

STATEMENT FOR THE RECORD
OF THE
AMERICAN COLLEGE OF PHYSICIANS
TO THE
HOUSE COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON HEALTH

Hearing on Options to Improve Quality and Efficiency Among Medicare Physicians

May 10, 2007

The American College of Physicians (ACP) -- representing 120,000 physicians and medical students -- is the largest medical specialty society and the second largest medical organization in the United States. Internists provide care for more Medicare patients than any other medical specialty.

ACP strongly believes that Medicare and other health plans should be reformed to advance the patient-centered medical home, a model of health-care delivery that has been proven to result in better quality, more efficient use of resources, reduced utilization, and higher patient satisfaction. The College greatly appreciates Subcommittee Chairman Stark and Ranking Member Camp convening today's hearing which will provide an opportunity to focus on key advantages of the patient-centered medical home.

In March, 2007, ACP, the American Academy of Family Physicians, American Academy of Pediatrics, and the American Osteopathic Association released a joint statement of principles that defines the characteristics of a patient-centered medical home. These four organizations represent 333,000 physicians and medical students. The joint principles are attached to this statement.

As described in the joint principles, a patient-centered health care medical home is a physician practice that has gone through a voluntary qualification process to demonstrate that it:

- Provides continuous access to a personal primary or principal care physician who accepts responsibility for treating and managing care for the whole patient through an a patient-centered medical home, rather than limiting practice to a single disease condition, organ system, or procedure,
- Supports the specific characteristics of care that the evidence shows result in the best possible outcomes for patients.
- Recognizes the importance of implementing systems-based approaches that will enable physicians and other clinicians to manage care, in partnership with their patients, and to engage in continuous quality improvement,

- Introduces transparency in consumer decision-making and accountability for getting better results by reporting on evidence-based quality, cost and patient experience measures of care.

The patient-centered medical home has the support of a broad collaborative of physician organizations, employers and other stakeholders. The Patient-Centered Primary Care Collaborative, of which ACP is a founding member, has submitted a statement to the record of this hearing that endorses the patient-centered medical home. The Collaborative includes employers that collectively employ more than 50 million Americans and primary care organizations that represent the physicians that provide primary care to the vast majority of Americans. Representatives of consumer organizations have been participating in the Collaborative's ongoing discussions and are expected to endorse and join the Collaborative in the near future. The Collaborative's joint statement of support for the patient-centered medical home has been submitted separately for the record of this hearing.

Evidence that a Patient-Centered Medical Home Will Improve Quality and Lower Costs

There is substantial and growing evidence that a health care system built upon a foundation of patient-centered medical home will improve outcomes, result in more efficient use of resources, and accelerate systems-based improvements in physician practices.

According to an analysis by the Center for Evaluative Clinical Sciences at Dartmouth, States that relied more on primary care:

- have lower Medicare spending (inpatient reimbursements and Part B payments),
- lower resource inputs (hospital beds, ICU beds, total physician labor, primary care labor, and medical specialist labor)
- lower utilization rates (physician visits, days in ICUs, days in the hospital, and fewer patients seeing 10 or more physicians), and
- better quality of care (fewer ICU deaths and a higher composite quality score).¹

Starfield's review of dozens of studies on primary-care oriented health systems found that primary care is consistently associated with better health outcomes, lower costs, and greater equity in care.

- Primary care oriented countries, such as Australia, Canada, New Zealand, and the United Kingdom are rated higher than the United States on many aspects of care, including the public's view of the health care system not needing complete rebuilding, finding that the regular physicians' advice is helpful, and coordination of care. "The United States rates the poorest on all aspects of experienced care, including access, person-focused care over time, unnecessary tests, polypharmacy, adverse effects, and rating of medical care received."
- An orientation to primary care reduces sociodemographic and socioeconomic disparities.

¹ Dartmouth Atlas of Health Care, Variation among States in the Management of Severe Chronic Illness, 2006

- Overall, primary care-oriented countries have better care at lower cost.
- Within the United States, adults with a primary care physician rather than a specialist had 33 percent lower cost of care and were 19 percent less likely to die, after adjusting for demographic and health characteristics.
- Primary care physician supply is consistently associated with improved health outcomes for conditions like cancer, heart disease, stroke, infant mortality, low birth weight, life expectancy, and self-rated care.
- In both England and the United States, each additional primary care physician per 10,000 population is associated with a decrease in mortality rates of 3 to 10 percent.
- In the United States, an increase of one primary care physician is associated with 1.44 fewer deaths per 10,000 population.
- The association of primary care with decreased mortality is greater in the African-American population than in the white population.²

Another analysis found that when care is managed effectively in the ambulatory setting by primary care physicians, patients with chronic diseases like diabetes, congestive heart failure, and adult asthma have fewer complications, leading to fewer avoidable hospitalizations.³

Patient-centered primary care will also accelerate the transformation of physician practices by making the business case for physicians, including those in small practice settings, to acquire and implement health information technologies and other systems-based improvements that contribute to better outcomes.

“Patient-centeredness, shared decision-making, teaming, group visits, open access, outcome responsibility, the chronic care model, and disease management are among the proposals intended to transform medical practice. The electronic health record’s greatest promise arguably lies in the support of these initiatives...”⁴

Reform of Medicare Payment Policies to Support a Patient-Centered Medical Home

Many physicians would like to redesign their own practices to become a patient-centered medical home, but are discouraged by doing so by Medicare payment policies that reward physicians for the volume of services rendered on an episodic basis, rather than for comprehensive, longitudinal, preventive, multi-disciplinary and coordinated care for the whole person. The authors of a recent survey found that “a gap exists between knowledge and practice—between physicians’ endorsement of patient-centered care and their adoption of practices to promote it. Physicians reported several barriers to their adoption of patient-centered care practices, including lack of training and knowledge (63 percent) and costs (84 percent). Education, professional and technical assistance, and financial incentives might facilitate broader adoption of patient-centered

² Starfield, presentation to The Commonwealth Fund, Primary Care Roundtable: Strengthening Adult Primary Care: Models and Policy Options, October 3, 2006

³ Commonwealth Fund, Chartbook on Medicare, 2006

⁴ Sidorov, Health Affairs, Volume 25, Number 4, 2006

care practices. With the right knowledge, tools, and practice environment, and in partnership with their patients, physicians should be well positioned to provide the services and care that their patients want and have the right to expect.”⁵

Congress should enact legislation that leads to a fundamental redesign of Medicare payment policies to support a patient-centered medical home. Such redesign should include the following five key elements:

1. Eliminate the SGR and provide stable, positive and predictable updates combined with performance-based additional payments for reporting on quality measures relating to care coordination and patient-centered care.

The sustainable growth rate (SGR) formula must be eliminated. Unless Congress acts, the SGR will cause a cut of almost 10 percent in physician services in 2008, and a cut of almost 40% over the next several years. Cuts of this magnitude will make it impossible for physicians to invest in the systems and technologies needed to become a patient-centered medical home, will accelerate the trend of physicians turning away from primary care medicine, and create access problems as primary care physicians leave medicine in increasing numbers and fewer young physicians go into primary care.

Specifically, Congress should *enact legislation that would lead to elimination of the SGR* and replace it with an alternative update framework that will:

- Assure stable, positive and predictable baseline updates for all physicians.
 - Set aside funds for a separate physicians’ quality improvement pool that would allocate dollars to support voluntary, physician-initiated programs that have the greatest potential impact on improving quality and reducing costs, and allow for a portion of savings in other parts of Medicare (such as reduced hospital expenses under Part A) that are attributable to programs funded out of this pool to be allocated back to the physicians’ quality improvement pool. Congress should direct that priority be given to those applications for funding under the quality pool that are most likely to improve care quality and efficiency by accelerating and supporting the ability of physicians to organize care processes to deliver patient-centered services through a medical home. Priority would also be given to programs that address regional variations in quality and cost of care. Our specific recommendations for revamping Medicare’s Physician Quality Reporting Initiative are presented below.
- 2. Revamp the Physicians Quality Reporting Initiative to focus on clinical and structural measures related to coordination of chronic diseases and other “high impact” interventions.*

The PQRI pays physicians a “performance bonus” of up to 1.5% for reporting on measures of care that are applicable to their specialty and practice. Physicians will receive the same reporting bonus without regard to the impact of the measures on quality or cost of care, the costs to the practice associated with reporting on the measures, or the number of measures that apply to their specialty or practice. ACP believes that Congress should redesign the PQRI to:

⁵ Commonwealth Fund study, "[Adoption of Patient-Centered Care Practices by Physicians: Results from a National Survey](#)" (*Archives of Internal Medicine*, Apr. 10, 2006)

- Assure that funding for the program is sufficient to offset the costs to physicians for reporting on the measures.
 - Focus on structural (health information technologies) measures associated with patient-centered care through a medical home.
 - Place priority on clinical measures for chronic diseases.
 - Pay physicians on a “weighted basis” for reporting on structural and clinical measures that will have the greatest potential impact on quality and cost, so that physicians who are reporting on measure that will have a greater impact, or that require a greater investment in health information technologies, will receive a proportionately higher payment than physicians who report on lower impact measures that do not require a substantial investment in HIT.
3. *Create incentives for physicians to acquire the health information technologies and systems to support patient-centered care in a medical home.*

Medicare should create payment incentives to encourage physicians to acquire specific structural enhancements and tools that are directly related to care management in the ambulatory setting, such as patient registry systems, secure email, and evidence based clinical decision support, which can be measured and reported on. (That is, paying doctors for acquiring the systems needed to become medical homes). This recommendation would be implemented by the National Health Information Incentive Act of 2007, H.R. 1952, introduced on April 19, 2007 by Representatives Charles Gonzalez and Phil Gingrey. The bill has been referred to the Ways and Means Committee. ACP urges the Health Subcommittee and full Committee to report the bill favorably. This legislation is based on the Bridges to Excellence program, which uses a scoring system that provides higher payments for having a fully functional EMR system than having a very basic registry system, and a similar scoring model, with tiered payments, could be used for Medicare:

- Tier 1 – the reporting on evidence-based standards of care; the maintenance of patient registries for the purpose of identifying and following up with at-risk patients and provision of educational resources to patients;
- Tier 2 – the use of electronic systems to maintain patient records (EHRs); the use of clinical-decision support tools; the use of electronic orders for prescriptions and lab tests (e-prescribing), the use of patient reminders; use of e-consults (communication between patient/physician or other provider) when an identifiable medical service is provided; and managing patients with multiple chronic illnesses; [Practices can qualify that utilize three or more incentives].
- Tier 3 - whether a practice’s electronic systems interconnect and whether they are “interoperable” with other systems; whether it uses nationally accepted medical code sets and whether it can automatically send, receive and integrate data such as lab results and medical histories from other organizations’ systems.

Such tiered payments for systems improvements could either be in the form of a tiered “add on” to the Medicare office visit payment that would increase as the practice achieves a higher tier, or in the form of a la carte coding and payment mechanisms to allow physicians to report when they use individual elements inherent to patient-centered care, such as use of a registry and use of clinical decision support. Congress should allocate funding to pay physicians when they appropriately use and report these tools and/or direct HHS to exempt the expenditures associated with these tools from the budget neutrality requirement pertaining to payments for Medicare Part B services.

4. Provide oversight of the Medicare Demonstration Project on Patient Centered Medical Homes

The Tax Relief and Health Care Act of 2006 mandates that CMS implement a demonstration project of a Medicare medical home in up to eight states nationwide. ACP supports and appreciates Congress's support for the Medicare Medical Home demonstration project but urges this Subcommittee to exercise oversight to assure that CMS implements it in a timely manner and provides sufficient funding for physician practices that choose to participate.

5. Require that CMS develop and implement additional changes in Medicare payment methodologies to support patient-centered primary and principal care for (a) practices that qualify as patient-centered medical homes and (b) practices that are not fully qualified as PC-MHs but are able to provide defined services, supported by systems improvements, associated with patient-centered care.

Physicians in practices that qualify as a patient-centered medical home should be given the option (based on standards to be established in statute) of being paid under an alternative to traditional Medicare fee-for-service. This alternative model would consist of the following:

- Bundled, severity-adjusted care coordination fee paid on a monthly basis for the physician and non-physician clinical staff work required to manage care outside a face-to-face visit and the health information technology and system redesign incurred by the practice.
- This bundled payment would be combined with per visit FFS payment for office visits and performance based bonus payments based on evidence based measures of care

Yesterday, Representative Gene Green and Senator Blanche Lincoln introduced the Geriatric Care Improvement Act of 2007, which will create a new Medicare benefit for geriatric assessments of patients with multiple chronic disease and/or dementia and monthly care management fees to physicians who enter into an agreement with HHS to provide ongoing care coordination services to such patients. ACP strongly supports this bill and urges that it be reported out favorably by the Subcommittee.

For physicians who are not practicing in a qualified patient-centered medical home, Medicare should be directed to pay separately for the following CPT/HCPCS codes that involve coordinating patient care for which Medicare currently does not make separate payment.

- Physician supervision of nurse-provided patient self-management education
- Physician review of data stored and transmitted electronically, e.g. data from remote monitoring devices
- Care plan oversight of patient outside the home health, hospice, and nursing facility setting—this is reported through CPT 99340, which is described in item #3, “Create a specific, new alternative and optional patient centered medical home benefit...”
- Anticoagulant therapy management
- New physician team conference codes
- New telephone service codes (scheduled to appear in CPT in 2008)

Conclusion

The 110th Congress has an historic opportunity to join with ACP, other physician organizations, employers, and health plans to redesign the American health care system to deliver the care that patients need and want, to recognize the value of care that is managed by a patient's personal physician, to support the value of primary care medicine in improving outcomes, and to create the systems needed to help physicians deliver the best possible care to patients. The College's policy recommendations and implementation road map are offered today as a comprehensive plan for Medicare to realign payment policies to support comprehensive, coordinated, and longitudinal care for beneficiaries through a physician-directed, patient-centered medical home.