This new model would apply to physicians in practices that have demonstrated key attributes necessary to manage care consistent with this approach, and would take into account the increased work and resources associated with providing this model of care.

Position 2: The College recommends that this new Medicare payment and delivery model be based on the principles of the Advanced Medical Home (AMH), which offers the benefits of a personal physician with a whole-person orientation and provides enhanced access to care, coordinated and integrated care, and increased efforts to ensure safety and quality. This model would improve the care for all patients and address current unmet needs of the chronically ill.

Position 3: The College recommends that a multi-component, bundled payment structure be implemented that results in a substantial increase in payments to primary and principal care physicians who accept responsibility for care management and coordination in recognized AMH practices. The payment structure should have a prospective component and be risk-adjusted to reflect differences in the case mix of patients being treated. The increased reimbursement resulting from this payment structure must be sufficient to support the initial and sustained practice redesign and clinical work associated with effective management of patients with chronic diseases in a variety of practice settings, particularly in smaller practices that provided the majority of care to Medicare beneficiaries. The bundled payment structure should specifically include a:

- **Prospective, bundled structural practice component that covers practice expenses linked to the delivery of services under the AMH model not covered by the Medicare RBRVS system.**
- **Prospective, bundled care coordination component to cover physician and nonphysician clinical and administrative staff work linked to the delivery of services under the AMH model not covered by the Medicare RBRVS system.**
- **Visit-based fee component for services that are delivered as part of a face-to-face visit and are already recognized by the Medicare RBRVS system.**
- **Performance-based component based on the achievement of defined quality and cost-effectiveness goals as reflected in evidence-based quality, cost of care, and patient experience measures.**

Position 4: The College recommends that Congress enact legislation to direct the Secretary of the Department of Health and Human Services (HHS) to implement a large-scale Medicare pilot project of the AMH model. The pilot would include a bundled payment structure that supports practices, including smaller practices, that qualify as AMHs; authority to institute incentives, such as reduced deductibles and co-insurance, for beneficiaries to select a physician within a recognized AMH as their personal physician; and non-financial incentives, such as reductions in documentation requirements, for practices that qualify as AMHs. The proposed pilot should also include representation from practices of varying sizes (with substantial representation from small practice settings), in different geographic settings and of varying levels of professional maturity. Upon completion of the pilot program, the Secretary should be authorized to implement changes in Medicare payment policies, including changes that will allow physicians in an AMH to share in program-wide savings attributable to them, to provide sustained and ongoing support to practices nationwide that meet the qualifications as an AMH.

The College proposes a significant change from the current model of how physicians are expected to deliver care and be reimbursed for the care provided to their ambulatory patients. Under this new model, physicians will be provided incentives to deliver patient-centered, longitudinal, coordinated care. More specifically, a new payment structure is proposed for those physicians attached to practices recognized as having the structural capability to consistently provide patient-centered, longitudinal, coordinated care services to all patients—so-called Advanced Medical Home practices.

Treatment Under the Advanced Medical Home

The concept of a medical home was first described by the American Academy of Pediatrics' Council on Pediatric Practice in the 1960s[70] and has been more recently offered by the American Academy of Family Physicians (AAFP)[71] and the ACP.[72] The AAFP and ACP recently collaborated to establish joint principles regarding a "patient-centered medical home" model, which incorporates the key elements of what the ACP has called the "advanced medical home" and the AAFP has called the "personal medical home." The joint principles are included in Appendix B. For the purposes of this paper, the term "advanced medical home" will be used, which can be viewed as essentially interchangeable with the "patient-centered medical home" described in the joint AAFP/ACP principles. This delivery model is also consistent with a redesigned practice model offered by the Society of General Internal Medicine[73] and with recommendations made by the non-profit Commonwealth Fund to transform our delivery of primary care.[74] Finally, ACP has called for a redesign of internal medicine training to provide residents with experiences in ambulatory settings that provide care that is consistent with this patient-centered treatment model.[75]

Elements of the Advanced Medical Home Model

The AMH model being proposed builds on the chronic care model,[76] leveraged to provide enhanced care for all patients with or without a chronic condition and contains the elements of patient-centered, longitudinal, coordinated care that are at the core of primary care practice. The elements of the model are:[77,78]

> **A practice (the "medical home")** voluntarily selected by the patient that has a **personal physician** (typically a primary care physician but could also be a qualified medical specialist or subspecialist) who has a whole person orientation and leads a team of individuals that collectively take responsibility for the on-going care of the patient. The personal physician is responsible for providing for all the patient's health care needs — this includes care for all stages of life; acute care; chronic care; preventive services; end of life care — or takes responsibility for appropriately arranging care with other qualified professionals. The practice of this Advanced Medical Home physician is designed to provide:
>
> - **Enhanced access to care** through facilitated visit scheduling (e.g. open access scheduling, web-based scheduling) and non face-to-face communication and consultation capability through secure telephone, e-mail, and remote monitoring of clinical data technology.
> - **Coordinated and integrated care** across the health care system through systems of active patient care follow-up, use of patient registries, use of information technology, and health informational exchanges.
> - **Ensured safety and quality** through practicing evidence-based medicine, using clinical decision support tools at the point of service, actively including the patient in the decision-making process, and accepting accountability for continuous quality improvement through voluntary engagement in performance measurement.

The personal physician practicing under this model is the patient's ally in facilitating treatment that is patient-centered, coordinated, and of high quality, and in navigating our complex system of care. This practitioner will also work with their patients to establish care management and disease self-management goals when appropriate and will help them accomplish these shared goals. The AMH practitioner is not a "gatekeeper" who controls access to other specialists. While the personal physician will provide advice and recommendations that will typically be valued due to the 'trusting' relationship between patient and doctor that is facilitated by the AMH model, the model has no punitive features if the patient chooses not to follow the physician's advice or recommendation.

A Proposed Payment Model for Care under the Advanced Medical Home

The ACP offers the following payment structure to fund delivery of care under the Advance Medical Home. This multicomponent bundled payment policy is for personal physicians who (a) manage patients who select to have their care delivered under the AMH model in a particular physician practice and (b) are in practices that have met the requirements of a recognition process that confirms its structural capability (practice design elements) to fulfill the services required by the AMH model. This recognition process can be provided by an independent third party and be conducted in a manner similar to the Physician Practice Connections (PPC) recognition program[79] currently used by the National Committee on Quality Assurance (NCQA) to assess office practices' performance in the areas of clinical information systems, patient education and support, and care management. This program provides different levels of recognition based on the number of passed modules and the level at which the elements in each module are passed. The components of this new payment policy include:

- **A prospective, bundled structural practice component –** to cover the practice expenses (e.g. equipment, maintenance, training) linked to the delivery of services under the advanced medical home model that are not covered under the current RBRVS payment system. These expenses include the costs associated with enhanced access and communication functions, population management and registry functions, patient medical data and referral tracking functions, provision of evidence-based care, implementation and maintenance of health information technology (e.g. e-prescribing, clinical decision support, electronic medical record), and reporting on performance and improvement functions. This proposed structural practice component could be based on a formula linked to the number of AMH patients in the practice, the size of the practice (recognizing the cost efficiencies in the larger practices), and the practice's degree of structural capability to fulfill the AMH model (e.g. paper-based practice vs. a practice with an implemented electronic medical record system), as reflected in the recognition process.
- **A prospective, bundled care coordination component –** to recognize the value of physician and nonphysician clinical and administrative staff work associated with care coordination that falls outside of face-to-face visits and is not covered under the current RBRVS payment system. This work includes care plan oversight, e-mail and telephone consultations, extended patient medical data review including data stored and transmitted electronically, and physician supervision of self-management education and follow-up that is accomplished by non-physician personnel such as nurses, medical assistants, or through contracted educators. Documentation requirements should be limited.

- **Visit-based fee-for-service component** – to recognize visit-based services already paid under the Medicare RBRVS system. These fees help both to integrate this new proposed system into the current Medicare system and to provide an incentive for the physician to continue to have face-to-face visits with the patient. Any E/M service work, including pre- and post-visit work, already considered in the current RBRVS system, would not be included in the newly proposed structural practice and care coordination payment components.

- **Performance-based component** – in recognition of achievement of defined quality and efficiency goals as reflected on evidence-based quality, cost of care, and patient experience measures. These measures may be the same used for all ambulatory-care physicians, but preferably should also include NQF/AQA-vetted measures directly assessing care coordination functions. The College believes that the pool to fund this fee and the size of the performance rewards available should be increased proportionately by any savings across all Medicare programs (e.g. Medicare Part A and D) attributable to practice reorganization and improvements related to this care model. This would require that Medicare—likely through legislation—eliminate the current "silo-like" nature of expenditures under the Medicare system. The current Medicare Physician Group Practice demonstration project provides a model of how this can be accomplished.[80] The ability to share substantially in these savings will serve as a significant incentive for physician practices to become AMH-recognized and to provide services under this payment and delivery model.

Thus, under this proposed new model, physicians within recognized AMH practices would receive prospective, bundled payments for the care coordination services and related practice expenses not covered under the current RBRVS payment system. These payments could be made as one combined AMH payment to the practice or reimbursed through a separate structural practice payment and physician care coordination payment. The College further proposes that one or both of these bundled payments be risk-adjusted to reflect differences in the amount of work required and resources employed for patients of varying clinical complexity (e.g. a relatively healthy patient vs. a patient with multiple chronic illnesses.) Furthermore, CMS would need to implement a monitoring system (e.g. random audits or review of patient experience surveys) to verify the delivery of the services under the bundled payments without adding undue administrative burden. These prospective, bundled payments would be in addition to the physicians' ability to continue to bill for visit-based care covered by the current RBRVS system. Finally, these AMH physicians would be eligible for payments based on the quality and effectiveness of their service delivery as reflected by performance measures – these payments could be made either at the practice or individual physician level.

The College also envisions that beneficiaries should receive incentives, such as reduced deductibles and co-insurance, in order to select a physician within a recognized AMH as their personal physician. The improved evidenced-based quality and savings from coordinated care anticipated under this delivery model support the value of including this type of incentive.

This proposed AMH model is significantly more aligned with the provision of patient-centered, longitudinal, coordinated care than the current model. It provides a transition from pure procedural-based fee-for-service to a more

prospective, bundled payment model for care delivery with its inherent efficiencies. The combination of bundled (capitated) care coordination and visit-based fee-for-service is similar to a primary care service model implemented in Denmark that is characterized by high patient satisfaction and good ambulatory clinical quality.[81] Finally, it meets the basic guidelines set by ACP policy.

The College also believes that care provided under this payment and delivery model, with its emphasis on evidence-based care delivery, care coordination, and quality and cost of care performance accountability will help decrease the wide geographic variability in health care expenditures reported in the literature.[82]

Financing and Establishing Payment for These Components

The College recognizes that this proposed AMH model provides work and practice expense obligations that are not covered under the current Medicare RBRVS PFS. Thus, implementation is problematic for Medicare under the current federal "budget-neutral" policy. Recent Medicare demonstration projects (e.g. Medicare Health Support pilot, Physician Group Practice demonstration) have allowed for the payment of current noncovered services by making a responsible entity (i.e. the participating disease management vendor or group practice) "at risk" for these extra expenses if the new interventions do not achieve a specified level of savings within the Medicare system (e.g. a 5 percent savings under the Medicare Health Support pilot) plus cover the additional expenses attributable to the new interventions. The typical small practice physician is in no position to be "at risk" for these funds. These practices already operate within low margins and could not remain financially viable if they had to front the costs of these additional services until adequate savings are documented or had to pay back the additional fees if adequate Medicare savings were not achieved. The previously cited research literature provides substantial evidence that the implementation of the AMH model has the potential of achieving significant quality improvements and related cost saving to the Medicare program. Thus, the College recommends that Congress pass legislation to direct the Secretary of HHS to implement a large scale Medicare pilot project of the AMH care model. The pilot would include a bundled payment structure that supports practices that qualify as AMHs; authority to institute incentives, such as reduced deductibles and co-insurance, for beneficiaries to select a physician within a recognized AMH as their personal physician; and non-financial incentives, such as reductions in or streamlining of documentation requirements, for practices that qualify as AMHs. Upon completion of the pilot program, the Secretary would be authorized to implement changes in the Medicare Part B physician payment program to provide sustained and ongoing support to practices nationwide that are recognized as an AMH.

The initial pilot preferably should include all patients who designate an AMH, but could be limited to a defined population consisting of those high-cost chronic care patients that research evidence strongly suggests would display significant care quality improvements and decreased system costs (e.g. decreased hospitalizations) under a patient-centered, longitudinal, coordinated model of care. The population definition employed should take into consideration the need to include enough eligible beneficiaries in a typical practice to make providing care under the AMH model financially feasible. The proposed pilot should also include representation from practices of varying sizes (e.g. solo, small, "virtual" groupings, academic medical settings, etc.), in different geographic settings (e.g. rural, suburban, urban.) and of different levels of professional maturity (e.g. new practitioners, practitioners with 10 or more years of experience.) Suggested legislative language is included in Appendix C.

Based upon the results of the proposed AMH pilot study, the funding for expanded implementation of the new AMH model throughout the Medicare system could be obtained either entirely from the Medicare system-wide savings that are attributable to the AMH as documented during the pilot, through savings from proposed processes to improve the valuation of work and practice expense service components under the current RBRVS system as detailed below in this paper, or through a combination of funds from system-wide and improved valuation savings and funds reallocated within the RBRVS system. Fund reallocation could be accomplished through new care coordination codes developed through the AMA Current Procedural Terminology (CPT) process, evaluated by the AMA/Specialty Society Relative Value Scale Update Committee (RUC) and submitted to CMS for approval. There is already precedent under the RBRVS payment system for coverage for physician care coordination without face-to-face contact. This includes:

- Care plan oversight for patients in hospice and home care settings. Activities under this coverage include communications with the interdisciplinary team and pharmacist, review of patient status reports and lab results, and making plan modifications.
- Physician certification and periodic recertification of a patient home health care plan
- Monthly care management payments to physicians who provide renal services to patients with end-stage renal disease (ESRD). This payment essentially consists of a bundle of previously separate E/M services typically provided to this patient population.

Care Management and Coordination Provided by Non-AMH Physicians

Position 5: The College recommends that CMS provide separate Medicare payments under the RBRVS system for services that facilitate patient-centered, longitudinal, coordinated care to be used by physicians in practices that cannot provide all of the attributes necessary to qualify as an Advanced Medical Home in order to encourage improved and more efficient delivery of services.

The College believes that the practice model reflected within the AMH will provide significantly more effective and efficient care than under the current payment and delivery model. Nonetheless, many primary care physicians may not be prepared to expend the human and financial capital at this time to redesign their practices to be consistent with the delivery model and to become recognized. In addition, the College is aware of many medical specialty and subspecialty providers who generally provide specific condition-focused services, but also have a subpopulation of patients for whom they assume overall care responsibility. An example of this would be an endocrinologist who is providing the principal treatment for a patient with advanced, complex diabetes, but who also serves the patient's general medical needs. The College believes that patients treated in these non-AMH practices should have access to the benefits of patient-centered, longitudinal, coordinated care and that physicians should be provided with an incentive to provide elements of this care. Thus, the College recommends that specific care coordination CPT codes should be made available, using established or newly developed codes, and recognized by Medicare to be employed in these situations. MedPAC has recently discussed this possibility.[83]

Examples of established CPT codes that are relevant include:

- Care plan oversight for patients receiving home health care.*
- Care plan oversight for patients who have elected hospice coverage.*
- Physician supervision of nurse-provided patient self-management education.
- Ambulatory blood pressure monitoring.*
- Continuous glucose monitoring initiation.*
- Anticoagulation management for patients conducting home monitoring.
- Physician team conference codes.
- Physician review of data stored and transmitted electronically.

* Already recognized and paid for separately by Medicare.

Examples of possible new codes related to patient-centered, longitudinal, coordinated care include:

- Care plan oversight, for additional specified conditions which would include communication with other providers offering the patient treatment, ongoing review of patient medical status and lab reports, and care plan modifications.
- Physician e-mail and telephone consultation related to a care plan.
- Disease self-management training related to a care plan conducted by the physician or nurse with related follow-up.

Thus, non-AMH recognized physicians would have the option to provide any of a spectrum of care coordination procedures that would be useful for specific patients, with a range in the level of necessary overhead expense and office retooling required. These physicians should be required to provide clear documentation of providing these services. This would be in contrast to the limited documentation proposed for AMH physicians, who are in practices that have been recognized as structurally capable of adequately providing this type of care. The College believes that the inclusion of these incentives within the RBRVS payment system for physicians to provide more patient-centered, longitudinal, coordinated care, coupled with several additional improvements to the current care system that are discussed below, will improve the overall care provided and will lead to direct cost savings to Medicare.

Additional Recommended Improvements to the General Medicare RBRVS Payment and Delivery System

Position 6: The College recommends that CMS implement procedures within the RBRVS system that:

- **improve the accuracy of work and practice expense relative values,**
- **provide an incentive for the adoption of health information technology linked to quality improvement efforts,**
- **provide incentives for physicians to participate in programs to continuously improve, measure, and report on the quality and cost of the care provided.**

Implementation of the proposed AMH model will still leave many patients receiving care under the current RBRVS payment and delivery system. ACP previously outlined in the policy paper, "Reform of the Dysfunctional Payment and Delivery System" specific changes that need to be made in this system to ensure an adequate primary care workforce and to improve the quality and efficiency of the provided care. These policy modifications consist of:

- **Implementation of procedures to improve the accuracy of work and practice expense relative values.** The recently published Physician Fee Schedule final rule[84] that made significant improvements in payments for office visits and other E/M services is a positive step. Furthermore, the College supports the MedPAC recommendation to establish an independent group of experts to review procedures that may be overvalued under the existing Medicare fee schedule. Under the current "budget-neutral" payment system, overvalued procedures—combined with consequent, inappropriate volume increases—divert resources from primary care and other services that are undervalued by Medicare. The College has also recommended specific steps that CMS can take to improve its methodology for determining the practice expense value for each service.
- **Provision of additional payments for office visits that are facilitated by the use of HIT, such as electronic health records, electronic prescribing, and clinical decision support tools.** The addition of these payments will facilitate the adoption of this technology, which relates to improved effectiveness and efficiency of care.[85] In order to ensure that this technology is used primarily to facilitate improved healthcare quality and safety, the College recommends that the additional payments be contingent on physician involvement in approved quality improvement and measurement programs. The College has endorsed the bipartisan National Health Information Incentive Act of 2005, H.R. 747, which is consistent with this recommendation. These payments may need to be adjusted for AMH providers since their proposed structural fee includes the practice expenses related to HIT adoption.
- **Provision of sustained and sufficient financial incentives for physicians to participate in programs to continuously improve, measure, and report on the quality and cost of the care provided.** As noted previously, the current Medicare payment policy does not provide any incentives for physicians to engage in performance improvement efforts – all physicians are provided the same standard payment for a procedure regardless of the quality of performance. The College believes that

linking Medicare payments to quality should be part of an overall redesign of payment policies to support models of health care delivery that result in better care of patients.[86] These P4P efforts should:

- Rely on valid and reliable clinical measures, data collection and analysis, and reporting mechanisms that ensure an accurate and meaningful performance measurement process.
- Consist of clinical measures that have been developed, endorsed, and selected for implementation through a multi-stakeholder process (e.g. NQF, NCQA, AMA/PCPI, and AQA) that assures that the measures meet criteria related to strength of the evidence, transparency in development, and consistency in implementation.
- Phase-in measures prioritized based upon their impact on the healthcare system in improving quality and reducing costs.
- Reward individual physicians based on the potential impact of the specific measures being reported, the level of work required by the physician to participate in the reporting process, and a combination of meeting quality thresholds and evidencing improvements.
- Allow physicians to benefit from reductions in spending in other parts of Medicare attributable to their performance improvement efforts.
- Include safeguards to reduce the potential to "cherry pick" patients to exclude sicker, higher risk, or noncompliant patients from a practice.

Review of Literature Regarding other Potential Payment and Delivery Structures

Several additional physician service delivery and payment models have been recently proposed in the literature and are broadly consistent with the AMH model and other ACP proposed payment and delivery changes. More specifically, these proposed models provide increased recognition of the value and cost of providing patient-centered, longitudinal, coordinated care services; increased recognition of the value of quality improvement and performance measurement; and a transition from the current procedure-oriented payment structure to a broader unit of care payment. The following is a summary of several of the models that have attracted the most interest.

- **Comprehensive Global Payment Model[87] —** 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, also referred to by the authors as a "retainer" fee, is linked to the number of patients in the practice and is based on a loosely defined method of cost accounting that 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 (10-20 percent) that is outcome-based and linked to validated measures of patient satisfaction and clinical performance.

The care provided would be documented by an annual random sample of practices. The documentation typically required for each visit would be eliminated and payment would be heavily risk- and needs-adjusted to match each patient's burden of care. The authors suggest that the highly compensated income provided through this model will "more than pay for itself in reduced spending elsewhere in the system that comes from improving quality, efficiency, safety and patient experience."

This model is very similar to the AMH model as proposed by the College, except for its complete separation from the current RBRVS payment system for primary care services. The College has some concern about the large component of payment (10-20 percent) that is linked to performance – this relatively high degree of risk may be financially difficult, particularly in the small practice setting. Nonetheless, the College remains interested in the further development of this model and the results of potential related demonstration projects.

- **"Prometheus" Evidence-based Case Rate Model[88] —** This recently proposed complex, technically sophisticated payment model establishes case rates for the treatment of specific conditions based on the cost of all services, tests, equipment, etc. needed to treat the condition following agreed upon evidence-based clinical practice guidelines. The cost accounting for the case rates would be developed using sophisticated technology from claims data, and would take into account regional cost variations, "normal" cost variations, severity of illness, and the inclusion of a reasonable profit margin for the provider. The case rate is not just limited to ambulatory providers, but would include the cost contributions from all aspects of the health care system (e.g. primary care provider, specialists, hospital care, etc.) and the technology allocates costs as required. Finally, approximately 10 percent of the provider's total payment (for chronic conditions) is placed in a Performance Contingency Fund and distributed based upon the provider's year-end performance on measures of clinical quality, patient experience, and cost-efficiency. A small percent of the provider's performance payment is contingent on the performance of the other providers involved in the patient's treatment.

  This model offers evidence-based case rates as the best means of providing physician payment and ensuring the delivery of quality, patient-centered, longitudinal, coordinated care. There remains the question of how this model deals with the many conditions for which there are not clear evidence-based guidelines. Furthermore, the technical complexity of the model serves as a barrier to rapid provider understanding and acceptance. Finally, the College has some concern about the 10 percent withhold contingent on performance – small practices in

particular may have difficulty carrying this degree of financial risk. The combination of sophisticated cost accounting procedures to establish a payment base, the provision of a bundled case rate payment that promotes continuous, coordinated care, and the linking of payment to performance are generally consistent with the College's goals and the College remains interested in the further development of this model and the results of potential demonstration projects.

- **MedPAC Care Management Fee Model** — MedPAC[89] has recently described two alternative payment models to illustrate how care coordination activities could be facilitated in Medicare:
  - Provider group model – under which provider groups would be responsible for and paid additionally for providing coordinated care activities that are not currently covered under the RBRVS system but are tied to the achieving of quality goals. Some additional fee may also be paid to the individual physicians involved. The size of the provider group that can support this model is debatable, but it must be able to provide case management and related informational technology infrastructure. This approach is similar to the model currently being used in the Medicare Physician Group Practice demonstration project.
  - Care management organization plus physician office model – under which a care management entity (e.g. disease management organization) would be responsible for and reimbursed for providing care coordination services and the physician's office would support the efforts of the care management entity and provide the required clinical care to the patient. Physicians would receive a monthly fee to cover the activities related to referral to the care coordination program, patient information transfers, care plan oversight, and ongoing communications between the physician's office and the care management organization regarding patient status and progress. The physician would also continue to capture all visit-based RBRVS fees. This approach is similar to a model currently being used by some of the vendors participating in the Medicare Health Support pilot project.

MedPAC suggests these models be used for targeted complex patients. MedPAC further suggests an at-risk payment of costs for the addition of the care coordination services – either through shared saving or an at-risk management fee to create an incentive to provide cost-effective interventions. The fees would be contingent on evidencing savings in beneficiary cost of care across both Medicare Part A and B services. Accountability would be measured through use of quality performance and patient experience measures—efficiency (cost savings) is reflected by the at-risk nature of the payments.

The "at risk" nature of the proposed MedPAC models makes these approaches unfeasible within the typical small practice setting. The "provider group model", absent the "at risk" factor and its applicability to only complex patients, is similar to the College's proposed AMH payment and delivery model in that it provides payment for the delivery of a bundle of care coordination services, continues to provide payment for visits through the RBRVS system, and has a performance measurement component. The results of the Physician Group Practice demonstration, which consists of large practices with at least 200 physicians, will potentially document that these care coordination services do provide significant cost savings within the system and perhaps the need for an "at risk" contract can

be eliminated. There will still remain the question of whether a small practice setting can also provide the required type of care and generate this type of savings. This is one of the questions that can be directly answered through Congress' support of the pilot of the AMH model proposed by the College.

The College recognizes that the "care management organization plus physician office" model provides a means of providing care coordination services in those practice settings that do not have the structural capability to provide such services on their own. It provides an alternative to the ACP-proposed model of providing non-AMH physicians with separate Medicare payments under the RBRVS system for services that facilitate patient-centered, longitudinal, coordinated care. This represents an improvement over the current system that does not provide a means for patients to receive these services. Unfortunately, these disease management programs have not had great success in integrating and coordinating their services with the treating physician,[90] which significantly reduces the benefits of these interventions. Thus, the College has concerns regarding the implementation of this particular model. Data from the Medicare Health Support pilot, particularly from those participating disease management entities (e.g. McKesson, Health Dialog) that have made significant efforts to integrate the treating physician into the process, will help determine the validity of the College's concerns.

ADDRESSING CONTROL OF SERVICE VOLUME ISSUES AND THE FLAWED SUSTAINABLE GROWTH RATE FORMULA

Problems with the SGR and its Disproportionate Effect on Primary Care

The current Medicare payment system uses a formula, the SGR, to determine annual updates to payments physicians receive for RBRVS services paid through the Medicare Physician Fee Schedule. This complex formula, implemented by Congress to control service volume growth and overall expenditures in physician services, decreases Medicare payment updates to physicians whenever the growth in expenditures on physician-related services exceeds changes in per capita gross domestic product (GDP), after modifications based on enrollment, changes in law and regulation, and other factors. The update is implemented through a change in the conversion factor used to convert the relative value of a procedure into a fee.

Since its implementation in 2000, the SGR formula has been ineffective in restraining inappropriate volume growth and spending, has led to unfair and sustained payment cuts to physician fees, and has been particularly harmful to primary care.

- Service volume has increased more than the targeted growth level for every year since 2000,[91] per capita service volume continued to grow at a higher rate in 2004 than seen in previous years (6.2 percent per beneficiary), and Medicare spending for physician services continues to display substantial increases. CMS found that spending on physician services increased by 11.5 percent in Part B in 2004.[92]
- The SGR has prescribed mandated yearly cuts in physician payment since 2002 – with annual cuts of approximately 5 percent projected at least through 2011.[93] While Congress has passed legislation in each previous year, except 2002, to negate the formula-prescribed payment cuts and provide updates from 0 to 1.5 percent, these increases have not kept up with physicians' costs to provide these services during this time period – as measured by the Medicare economic index (MEI).

- Primary care physicians are hurt the most by SGR-mandated cuts and inadequate updates because they already are paid far less than most other physicians. In addition, they have high overhead and low practice margins and have little or no ability to offset cuts (relative to other medical specialties) by increasing the volume of care provided due to the time-intensive nature of E/M services (e.g. typical procedural specialists generate nearly twice the total relative value units per hour as primary care physicians.)[94]

MedPAC has recently expressed significant concern about the impending cuts resulting from the flawed SGR formula – particularly its effects on primary care.

> "The Commission does not support these impending fee cuts. We are concerned that such consecutive annual cuts would threaten beneficiary access to physician services over time, particularly those provided by primary care physicians. Reimbursement cuts may disproportionately affect primary care providers who average lower volume growth in their practices than procedure-based specialists. Because many Medicare beneficiaries rely on primary care providers for important health care management, payment policies that may discourage medical students and residents from becoming primary care physicians raise particular concern for the Commission."[95]

Additional problems with the SGR formula are:

- It cuts payments to the most efficient and highest quality physicians by the same amount as those who provide the least efficient and lowest quality care.
- It penalizes physicians for appropriate volume increases (e.g. increases resulting from following evidence-based guidelines.)
- It unfairly holds individual physicians responsible for nationwide factors—growth in per capita gross domestic product and overall trends in volume and intensity—that are outside of their individual control.
- It disconnects the yearly payment updates from changes in the costs of providing the service.

Search for SGR Replacement

Position 7: The College strongly supports the MedPAC recommendation to eliminate the flawed SGR formula and further recommends that it be replaced with a methodology that provides positive, stable, and predictable updates to physician payments.

MedPAC[96] has recommended that the SGR formula be eliminated and that physicians should be provided yearly updates linked to an analysis of payment adequacy based on the most current available data (e.g. beneficiary access, private sector reimbursement) and an assessment of factors that will affect provider's costs in the coming year. Furthermore, MedPAC has also expressed a preference that inappropriate volume increases for specific procedures should be addressed individually. For example, CMS has recently addressed an observed increase in imaging procedures by reducing payment for multiple procedures at the same site or contiguous areas.[97]

Members of Congress have also expressed interest in eliminating the SGR formula, as indicated by legislation (HR 3617) introduced in the 109th Congress by Rep. Nancy Johnson, chair of the Health Subcommittee of the House Ways and Means Committee, and provisions in the Deficit Reduction Act of 2005 that mandate MedPAC to submit a report to Congress by March 2007 on mechanisms that could be used to replace the SGR.

Position 8: The College recommends that alternative volume or budget controls be considered by Congress only as a backup mechanism and only to the extent that other reforms in payment methodologies to improve quality and introduce greater efficiency are found to be insufficient. These other reforms include aligning Medicare payments with quality improvement, promoting adoption of HIT in support of quality improvement, promoting physician-guided care management and the advanced medical home, encouraging evidence-based medicine, supporting the value of primary care, and addressing mispricing of services.

The College understands Congress' desire to explore alternative formula-based targets as mentioned in the Deficit Reduction Act of 2005 to control volume growth and expenditures. It is suggested that Congress consider these alternatives in a deliberative manner mindful of the failures and unintended consequences that occurred following previous Congressional attempts to enact volume controls on physician spending. In 1989, Congress enacted the Medicare "volume performance standards (VPS)" formula to control volume based on historical growth targets. Ultimately, the VPS formula was not effective in controlling volume and, due to the implementation of differing targets and yearly update rates for different categories of services, resulted in distorted relative payments among the categories of services such that services of equivalent RVUs were no longer paid at the same rate.[98] In 1997, Congress ended the policy of applying different targets and updates and replaced the VPS formula with the current flawed SGR formula. This history suggests that any alternative that proposes to replace one formula (the SGR) with another formula or set of formulas needs to be carefully considered. ACP believes that the broad policy changes suggested in this paper would result in substantial healthcare quality improvements with related cost efficiencies (e.g. decreased need of costly emergency room and in-patient hospital care) and will more effectively contribute to a reduction in inappropriate volume/expenditure growth.

Discussion of SGR Alternatives under Review by MedPAC

While the College recommends that alternative volume and budget controls only be used if recommended broad policy changes are insufficient to control service volume and expenditures, Congress has mandated MedPAC to investigate various alternatives to the SGR under the Deficit Reduction Act of 2005. More specifically, MedPAC is required to evaluate the effects of employing smaller volume target pools within an SGR-type volume control formula. These target pools include type of service, geographic area, outliers, hospital medical staff, and group practices. Each of these alternatives is associated with multiple issues that need to be considered. The College provides an analysis of each of these alternatives in Appendix D.

Averting Pending SGR-Induced Payment Cuts; Recommended Process for Eliminating the SGR

Position 9: The College recommends that Congress establish a pathway toward eliminating the SGR and creating a more stable and predictable method for updating payments to physicians that would combine annual updates reflecting increases in practice expenses, performance based payments, and additional optional payment increases to achieve specific policy objectives. The College, furthermore, offers the following steps for Congress to consider as a means of reaching this goal:

1. **Congress should enact legislation to set a specified timeframe and pathway—no later than five years—for sunsetting the use of the flawed SGR formula.**

The College recognizes that the cost of eliminating the SGR on January 1, 2008 will be very expensive, but the cost of keeping it—as measured by reduced access and quality—is much higher. Instead of enacting another one-year temporary reprieve from the cuts without eliminating the SGR, the College believes that it would be preferable to set a "date certain"—no more than five years from now—when the formula will be sunsetted. Such a timetable will allow for a transition period during which Congress and CMS could implement other payment reforms that can improve access and quality, and reduce costs; thereby reducing the perceived need for formula-driven volume controls like the SGR.

2. **Legislation to create such a pathway should specify, in advance, a percentage floor on updates in the Medicare dollar conversion factor for each year of the transition, beginning in 2008, that yields positive, stable, and predictable payments to all physicians.**

The College specifically recommends that any legislation that creates a pathway and timetable for repeal of the SGR should specify in statute the minimum annual percentage updates (floor) during the transition period. Establishing the minimum updates by statute will provide assurance to physicians and patients that payments will be fair and predictable during the transition. In establishing the floor, Congress should consider projected increases in physician practices costs as measured by the Medicare economic index, but not tie the minimum percentage updates specifically to the MEI. The legislation should also direct MedPAC to report annually to Congress, during each year of the transition period, on the adequacy and appropriateness of the floor compared to changes in physician practice costs, data on beneficiaries' access to services, private payment level comparisons, volume of physician services used, and desired policy objectives. Congress would then have the discretion to set a higher update than the floor based on the MedPAC recommendation.

3. **During the transition period, Congress should continue the voluntary pay-for-reporting program that will begin on July 1, 2007 with appropriate refinements. The pay-for-reporting program should gradually move to a pay-for-performance program during the transition period that would provide additional, positive increases in payments to physicians who demonstrate quality improvement and/or meet defined quality thresholds based on evidence-based measures.**

The Tax Relief and Health Care Act of 2006[99] implemented a voluntary and transitional pay-for-reporting program to begin on July 1, 2007. The program ends on December 31, 2007. ACP recommends continuation of the program with appropriate refinements to emphasize systems approaches to improving care and adequate funding to provide a stronger and positive incentive for physicians to participate.

ACP believes that the implementation of this performance improvement program will stimulate the increased adoption of evidence-based practices throughout the health care system, with the result of improved care quality and increased cost efficiencies ultimately reducing the need for reliance on an SGR-like expenditure control mechanism. The College further calls for CMS to take efforts to minimize the administrative burden placed on providers to collect and report the required performance data. These efforts should include the option, whenever possible, to collect such data directly from electronic medical record systems using accepted clinical standards; thus leveraging existing investments in and use of health information technology.

4. **Following the end of the transition period, Congress should establish a new way of updating payments to physicians that will include the following three components:**

- **Each year, MedPAC will recommend a stable and positive percentage update in the conversion factor for all services that takes into account increases in physicians' costs of delivering services as measured by the Medicare Economic Index, data on beneficiaries' access to services, private plan comparisons, workforce trends that may affect the access and quality of care received by beneficiaries, and trends in the volume and appropriateness of physician services.**
- **Each year, MedPAC will recommend an additional percentage amount, above Medicare baseline spending on physician services, to fund a physicians' quality improvement pool. This pool will provide a dedicated source of funding for physician-led programs that the HHS Secretary has determined can achieve program-wide quality improvements and cost efficiencies, such as programs to address regional variations in quality and cost of care, programs to improve care of patients with chronic diseases, and surgical outcome and measurement programs. Funds dedicated to the pool would include shared savings from program-wide improvements rather than being limited to Part B funding.**
- **Each year, MedPAC will have the option to recommend additional targeted increases in payments for certain categories of services to achieve desired policy objectives. Such increases would be provided to physicians as an "add on" to the regular payment rates, not through different conversion factors.**

ACP suggests that that the first two components—positive updates that take into account inflation, beneficiary access, and other factors and funding for the physicians' quality improvement pool—would automatically go into effect on January 1 of the following calendar year unless Congress acts to substitute different percentages.

ACP further suggests that the funds allocated to the physicians' quality

improvement pool be set aside and made available only to physicians who voluntarily participate in the pay-for-performance program and “other programs” that the Secretary has determined can result in substantial quality improvements and potential cost efficiencies. Legislation should specify the criteria to be used by the Secretary in making such determinations. Recommendations for these “other programs” can be made by an advisory group of physicians and other health care professionals, health economists, and other experts in quality measurement and improvement. Funds set aside for the physicians’ quality improvement pool, while initially coming from funds budgetarily allocated to the Medicare Part B Physician Fee Schedule, should be allowed to grow by a portion of savings in other parts of Medicare attributable to physician quality improvement efforts funded through this quality pool, including reductions in Part A expenses due to avoidable hospital admissions, reductions in non-physician Part B expenses such as reduced need for durable medical equipment, and reductions in Part D expenses due to more effective use of medications.

It is also suggested that legislation to create the physicians’ quality improvement pool should also direct the Secretary to prioritize and weight payments to physicians participating in programs funded out of the pool based upon:

- The Secretary’s determination of the potential of the specific quality improvement program to improve quality and achieve cost efficiencies.
- The effort involved on the part of the individual physician in achieving the improved quality and savings in the other parts of Medicare (e.g., the number of measures involved or the amount of work required to report on the measures).

Finally, the College suggests that MedPAC be provided the option to make recommendations on additional payment adjustments to achieve desired policy objectives. Examples of such policy objectives would be increases in payments for E/M services to increase the supply of primary care physicians or an adjustment in a particular service area in response to collaborative efforts by physicians to reduce inappropriate volume increases. These targeted adjustments should require legislation and be implemented as a separate “add-on” to payments to physicians who bill for such services, rather than as part of the annual conversion factor increase that applies to all services.

In summary, at the end of the transition period, the flawed SGR system will be replaced with a system that would provide stable and predictable updates to physicians and protect beneficiary access to care. These updates will reflect a combination of a percentage update in the dollar conversion factor as recommended by MedPAC, plus the weighted payments that a particular physician may qualify for because of their participation in programs funded out of the physicians’ quality improvement pool, plus any “add-on” payments recommended by MedPAC and authorized by Congress to achieve specified policy objectives. Furthermore, during the transition period, broad policy changes to promote improved quality and cost-savings through the system can be gradually implemented, potentially eliminating the need for employing an SGR-like target formula to control volume and expenditures. These policy changes include aligning Medicare payments with quality improvement, promoting adoption of HIT in support of quality improvement, promoting physician-guided care management and the advanced medical home, encouraging evidence-based medicine, supporting the value of primary care, and addressing mispricing of services. Finally, MedPAC can use the transition period and beyond to engage in an in-depth analysis of alternative volume or budget controls in case the control predicted from the broad policy changes do not materialize.

Conclusion

This policy paper has attempted to address problems in the current Medicare payment and care delivery system. More specifically, it proposes changes to a system modeled on the acute-care orientation of available health insurance that existed when Medicare was enacted in 1965, that will result in a more effective approach for meeting the health care needs of all patients; but particularly for meeting the needs of an aging population with increasing prevalence and incidence of chronic illness. Many of the proposals suggested in this policy paper are equally suitable to private sector health care systems. At its basic level, the guiding philosophy of these recommendations is that patient needs are best met through the delivery of patient-centered, longitudinal, coordinated care. This is the model of care that primary care providers and other physicians who provide principal care are trained and well-suited to deliver but has been historically unrecognized or under-recognized by the payment system. The College believes that the positions outlined in this policy paper will improve the quality and effectiveness of care provided in this country. Furthermore, these policies facilitate a sustainable environment in which physicians are provided adequate incentives for furnishing care appropriate to the patient population. The College looks forward to future discussions with the health care community at large concerning these recommendations with the goal of achieving consensus regarding the correct path to take to ensure a health care system that meets both the needs of the population, and the providers who deliver the required care.

Appendix A

The Medicare payment for physician services is based on the Resource-Based Relative Value Scale (RBRVS). Payments are determined by the resource costs required to provide the service. The relative value of each service is divided into 3 relative value unit (RVU) components:

1. Physician work – accounts for approximately 52 percent of the total relative value of the service, and consist of factors recognizing the time it takes to perform the service; the technical skill and physical effort; the required mental effort and judgment; and stress due to the potential risk to the patient.
2. Practice expense (PE) – accounts for approximately 44 percent of the total relative value of the service, and consists of factors recognizing the direct (e.g. equipment, supplies, and cost of administrative and clinical staff) and indirect (e.g. office rent, utilities) costs to the physician to provide the service.
3. Professional liability insurance (PLI) – accounts for approximately 4 percent of the relative value and reflects the cost of professional liability insurance to the physician.

All relative value components are adjusted for geographic differences in resource costs by a geographic practice cost index (GPCI) and the combined relative value for a service is multiplied by a standard conversion factor expressed in dollars that is established by CMS and that determines the actual fee for the service.

The payment formula is:

Payment Amount = [(Work RVU * Work GPCI) + (PE RVU * PE GPCI) + (PLI RVU * PLI GPCI)] * Conversion Factor

Appendix B

American Academy of Family Physicians
American College of Physicians

Joint Principles of the Patient-Centered Medical Home

Introduction

The American Academy of Family Physicians and the American College of Physicians have developed proposals for improving care of patients through a patient-centered practice model called the "medical home" (AAFP, 2004) or "advanced medical home" (ACP, 2006). Similarly the American Academy of Pediatrics has proposed a medical home for children and adolescents with special needs.

AAFP and ACP offer these joint principles that describe the elements of the patient-centered, physician-guided medical home.

Principles

Personal physician - each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous, and comprehensive care.

Physician-directed medical practice – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

Whole-person orientation – the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life, acute care, chronic care, preventive services, and end-of-life care.

Care is coordinated and/or integrated across all domains of the health care system (hospitals, home health agencies, nursing homes, consultants, and other components of the complex health care system), facilitated by registries, information technology, health information exchange, and other means to assure that patients get the indicated care when and where they need and want it.

Quality and safety are hallmarks of the medical home:

- Evidence-based medicine and clinical decision–support tools guide decision making.
- Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.
- Patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met.
- Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication.
- Practices go through a voluntary recognition process by an appropriate non governmental entity to demonstrate that they have the capabilities to provide patient-centered services consistent with the medical home model.

Enhanced access to care through systems such as open scheduling, expanded hours, and new options for communication between patients, their personal physician, and office staff.

Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework:

- It should reflect the value of physician and nonphysician staff work that falls outside of the face-to-face visit associated with patient-centered care management.
- It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources.
- It should support adoption and use of health information technology for quality improvement.
- It should support provision of enhanced communication access such as secure e-mail and telephone consultation.
- It should recognize the value of physician work associated with remote monitoring of clinical data using technology.
- It should allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits.)
- It should recognize case mix differences in the patient population being treated within the practice.
- It should allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting.
- It should allow for additional payments for achieving measurable and continuous quality improvements.

Appendix C

ACP's Proposed Legislation to Implement a Pilot of the Patient-Centered Medical Home[1]

SEC.___.PILOT PROJECT TO TEST THE QUALIFIED PATIENT-CENTERED MEDICAL HOME MODEL.

(a) For years 2008, 2009, and 2010, the Secretary shall establish a process creating a qualified patient-centered medical home model in accordance with the provisions of this subsection:

(1) QUALIFIED PATIENT-CENTERED MEDICAL HOME.- The 'qualified patient-centered medical home' (PC-MH) is a physician-directed practice that has voluntarily participated in a qualification process to demonstrate it has the capabilities to achieve improvements in the management and coordination of care of eligible patients, including those with multiple chronic diseases, by incorporating attributes of the Care Model.

(2) CARE MANAGEMENT MODEL.- The 'care management model' is a model that uses health information and other physician practice innovations to improve the management and coordination of care provided to patients with one or more chronic illnesses. Attributes of the model include:

(A) use of health information technology, such as patient registry systems, clinical decision support tools, remote monitoring, and electronic medical record systems to enable the practice to monitor the care provided to patients, including patients with one or more chronic diseases, who have selected the practice as their medical home (eligible patients), to provide care consistent with evidence-based guidelines, to share information with the patient and other health care professionals involved in the patient's care, to track changes in the patient's health status and compliance with recommended treatments and self-management protocols, and to report on evidence-based measures of quality, cost, and patient satisfaction measures;

(B) use of e-mail or telephone consultations to facilitate communication between the practice and the patient on non-urgent health matters;

(C) designation of a personal physician within the practice who has the required expertise and accepts principal responsibility for managing and coordinating the care of the eligible patient;

(D) arrangements with teams of other health professionals, both internal and external to the practice, to facilitate access to the full spectrum of services that the eligible patient requires;

[1]On December 9, 2006 Congress passed the Tax Relief and Health Care Act of 2006 that included a provision that authorized a Medicare Home Demonstration Project. The provision contained many of the elements suggested in this draft legislative language. ACP will work closely with CMS to ensure that the primary elements regarding the Medical Home outlined in this policy paper and draft legislative language are included in the project's implementation. ACP will also work with Congress on additional legislative approaches that would allow the demonstration project to be expanded nationwide rather than being limited to eight states and to implement a risk-adjusted bundled payment structure to practices that participate in the demonstration project.

(E) development of a disease self-management plan in partnership with the eligible patient and other health care professionals, such as nurse-educators;

(F) open access, group visits, or other scheduling systems to facilitate patient access to the practice;

(G) other process system and technology innovations that are shown to improve care coordination for eligible patients.

(3) PATIENT-CENTERED MEDICAL HOME REIMBURSEMENT METHODOLOGY.- The patient-centered medical home reimbursement methodology is a methodology to reimburse physicians in qualified PC-MH practices based on the value of the services provided by such practices. Such a methodology will be developed in consultation with national organizations representing physicians in primary care practices, health economists, and other experts. Such methodology shall include, at a minimum—

(A) recognition of the value of physician and clinical staff work associated with patient care that falls outside the face-to-face visit, such as the time and effort spent on educating family caregivers and arranging appropriate follow-up services with other health care professionals, such as nurse-educators;

(B) recognition of expenses that the PC-MH practices will incur to acquire and utilize health information technology, such as clinical decision support tools, patient registries, and/or electronic medical records;

(C) additional performance-based reimbursement payments based on reporting on evidence-based quality, cost of care, and patient experience measures;

(D) reimbursement for separately identifiable e-mail and telephone consultations, either as separately-billable services or as part of a global management fee;

(E) recognition of the specific circumstances and expenses associated with physician practices of fewer than five (5) full-time employees (FTEs) in implementing the attributes of the chronic care model and the qualified PC-MH;

(F) recognition and sharing of savings under part A, B, C, and D of the Medicare program that may result from the qualified PC-MH;

(4) REIMBURSEMENT.- Reimbursement under the Care Management reimbursement methodology for services in the qualified PC-MH practice shall be risk-adjusted and consist of the following components:

(A) a prospective, bundled, and structural practice component to cover practice expenses (e.g. equipment, maintenance, training) linked to the delivery of services under the PC-MH model. These expens-

es include the costs associated with enhanced access and communication functions, population management and registry functions, patient medical data and referral tracking functions, provision of evidence-based care, implementation and maintenance of health information technology, and reporting on performance and improvement conditions;

(B) a prospective, bundled, care coordination component that recognizes the value of physician work that falls outside the face-to-face visit. This work includes care plan oversight, e-mail and telephone consultations, extended patient medical data review (including data stored and transmitted electronically), and physician supervision of self management education and follow-up that is accomplished by non-physician personnel;

(C) a visit-based fee-for-service component to recognize visit-based services already covered in traditional fee-for-service payments;

(D) a performance-based component to recognize achievement of defined quality and efficiency goals as reflected on evidence-based quality, cost of care, and patient experience measures.

(5) RISK-ADJUSTED PAYMENT.- A 'risk-adjusted' payment is an adjustment to the prospective, bundled structural and/or care coordination payment component to take into account differences in the severity of illness; chronic disease conditions; age; dementia; and cultural, socioeconomic, and/or other health factors that affect a patient's need for care coordination and the resources and physician work required.

(6) BUNDLED PAYMENT. - A 'bundled payment' refers to a package of services and structural components required for a practice to qualify as a PC-MH and to provide the services described under the Care Coordination Model.

(7) PROSPECTIVE PAYMENT.- A 'prospective payment' is a set amount of payment per eligible patient that is provided on a regularly scheduled basis, such as on a monthly basis, in advance of and separate from payments made for face-to-face encounters with such eligible patients.

(8) PERSONAL PHYSICIAN.- A 'personal physician' is defined as a physician who practices in a qualified PC-MH and whom the practice has determined has the training to provide first contact, continuous, and comprehensive care for the whole person, not limited to a specific disease condition or organ system.

(9) ELIGIBLE BENEFICIARIES.- The term 'eligible beneficiaries' are beneficiaries enrolled under part B of the Medicare program who select a primary care or principal care physician in a qualified PC-MH as their personal physician. The Secretary may offer incentives for eligible beneficiaries to select a physician in a qualified PC-MH, such as a reduced copayment or other appropriate benefit enhancements as determined by the Secretary. The Secretary may offer specific incentives for patients with multiple chronic diseases to select care from a qualified PC-MH.

(10) PATIENT-CENTERED MEDICAL HOME QUALIFICATION.- The PC-MH qualification is a process whereby an interested practice will voluntarily submit information to an objective external private-sector entity. Such entity shall be deemed by the Secretary to make the determination as to whether the practice has the attributes of a qualified PC-MH based on standards the Secretary shall establish.

(11) PILOT PROJECT.- The term 'pilot project' means a pilot project established under subsection (b)(1).

(12) MEDICARE PROGRAM.- The term 'Medicare program' means the health benefits program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(b) PILOT PROJECT TO TEST THE QUALIFIED PATIENT-CENTERED MEDICAL HOME MODEL.—

(1) ESTABLISHMENT AND LENGTH.- For years 2008, 2009, and 2010, the Secretary shall establish a pilot project in accordance with the provisions of this section for the purpose of evaluating the feasibility, cost effectiveness, and impact on patient care of covering the patient-centered medical home model under the Medicare program.

(2) CONSULTATION.- In establishing the pilot project, the Secretary shall consult with primary care physicians and organizations representing primary care physicians and patient advocacy organizations representing patients who would be eligible for the program.

(3) PARTICIPATION.- Qualified practices shall participate in the pilot project on a voluntary basis.

(4) NUMBER AND TYPES OF PRACTICES.- The Secretary shall establish a process to invite a variety and sufficient number of practices nationwide to participate in the pilot project. Participation must be sufficient to assess the impact of the qualified PC-MH in rural and urban communities, underserved areas, and large and small states; and be designed to facilitate and include the participation of physician practices with fewer than five (5) FTEs.

(c) CONDUCT OF THE PILOT PROJECT.—

(1) PILOT PROJECT SITES.- The Secretary shall conduct the pilot project with any qualified PC-MH and eligible beneficiary.

(2) IMPLEMENTATION; DURATION.

(A) IMPLEMENTATION.- The Secretary shall implement the pilot project under this section no later than January 1, 2008.

(B) DURATION.- The Secretary shall complete the pilot project by the date that is three (3) years after the date on which the pilot project is implemented.

(d) EVALUATION AND REPORT.—

(1) EVALUATION.- The Secretary shall conduct an evaluation of the pilot project—

(A) to determine the cost of providing reimbursement for the medical home model concept under the Medicare program, and to determine savings offsets, including the impact on reducing hospital admissions and re-admissions that have been shown to be sensitive to physician management in the ambulatory setting, impact on reducing emergency room visits for nonurgent care, impact on use of pharmaceuticals covered under Medicare Part D, and use of durable medical equipment;

(B) to determine the impact on improving health outcomes and adherence to evidence-based guidelines;

(C) to determine the satisfaction of eligible beneficiaries participating in the pilot project and the quality of care received by such beneficiaries, and to determine the satisfaction of participating primary care physicians and their staff;

(D) to evaluate such other matters as the Secretary determines is appropriate.

(2) REPORT.- The Secretary shall submit to Congress periodic reports on the pilot project under this subsection.

(e) AMOUNT OF REIMBURSEMENT.- The amount of reimbursement to a qualified PC-MH participating in the pilot project shall be in a manner determined by the Secretary that takes into account the components under subsection (a)(4), the costs of implementation, additional time by participating physicians, and training associated with implementing this section;

(f) EXEMPTION FROM BUDGET NEUTRALITY UNDER THE PHYSICIAN FEE SCHEDULE.- Any increased expenditures pursuant to this section shall be treated as additional allowed expenditures for purposes of computing any update under section 1848(d).

(g) NO REQUIRMENT FOR FINANCIAL RISK.- Financial risk is any requirement that qualified PC-MHs demonstrate and commit to achieving a specified level of savings in order to participate in the program and/or a requirement that they would pay monies back to the program received from the Care Management Reimbursement Methodology if such savings targets are not achieved. Practices participating in the pilot project shall not be required to accept financial risk as a condition of participating in the pilot project established under this section.

Appendix D

The College provides the following analysis of the five volume control alternatives to the SGR to be addressed by MedPAC under the Deficit Reduction Act of 2005. This analysis is partially informed by a previous analysis of alternatives to the Volume Performance Standard perform by the Rand Corporation[101] and a recent preliminary discussion on alternatives to the SGR by MedPAC.[102] MedPAC was mandated to evaluate the effects of employing smaller volume target pools within an SGR-type volume control formula. Thus, rather than reducing updates for all procedures and affecting all physicians due to inappropriate overall physician service growth, the conversion factor and related procedure fees would be modified based on inappropriate volume growth by one or more of the following:

- **Type of service:** This would reduce updates for those specific medical services displaying inappropriate growth. For example, volume growth for visits (E/M services) and major procedures was 3.3 and 3.4 percent respectively in 2004, while volume growths for imaging and test services were 11 percent and 8.9 percent respectively.[103] Reducing the update for the specific services for which growth exceeds the identified target (e.g. imaging and tests) may provide an increased incentive for related providers and their medical specialty societies to encourage and assist practices to decrease unnecessary growth (i.e. develop practice standards). This approach continues not to differentiate between efficient and inefficient providers, and appropriate and inappropriate volume increases. More importantly, historically this approach has led to stark inequities in the payment for different services of roughly equivalent relative work value. These inequities can affect the volume of service use, and the selection by physicians to enter a given medical specialty.[104,105] This approach must also recognize that there are medical specialty groups (e.g. surgeons, radiologists) who are not totally responsible for the service growth in their area – it is significantly affected by referral patterns of other providers. Finally, it may provide a perverse incentive for providers to increase volume to make up for income loss.
- **Geographic area:** This would focus reduced updates on areas in which medical services display inappropriate growth. Focusing these volume controls on regional pools of physicians may provide a greater incentive for physicians in high-growth states to decrease unnecessary volume growth. Local medical societies and the Quality Improvement Organizations (QIOs) could assist by providing practice guidelines, educational programs, and even local physician profiles of service. This approach continues not to differentiate between efficient and inefficient providers. It will also have to recognize baseline volume and quality of care differences among the regions to be effective. It also has the potential to affect physician location decisions and possibly service access – with providers selecting to practice in those regions that have received higher fee updates.
- **Outliers:** This approach would focus volume controls on those physicians that provide a significantly higher volume of services than defined peers based on an analysis of claims data. This highly focused approach would provide a significant incentive for these outlier providers to examine their practices and reduce unnecessary service use. The successfulness of this approach would depend on CMS's ability to include

case mix/severity adjustment and quality-of-care factors in defining this outlier group. A high volume of services may be appropriate under certain circumstances. If these factors are not successfully considered, this approach would provide an incentive for providers to avoid the more complex, service-intensive patients or provide poorer quality care. It is questionable whether claims data alone will allow for these necessary differentiations. In addition, the large number of individual providers involved, each possibly having different fee schedules over time, would pose a significant administrative challenge to CMS. Finally, there remains the possibility that this approach will provide an incentive for these providers to increase volume to make up for lost income.

- **Hospital medical staff:** This approach would focus spending targets based on services provided by hospital medical staff. These staff have the organizational structure to influence member service provision. Updates would be lower for those staff that do not successfully control spending growth compared some national or regionally-adjusted target. Case mix and quality-of-care factors would need to be included in the analysis to reduce the incentive to avoid complex, service-intense patients or provide inadequate care. This approach doesn't directly differentiate between appropriate/inappropriate volume providers within a staff, it may have difficulty attributing staff membership to a provider, and it appears administratively complex. Finally, it may contribute to major changes in physician referral practices based on hospitals' success in controlling physician service volume growth and the resulting fees paid – this may create financial problems for certain facilities, and potentially lead to referrals based on payment incentive rather than which facility could best meet the patient's needs.
- **Group practices:** This approach creates an alternative voluntary spending pool of group practices that have a means of "organization, accountability, and commitment to the use of evidence-based medicine." Similar to hospital medical staffs, these groups have the ability to influence the service provision of its members. Group membership would likely require HIT and care coordination processes. Reimbursement would combine fee-for-service payments with performance-payments based on improved care management. Enhanced payments based upon meeting quality and efficiency standards would serve as an incentive to be part of this spending pool. Case mix/severity adjustment and service attribution processes would have to be developed by CMS to implement this idea. Further, the criteria for spending pool membership appears more suited for large group practices – similar to those participating in the Physician Group Practice demonstration – and may discriminate against the smaller practices that see most of the Medicare population.

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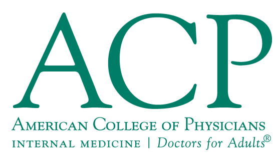

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