



Statement for the Record

American College of Physicians

Hearing before the House Energy & Commerce Subcommittee on Health

**“SGR: Data, Measures and Models; Building a Future Medicare
Physician Payment System”**

February 14, 2013

The American College of Physicians (ACP) applauds Chairman Pitts and Ranking Member Pallone for holding this hearing and for the committee’s bipartisan efforts in trying to develop a solution to Medicare’s physician payment system. ACP is the largest medical specialty organization and the second largest physician group in the United States, representing 133,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

ACP agrees with the Energy and Commerce Subcommittee on Health that it is imperative to permanently eliminate the fatally flawed Sustainable Growth Rate (SGR) formula and implement a framework for transition to value-based payment models. Therefore, we would like to reiterate and expand upon testimony provided by ACP President, David L. Bronson, on July 18, 2012 as

part of your Subcommittee hearing titled, “Using Innovation to Reform Medicare Physician Payment.”¹ In that testimony, we offered the following for the Subcommittee’s consideration:

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 We explained why it is imperative that the SGR be repealed and replaced with a framework to align payment incentives with the value of care provided to beneficiaries.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

We invite the Subcommittee members to review this earlier testimony as it is still central to ACP’s vision for how the U.S. should move beyond the flawed SGR formula. In addition, we

¹ Testimony available at: http://www.acponline.org/advocacy/where_we_stand/medicare/reform_statement7-18-12.pdf

would like to take this opportunity more specifically to respond to the focus of this hearing and the joint Energy and Commerce Committee/Ways and Means Committee SGR proposal, as released on February 7, 2013. Therefore, this statement will address the following areas:

- A phased framework to repeal the SGR and progress to better models;
- Approaches to reforming fee-for-service and transitioning to a value-based payment system;
- The role of performance assessment in a reformed health care system; and
- Specific payment and delivery reforms that can serve as the basis for a new Medicare payment system.
- A legislative pathway to achieving comprehensive payment and delivery system reforms, as outlined in the Medicare Physician Payment Innovation Act, H.R. 574.

A FRAMEWORK TO REPEAL THE SGR AND PROGRESS TO BETTER MODELS

ACP is supportive of a phased approach, along the lines of what is outlined in the February 7th Energy and Commerce and Ways and Means Committees proposal, as our own legislative framework specifically outlines a two phase approach. During the first stage, Medicare would stabilize and improve payments under the current Medicare fee schedule for at least the next five years by eliminating the SGR as a factor in establishing annual updates and by ensuring higher payments and protection from budget neutrality cuts for undervalued primary care, preventive and care coordination services. Such incentives are critical to improving care coordination and addressing historical payment inequities that contribute to severe shortages in internal medicine, family medicine, internal medicine subspecialties, neurology, and other fields. This overall sustained period of stability is needed to ensure access to care, while allowing time for Medicare

to work with physicians to test, disseminate, and prepare for adoption of new patient-centered payment and delivery models.

During stage two, physicians would be given a set timetable to transition their practices to the models that Congress and the Department of Health & Human Services (HHS) have determined to be most effective based on experience with the payment/delivery system models evaluated during stage one, leading to permanent replacements to the existing Medicare payment system. ACP supports broad adoption of models including the patient-centered medical home and the patient-centered medical home neighborhood, Accountable Care Organizations (ACOs), and other models that meet suggested criteria for value to patients. We recommend the development of different payment initiatives for different specialties and types of practice, rather than a “one-size-fits-all” model for all physicians.

REFORMING FEE FOR SERVICE AND TRANSITIONING TO VALUE-BASED PAYMENT

The February 7th joint proposal has a strong focus on reforming Medicare’s fee-for-service (FFS) payment system “to better reflect the quality of care provided.” ACP is supportive of shorter term reforms to start more physicians on the road to better payment models, and reward “early adapters” who already have taken the leadership to participate in payment programs focused on higher quality, improved patient experience, and greater value.

One of these shorter term changes that ACP is supporting is the development and recognition under Medicare fee-for-service payment policies of two new sets of CPT codes—(1) transition care following a facility-based discharge and (2) for chronic, complex care. These code sets are designed to allow physicians to report their non-face-to-face time, and the clinical staff (team) time spent on patient cases—an important element of the overall Patient Centered Medical Home (PCMH) model, which will be discussed further below. These new codes were developed by a CPT Panel workgroup and approved by the CPT Editorial Panel during their May 2012 CPT Meeting; they underwent the Relative Value Update Committee (RUC) survey process in order to be assigned recommended values; and the Centers for Medicare and Medicaid Services (CMS), in the 2013 fee schedule, assigned final valuations to the set of transition care codes and is now currently reimbursing physicians who meet the requirements of those codes. ACP is continuing to be actively engaged in this process in order to ensure that the complex, chronic care codes can also become part of the Medicare physician fee schedule in the near future.

In our previous testimony, we also outlined the following principles for developing a transitional quality improvement (QI)/value-based payment (VBP) program:

1. ACP supports in concept the idea of providing an opportunity for performance-based updates based on successful participation in an approved transitional VBP initiative that meets standards relating to the effectiveness of each program, building on successful models in the public and private sectors.

2. Transitional performance-based update programs should be incorporated into a broader legislative framework to stabilize payments and transition to new models. This is important so that physicians and the Medicare program have a clear “destination” and pathway to achieving it, even as physicians begin the journey through the transitional VBP initiative.

3. Any transitional performance-based payment updates should be in addition to a higher “floor” on payments for undervalued primary care/preventive/and coordinated care services, such as that specified by the Medicare Physician Payment Innovation Act, H.R. 574. This is important to address the continued under-valuation of these critically important services, even as payments also begin to reflect physician participation in the transitional VBP initiative.

4. The transitional performance-based payment program should include models for which extensive data and experience already exist, and that can more readily be scaled up for broader adoption by Medicare. Specifically, participation in the PCMH and PCMH-N models, as determined by practices meeting designated standards through an accreditation body and/or standards to be developed by the Secretary with input from the medical profession. Other established models that have demonstrated the potential to improve care coordination, such as Accountable Care Organizations (ACOs), bundled payments, and global primary care payments should also be considered for inclusion in a transitional VBP program. In addition, physicians who agree to incorporate programs,

like ACP's High Value, Cost-Conscious Care Initiative², into their clinical practice through shared decision-making with patients, might also qualify for a transitional VBP payment.

5. Existing QI/VBP payment models—the Medicare PQRS, e-RX, and meaningful use programs—if included in a transitional performance-based payment update program, should be improved to harmonize measures and reporting to the extent possible and to establish a consistent incentive program across all-elements. Efforts should also be made to align them with specialty boards' maintenance of certification programs.
6. Transitional performance-based updates could be tiered so that programs that provide coordinated, integrated and patient-centered care get a higher performance update than less robust programs built on the current, siloed fee-for-service system.
7. CMS will need to improve its ability to provide “real time” data to participating physicians and practices. A method will need to be created to map practice-level participation in a transitional QI/VBP initiative to the individual physician updates under the Medicare Physician Fee Schedule.

THE ROLE OF PERFORMANCE ASSESSMENT IN A REFORMED HEALTH CARE SYSTEM

Overall, ACP supports payment and delivery system reforms that promote high-value care, improved patient experiences, better population health, improved patient safety, and reduced per

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

capita spending. Further, as indicated above, ACP supports the use of existing QI programs such as Medicare PQRS, e-RX, and meaningful use programs. However, we do share the significant concerns expressed by many organizations that these programs are burdensome and currently not well-aligned with one another, with private payer initiatives, or with specialty boards' maintenance of certification programs. In the College's recent comments on the notice of proposed rulemaking from both CMS³ and ONC⁴ on Stage 2 Meaningful Use, we highlighted our support of the government's vision to use EHRs and health IT to improve care, but note that more needs to be done to align the measures across all of the initiatives currently underway including CMS PQRS and e-prescribing programs. While CMS has made strides in aligning the measures, at a high level, the technical requirements within each of the programs are different enough that dual processes must be undertaken. We also noted our concern about the approach that CMS has taken when structuring the penalty phases of the EHR Incentive Programs, e-Prescribing Incentive Program, and PQRS by requiring that the activity to avoid the penalty must be completed in the prior year or even two years in advance of the legislated deadline. As a result, CMS has effectively moved up the legislated deadline beyond what the market can bear. It is important to note though that CMS has expressed interest in continuing to better align their programs through the feedback they have sought via the 2013 physician fee schedule proposed rule and a recent request for information (RFI), which is soliciting ways in which physicians might use the clinical quality measures (CQM) data reported to their specialty boards, specialty societies, regional health care quality organizations or other non-federal reporting programs to also report under PQRS, as well as the Electronic Health Record (EHR) Incentive Program. ACP encourages the Subcommittee to take these efforts into account, and perhaps consider

³ These comments can be found at:

http://www.acponline.org/advocacy/where_we_stand/health_information_technology/cms_nprm.pdf.

⁴ These comments can be found at:

http://www.acponline.org/advocacy/where_we_stand/health_information_technology/onc_nprm.pdf.

encouraging and facilitating these improvements before creating an alternative quality reporting program.

ACP also shares the concern expressed by the Energy and Commerce and Ways and Means Majority about CMS's ability to provide timely data to participating physicians and practices, which is critical to enable physicians to make adjustments to improve patient care. However, ACP is encouraged that the Comprehensive Primary Care Initiative (CPCI), as well as other initiatives being conducted by the CMS Innovation Center, include a commitment by CMS to share data in a more frequent and consistent manner and hope that this will provide an opportunity to learn the most efficient and effective means of regular data sharing with practices.

In 2012, ACP released a paper titled, *The Role of Performance Assessment in a Reformed Health Care System*,⁵ in which we laid out a series of policy statements focused on the evolving roles of performance assessment efforts within the realm of medical care, including programs linking payments to reporting and performance on specific quality measures—an area of significant focus in the February 7th joint proposal. Therefore, we offer for the Subcommittee's consideration some key highlights of ACP's policy with regard to performance assessment efforts that are linked to payment.

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

- Be integrated into innovative delivery system reforms such as the patient-centered medical home (PCMH) and other payment reform efforts that promote systems-based collaboration and health care delivery;

⁵ This paper can be accessed at:
http://www.acponline.org/advocacy/where_we_stand/policy/performance_assessment.pdf.

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

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

- A 2006 literature review by Petersen et al. concluded that 12 of 15 studies of physician and provider group-level P4P programs yielded partial or positive effects on quality measures.⁶
- A more recent literature review concluded that while results vary significantly based on measures and other program design factors, pay-for-performance efforts improve quality of care by about 5%.⁷
- Another review of performance assessment initiatives failed to find substantial evidence supporting or not supporting pay-for-performance effectiveness and expressed concern that such programs did little to address for selection bias. The authors suggested that quality improvement-based payment models should be carefully designed prior to implementation to ensure effectiveness.^{8,9}
- A study of a hypertension care performance program conducted in the United Kingdom found that even significant financial incentives did not lead to better quality. The study's authors speculated that most doctors may have already been delivering the recommended services, limiting the potential for large gains.¹⁰

⁶ Petersen L. et al. Does Pay-for-Performance Improve Quality of Health Care? *Ann Intern Med.* 2006;145:262-272.

⁷ Van Herck P, De Smedt D, Annemans L, Remmen R, Rosenthal MB, Sermeus W. Systematic review: Effects, design choices, and context of pay-for-performance in health care. *BMC Health Serve Res.* 2010 August 23; 10: 247. Accessed at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2936378/?tool=pubmed> on June 9, 2011.

⁸ Lowes R. Little Evidence For or Against Pay-for-Performance Plans. *Medscape News.* September 7, 2011. Accessed at <http://www.medscape.com/viewarticle/749303> on October 11, 2011.

⁹ Scott A et al. The effect of financial incentives on the quality of health care provided by primary care physicians. *The Cochran Library.* September 7, 2011.

¹⁰ Abelson R. Financial Rewards for a Doctor's Care. *NY Times.* January 26, 2011. Accessed at <http://prescriptions.blogs.nytimes.com/2011/01/26/financial-rewards-for-a-doctors-care/> on May 4, 2011.

- A review of physician cost-profiling initiatives in Massachusetts found that the measures produced inaccurate conclusions and that the average misclassification rate for internists was 25%.¹¹
- Additionally, a comprehensive literature review found pay-for-performance-connected improvement in the quality of diabetes care management but little effect on acute care effectiveness.¹²

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

- The HealthSpring/Sumner Medical Group pay-for-quality initiative centered on Medicare Advantage-enrolled patients and provided free nursing assistance to engage patients between office visits and facilitate disease management. Participating doctors who met quality targets were paid a 20% performance bonus. After the disease management and performance bonuses were provided, “patient outcomes improved across the board” and more preventive screenings were performed. Patient outcome improvements of at least 30% were achieved for diabetes control, prostate and breast cancer screenings, and cholesterol screenings.¹³¹⁴
- Evidence also demonstrates that systems-based payment reforms can improve patient experience. A review of a California performance incentive program showed that

¹¹ Adams JL, Mehrotra A, Thomas JW, McGlynn EA. Physician Cost Profiling-Reliability and risk of Misclassification. *NEJM*. 2010;362:1014-1021.

¹² Van Herck P, De Smedt D, Annemans L, Remmen R, Rosenthal MB, Sermeus W. Systematic review: Effects, design choices, and context of pay-for-performance in health care. *BMC Health Serve Res*. 2010 August 23; 10: 247. Accessed at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2936378/?tool=pubmed> on June 9, 2011.

¹³ Glendinning D. “Pay-for-quality” pilot project gets high marks. *American Medical News*. July 24/31, 2006. Accessed at <http://www.ama-assn.org/amednews/2006/07/24/gvsb0724.htm> on February 7, 2011.

¹⁴ Ward G. Managed-care company sees benefits of pay-for-performance. *The Tennessean*. February 27, 2008. Accessed at <http://library.corporate-ir.net/library/22/226/226354/items/324480/Tennessean2%20-%20P4Q%20results%20-%202.08.pdf> on February 7, 2011.

adherence to physician communication, care coordination, access to care, and office staff interaction measures improved greatly, demonstrating that performance assessment–based payment may improve the patient–physician relationship.¹⁵

- According to CMS, the number of physicians reporting on PQRS quality measures has expanded (although many physicians do remain frustrated with the program) and evidence indicates that recommended care is being delivered more frequently since the program’s launch.¹⁶ Among the reported quality improvements, CMS found that in 2009, 93% of physicians told diabetes patients about potential eye-related complications, an increase of 41% compared with 2007 reports.¹⁷

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

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

Potential rewards should be:

¹⁵ Rodriguez HP, Von Glahn T, Elliot MN, Rogers WH, Safran DG. The Effect of Performance-Based Financial Incentives on Improving Patient Care Experiences: A Statewide Evaluation. *J Gen Intern Med.* 2009;24(12):1281-1288. Accessed at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2787940/?tool=pubmed> on May 3, 2011.

¹⁶ O’Kane M. The Acute Need for Delivery System Reform. NCQA. Power Point Presentation, March 9, 2009. Accessed at http://www.ehcca.com/presentations/pfpsummit4/okane_1.pdf on September 15, 2010.

¹⁷ Centers for Medicare and Medicaid Services. Medicare News: CMS data show gains in key quality indicators through Physician Quality Reporting system and ePrescribing Incentive Program. CMS Office of Media Affairs press release. April 19, 2011.

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

Fourth, physicians should have a key role in determining methods used to develop and select measures (including the measurement evidence and any evidence grading methods used), collect data from physicians, aggregate and score performance, and report performance data internally and publicly. These processes should be transparent so that physicians, consumers, and payers know that methods, expectations, rationale, and results are valid and reliable. Sponsors of programs that link payment to assessment of performance, including CMS, should collaborate

with physicians who are potential participants regarding program implementation, educate physicians about the potential risks and rewards inherent in program participation, and immediately inform physicians of any changes in program requirements and evaluation methods and newly identified risks and rewards. CMS and other payers should inform patients at the time of enrollment of such efforts, potential risks, and physician participation.

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

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

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

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

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

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

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

The Patient Centered Medical Home

As was outlined in our testimony before this Subcommittee on July 18, 2012, **ACP strongly believes that the PCMH model will be ready to be a part of a new, value-based health care payment and delivery system, particularly given all of the federal, state, and private sector**

activity, as well as ongoing efforts to address the challenges to those models. Under this model, practices that provide comprehensive primary care to their patients will be:

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

- Delivery of patient-centered care, which could be determined by recognition from a national “patient-centered medical home” program such as the Accreditation Association for Ambulatory Health (AAAHA), the Joint Commission, NCQA, URAC, or a state-based accreditation program; and/or by criteria developed by the Secretary of HHS that may pull from the national programs, current CMS Innovation Center Initiatives (e.g., the Comprehensive Primary Care Initiative), or other sources.
- Delivery of high quality and efficient care – potentially looking to the core measures recommended by the PCMH Evaluators’ Collaborative established by the Commonwealth Fund¹⁸, which includes measures in the following domains: clinical quality (process and outcome), utilization, cost and patient experience of care.
- Delivery of coordinated care, which could be determined, in part, by recognition of non-primary care practices through the Specialty Practice Recognition program currently being developed by NCQA for release in spring, 2013. This program will assess a specialty/subspecialty practice’s ability to integrate/coordinate with primary care practices, and engage in processes to deliver patient centered care, improved patient access, improve care quality and implementation of “meaningful” health information technology.

¹⁸ Rosenthal MB. Abrams MK. Biton A. et. al. Recommended core measures for evaluating the patient-centered medical home: Cost, utilization and clinical quality. Commonwealth Fund. May 2012. http://www.commonwealthfund.org/~media/Files/Publications/Data%20Brief/2012/1601_Rosenthal_recommended_core_measures_PCMH_v2.pdf

- In addition, the Agency for Healthcare Research and Quality (AHRQ) has available an atlas of care coordination measures;¹⁹ and
- The National Quality Forum (NQF) has established a platform for the development of care coordination measures consisting of a set of domains, principles and preferred practices.²⁰

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

The Patient Centered Medical Home Neighbor

¹⁹ Agency for Healthcare Research and Quality. Care Coordination and Measures Atlas. Accessed at <http://www.ahrq.gov/qual/careatlas/>

²⁰ NQF. Preferred practices and performance measures for measuring and reporting care coordination. 2010. Accessed at http://www.qualityforum.org/Publications/2010/10/Preferred_Practices_and_Performance_Measures_for_Measuring_and_Reporting_Care_Coordination.aspx

As discussed in our previous testimony, the importance of involvement of the “medical neighborhood” to the ultimate success of the PCMH model to fully achieve its quality and efficiency goals has been highlighted by recent policy papers by ACP²¹ and the Agency for Healthcare Quality and Research (AHRQ).²² The NCQA, acknowledging the importance of the involvement of the “medical neighborhood” in support of PCMH (primary) care, is in the process of finalizing a “medical neighbor” recognition process that identifies specialty and subspecialty practices that engage in activities supportive of the PCMH model—with particular emphasis on care coordination and integration. Several areas of the country are also involved in testing and implementing the PCMH neighborhood concept, including: the Vermont Blueprint for Health program, the Texas Medical Home Initiative, and programs in both the Denver and Grand Junction areas of Colorado.

Accountable Care Organizations (ACOs)

Substantial evidence toward ACO development throughout the country is already occurring with the implementation of the Pioneer (32 approved programs-UPDATE) and Medicare Shared Savings Programs (132 approved programs) within the public sector, and the report of over 220 ACOs being developed across 45 states and the District of Columbia within the private sector – an increase of 38 percent in the private sector within only the past 6 month.²³ The selected ACOs operate in a wide range of areas of the country and almost half are physician-driven

²¹ American College of Physicians. The patient centered medical home neighbor: The interface of the patient centered medical home with specialty/subspecialty practice. 2010. Accessed at http://www.acponline.org/acp_policy/policies/pcmh_interface_subspecialty_practices_2010.pdf

²² Agency for Healthcare Research and Quality (AHRQ). Coordinating care in the medical neighborhood: Critical components and available mechanisms. 2011. Available at http://pcmh.ahrq.gov/portal/server.pt/community/pcmh_home/1483/what_is_pcmh.

²³ Muhlestein D et. al. Growth and Dispersion of Accountable Care Organizations: June 2012 Update. Leavitt Partners. Accessed at <http://leavittpartners.com/wp-content/uploads/2012/06/Growth-and-Dispersion-of-ACOs-June-2012-Update2.pdf>

organizations serving fewer than 10,000 beneficiaries, demonstrating that smaller organizations are interested in operating as ACOs. One example of these private sector programs is the Alternative Quality Contract offered through BCBS of Massachusetts, which has shown both improved quality and a downward bending of the cost growth curve after only one year of implementation.²⁴ The growth of the ACO model has led NCQA (released) and URAC (in process) to develop an ACO recognition process that helps ensure that these organizations engage in processes that promote patient centered, high quality, efficient integrative care.

Other Reform Programs

In our previous testimony, we also discussed two additional promising payment models: the Comprehensive Global Payment Model²⁵ and the “Prometheus” Evidence-informed Case Rate (ECR) Model.

In addition to the programs noted above, ACP’s High Value, Cost-Conscious Care Initiative (HVCCC), which includes clinical, public policy, and educational components,²⁶ was designed to help physicians and patients understand the benefits, harms, and costs of an intervention and whether it provides good value, as well as to slow the unsustainable rate of health care cost increases while preserving high-value, high-quality care.

²⁴ Song B, Safran D, et. al. Health Care Spending and Quality in Year 1 of the Alternative Quality Contract. *N Engl J Med* 2011; 365:909-918 September 2011. Accessed at <http://www.nejm.org/doi/full/10.1056/NEJMSa1101416#t=articleTop>.

²⁵ Goroll AH, Berenson RB, Schoenbaum SC, Gardner LA. Fundamental reform of payment for adult primary care: comprehensive payment for comprehensive care. *J Gen Intern Med.* 2007;22:410-415. Summary available at http://www.commonwealthfund.org/~media/Files/Publications/In%20the%20Literature/2007/Mar/Fundamental%20Reform%20of%20Payment%20for%20Adult%20Primary%20Care%20%20Comprehensive%20Payment%20for%20Comprehensive%20Care/Goroll_fundamentalreformpaymentadultprimarycare_1014_itl%20pdf.pdf.

²⁶ Additional information can be found at: http://www.acponline.org/clinical_information/resources/hvccc.htm.

Based on the evidence cited above, and in our earlier testimony before this Subcommittee, ACP recommends that Congress look to the PCMH as being one of the most promising models for improving outcomes and lowering costs; learning from the extensive and growing experience in the private sector and from the new CPCi and Advanced Primary Care Initiatives in CMS as well as from private sector recognition and accreditation programs. We are confident that the PCMH model, the related PCMH-Neighborhood, and ACOs—in conjunction with efforts by ACP and other physician membership organizations to provide guidance to physicians on high-value, cost-conscious care—can be scaled up in the more immediate future, as part of a transition to better payment and delivery systems to replace the SGR and pure fee-for-service. ACP recognizes that a one-size fits all approach is not ideal and therefore believes that moving toward alternative delivery system and payment models can be done in parallel with reforming a post-SGR fee-for-service system to incentivize improved care coordination and better reflect the quality of care provided, particularly for those physicians and specialties for which FFS is better suited.

A LEGISLATIVE PATHWAY TO ACHIEVING COMPREHENSIVE PAYMENT AND DELIVERY SYSTEM REFORMS

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

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

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

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

SUMMARY AND CONCLUSION

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

1. Congress and the Medicare program should work with ACP and other physician organizations to develop a transitional value-based payment initiative, which would

provide higher updates to physicians who successfully participate in a transitional VBP initiative, consistent with the principles discussed above.

2. Congress should look to the PCMH as being one of the most promising models for improving outcomes and lowering costs; learning from the extensive and growing experience in the private sector and from the new CPCi and Advanced Primary Care Initiatives in CMS as well as from private sector recognition and accreditation programs. We are confident that the PCMH model, the related PCMH-Neighborhood, and ACOs—in conjunction with efforts by ACP and other physician membership organizations to provide guidance to physicians on high-value, cost-conscious care—can be scaled up in the more immediate future, as part of a transition to better payment and delivery systems to replace the SGR and pure fee-for-service.
3. Medicare should make improvements in the existing Medicare physician fee schedule to create incentives for care coordination and improved quality. ACP recognizes that a one-size fits all approach is not ideal and therefore believes that moving toward alternative delivery system and payment models can be done in parallel with reforming a post-SGR fee-for-service system to incentivize improved care coordination and better reflect the quality of care provided, particularly for those physicians and specialties for which FFS is better suited.
4. Congress should require that measures of the quality and value of care used by Medicare and potentially other payers in a reformed delivery and payment system be evaluated through and collected in a consistent, reliable, feasible, and transparent manner; thoroughly tested prior to full implementation to the extent possible; and applied as part of overall payment and delivery system reform emphasizing collaborative system-based health care. Additionally, to the extent that such reforms include linking payments to

reporting and performance on specific quality measures, such incentives must take into consideration the conflicting evidence on the effectiveness of performance assessment-based payment programs and potential adverse consequences.

5. The Energy & Commerce Committee should report legislation to repeal the SGR, provide for stability in payments for all physicians, higher updates for undervalued care coordination, preventive, and primary care services, and transition to new payments and delivery models, working from the bipartisan Medicare Physician Payment Innovation Act, H.R. 574.