



Statement for the Record
American College of Physicians
25 Massachusetts Ave, NW Washington, DC 20001
Senate Finance Committee Roundtable Discussion
Medicare Physician Payments: Perspectives from Physicians
July 11, 2012

The American College of Physicians (ACP) applauds Chairman Baucus and Ranking Member Hatch for holding this roundtable discussion and for the committee's bipartisan efforts in trying to develop a solution to Medicare's physician payment system, which has been a burden on physician practices for over a decade. We share your view that "we need physicians to suggest changes to the Medicare physician payment system that will spur high quality, high value care." In that spirit, ACP's statement will focus primarily on how Congress could build upon physician-led initiatives to transition to a new value-based payment and delivery system. We will discuss delivery and payment reform models that we view as the most promising in any post-Sustainable Growth Rate (SGR) environment, as well as noting the kinds of structural and reporting capabilities, payment incentives, and measurement systems needed for them to work.

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

1. Discussion of why fundamental payment and delivery system reform is imperative.
2. Principals for transitioning to value based payment initiative
3. Analysis of specific payment and delivery system reform models, in both the private and public sectors, which could be the basis for transitioning to fundamental reform.
4. Developing payment policies to support physician-led programs to promote high-value care
5. Improving Medicare fee-for-service to support care coordination
6. Leveraging and improving existing quality improvement/value-based payment programs
7. Suggestions on a legislative framework to transition to better payment models

WHY FUNDAMENTAL PAYMENT AND DELIVERY SYSTEM REFORM IS IMPERATIVE

Fundamental reform of the Medicare payment system is long overdue, including repeal of the SGR. For more than a decade, the SGR has caused annual scheduled cuts in payments to physicians, endangering access to care, destabilizing the program, and creating barriers for physicians to develop the practice capabilities to improve clinical quality and effectiveness. Although Congress usually over-rides the scheduled cut with a freeze of current payment rates or a small positive update, such short-term "patches" have not offered the stability needed to ensure stability and access, nor have they provided a roadmap to transitioning to better payment models—while adding hundreds of billions of dollars to the cost of full SGR repeal.

Further, the current Medicare payment system contributes to fragmentation of care and higher costs by undervaluing critically-important primary, preventive and care coordination services, by creating payment "silos" between physicians and hospitals and among physicians themselves, and by aligning payments with the volume of services provided rather than the value of those services to patients.

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

PRINCIPLES TO CREATE A TRANSITIONAL VALUE-BASED PAYMENT INITIATIVE

ACP believes that steps can be taken over the next 1-5 years, while providing physicians and patients with a necessary period of stable payments, to start more physicians on the road to better payment models, and reward “early adapters” who already have taken the leadership and risk of participating in new value-based payment and delivery models. During such a transitional period, we propose that physicians receive higher updates for demonstrating that they have successfully participated in an approved transitional quality improvement (QI) or value-based payment program (VBP). We begin by offering the following principles for developing a transitional QI/VBP program, and then we provide an assessment of specific physician-led models that could be incorporated into such a transitional QI/VBP program:

1. ACP supports in concept the idea of providing an opportunity for performance based updates based on successful participation in an approved Transitional QI/VBP initiative that meets standards relating to the effectiveness of each program, building on successful models in the public and private sectors.
2. Transitional performance based update programs should be incorporated into a broader legislative framework to stabilize payments and transition to new models. This is important so that physician and the Medicare program have a clear “destination” and pathway to achieving it, even as physicians begin the journey through the transitional QI/VBP initiative.
3. The transitional QI/VBP program should include models for which extensive data and experience already exist, and that can more readily be scaled up for broader adoption by Medicare. Specifically, participation in the Patient Centered Medical Home (PCMH) and Patient-Centered Medical Home Neighborhood (PCMH-N) models, as determined by practices meeting designated standards through a deemed accreditation body and/or standards to be developed by the Secretary with input from the medical profession. Participation in other established models that have demonstrated the potential to improve care coordination, such as Accountable Care Organizations (ACOs), bundled payments, and global primary care payments should also be considered for inclusion in a transitional QI/VBP program. In addition, physicians who agree to incorporate programs, like ACP’s High-Value, Cost-Conscious Care Initiative, into their clinical practice through shared decision-making with patients, might also qualify for a transitional QI/VBP payment. We discuss these initiatives in more detail later in our testimony.
4. Existing QI/VBP payment models—the Medicare 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. Later in our testimony, we provide specific recommendations on leveraging and improving such programs.
5. Transitional performance-based updates could be tiered so that programs that provide coordinated, integrated and patient-centered care get a higher performance update than less robust programs build on the current, silo-ed fee-for-service system.
6. Performance-based payment updates should be in addition to a higher “floor” on payments for undervalued primary care/preventive/and coordinated care services, not limited by physician specialty, so that any physician who principally provides such undervalued services could qualify for the higher update. This is important to address the continued under-valuation of these critically important services, even as payments also begin to reflect physician participation in the transitional QI/VBP initiative.
7. For a transitional QI/VBP program to be effective, in improving quality, CMS will need to improve its ability to provide “real time” data to participating physicians and practices. A method will need to be created to map practice-level participation in a transitional QI/VBP initiative to the individual physician updates under the Medicare Physician Fee Schedule.

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

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

1. Patient-Centered Medical Home (PCMH)

ACP has joined with other physician organizations in advancing new models of payment and delivery that are centered on patients' needs, including working with the Centers for Medicare and Medicaid Services (CMS), private payers, business, and consumer groups to broadly test the PCMH model, which already is showing success in improving outcomes and reducing costs.

PCMH in the Public and Private Sector

A series of PCMH initiatives are being implemented throughout the public and private sector. In its first year the CMS Innovation Center (CMMI), established by the Affordable Care Act (ACA), has introduced 16 initiatives, involving over 50,000 health care clinicians. CMMI's initial efforts have focused on improving patient safety, promoting care coordination, investing in primary care transformation, creating bundled payment models, and addressing the needs of dual-eligibles. One critical program of the CMMI is the Comprehensive Primary Care Initiative (CPCi), which is collaboration between private and public payers and primary care practices to support patient centered primary care. In this initiative, primary care practices will receive new, public and private funding for primary care functions not included in the fee-for-service payments and will have the opportunity to share net savings generated through the program. Forty-four commercial and State insurers are joining with Medicare to support comprehensive primary care, provided that selected practices demonstrate capabilities aligned with the PCMH model. If successful, CMS has the authority to expand the program throughout Medicare, potentially leading to a sustainable new payment and delivery model for primary care.

In addition to these pilot programs, a number of large insurers have announced their intent to roll the PCMH model out more widely. For instance, in January 2012, Wellpoint, a private insurer covering 34 million Americans with a network of 100,000 primary care doctors, publicly announced its decision to invest in the medical home model across its entire network. Aetna, another large private health plan insuring more than 18 million Americans with a network of 55,000 primary care doctors, also recently announced a PCMH program roll-out in Connecticut and New Jersey, with expectations to expand the program nationally in 2012. And, building on a large medical home pilot project already underway, UnitedHealthcare, insuring 34 million Americans, announced in February 2012 an expansion of its value-based payment model, affecting between 50 percent and 70 percent of its customers. Numerous Blue Cross Blue Shield (BCBS) plans across the U.S. have been leaders in their respective marketplace, with over 4 million BCBS members in 39 states currently participating in some version of a PCMH initiative. For example, Care First, the BCBS affiliate in the Maryland/DC area, has implemented the PCMH model within over 75 percent of its participating primary care practices.

These private insurers have made the decision to roll the PCMH model out based on their experience to date with pilot programs, as well as the substantial evidence that health systems with a strong primary care foundation deliver higher-quality, lower-cost care overall and greater equity in health outcomes.¹ Taking this a step further, research also shows that patient-centered primary care is best delivered in a medical home.² Although peer-reviewed academic studies evaluating

¹ Johns Hopkins Bloomberg School of Public Health. Publications of the bureau of primary health care and primary care policy center. (2012). Available at: <http://www.jhsph.edu/pccp/publications.html>.

² Commonwealth Fund (2012, March 12). Patient-Centered Coordinated Care. Program Description.

http://www.commonwealthfund.org/~media/Files/Programs/2012/Program%20PDFs/2011_PatientCentered_Coord_Care_with_caption.pdf.

the medical home model in its full implementation are still limited^{3,4,5} there is much to be learned from the numerous PCMH evaluations that have considered individual components of the PCMH model in specific settings, including a recent Institute of Medicine report that evaluated methods of care for those who are chronically ill.⁶ One compelling indication of the value of PCMHs in improving outcomes and lowering costs is the simple fact that so many large, private sector payers have embraced the PCMH model, scaling it up to make PCMHs widely available to their subscribers, with many of them are reporting substantial costs savings as a result.

Scaling Up the PCMH Model

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

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

- The need for care coordination across settings and the continuum of patient care. ACP has taken a leadership role in helping to address this challenge through our work on the development of the PCMH-Neighborhood model, which is discussed below.
- Related to the issue of care coordination is the lack of real- or near-time data being provided to practices on their patients, which makes it extremely challenging for them to provide proactive, patient-centered care. This is exacerbated by the lack of effective data and information sharing across sites of care. ACP has been deeply involved in the national policy issues surrounding the use of health information technology to facilitate effective clinical data sharing—including the EHR Incentive Program as initiated with the HITECH act. In our most recent comments on the notice of proposed rulemaking from both CMS⁷ and ONC⁸ on Stage 2 Meaningful Use, we highlighted our support of the government's vision to use EHRs and health IT to improve care, but believe that more needs to be done to align the measures across all of the initiatives currently underway including CMS PQRS and e-prescribing programs. While CMS has made strides in aligning the measures, at a high level the technical requirements in each of the programs are different enough that dual processes must be undertaken. We are also concerned about the approach that CMS has taken when structuring the penalty phases of the EHR Incentive Programs, e-Prescribing Incentive Program, and Physician Quality Reporting System (PQRS) by requiring that the activity to avoid the penalty must be completed in the prior year or even two years in advance of the legislated deadline. As a result, CMS has effectively moved up the legislated deadline beyond what the market can bear. More about ACP's effort to facilitate the adoption of health IT will be addressed below.
- Practices that are trying to transform and that are actively engaging in or pursuing PCMH recognition/accreditation, meaningful use for their electronic health records, e-prescribing, etc. also struggle when they do not receive timely payments from their payers for these activities.
- Finally, in many cases practices are transforming to provide services to their patients in line with the PCMH model, but are only paid to do so for a subset of their patient population (e.g., Wellpoint and Aetna are paying

³ Peikes, D., Genevro, J., Scholle, S. H., Torda, P. (2011, Feb). The patient-centered medical home: Strategies to put patients at the center of primary care. Agency for Healthcare Research and Quality. AHRQ No. 11-0029. Rockville, MD. Retrieved from http://www.pcmh.ahrq.gov/portal/server.pt/community/pcmh_home/1483/pcmh_tools_resources_patient-centered_v2.

⁴ Jaén C. R., Ferrer R. L., Miller W. L., Palmer R. F., Wood R., Davila M., et al. (2010, May 1). Patient outcomes at 26 months in the patient-centered medical home national demonstration project. *Ann Fam Med*, 8(1 Suppl):S57–S67; S92.

⁵ Reid, R. J., Coleman, K., Johnson, E. A., Fishman, P. A., Hsu, C., Soman, M. P., Trescott, C. E., et al. (2010, Mar) The group health medical home at year two: cost savings, higher patient satisfaction, and less burnout for providers. *Health Affairs*, 29(5):835–43.

⁶ Institute of Medicine. (2012). *Living well with chronic illness: A public health call to action*. Washington, DC: National Academy Press.

⁷ These comments can be found at: http://www.acponline.org/advocacy/where_we_stand/health_information_technology/cms_nprm.pdf.

⁸ These comments can be found at: http://www.acponline.org/advocacy/where_we_stand/health_information_technology/onc_nprm.pdf.

them a per member per month payment for their beneficiaries, but they are not receiving payment from CMS for their Medicare patients). This issue is being addressed in some areas of the country, particularly those that were selected to participate in the CPCi, discussed above, but many other practices across the country are not being “made whole” in terms of payment for the work they are doing.

The Role of the PCMH in a Post-SGR Environment

Given all of the federal, state, and private sector activity described above, as well as ongoing efforts to address the challenges that have been discussed, it is reasonable to expect that the PCMH model will be ready to be a part of a new, value-based health care payment and delivery system. Under this model, practices that provide comprehensive primary care to their patients will be:

- Paid differently, including:
 - A periodic (e.g., monthly, quarterly) care management fee to allow them to strengthen their capacity to provide comprehensive, patient-centered care. This fee could go toward additional staffing, infrastructure, health information technology, and/or otherwise uncompensated physician and staff time.
 - A potentially revised, improved, and/or expanded set of fee-for-service evaluation and management codes that better incorporate physician and staff non-face-to-face time when providing care management and care coordination services.
 - Shared savings based upon improved quality of care and better patient outcomes.
- Organized differently, in order to:
 - Deliver proactive, timely preventive care to their patients.
 - Provide 24/7 access to their patients through online interactive tools, data, and information.
 - Actively engage patients, their families, and their caregivers in their health care.
 - Provide comprehensive care management services to their patients, particularly those with high health care needs (e.g., multiple chronic conditions).
 - Coordinate care across their patients’ medical neighborhoods by acting as the first point of contact and working collaboratively with the team of clinicians involved in their patients’ care.
- Measured differently, via measures that are focused on:
 - Delivery of patient-centered care, which could be determined by recognition from a national “patient-centered medical home” program such as the Accreditation Association for Ambulatory Health (AAAH), 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 Fund⁹, 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.

⁹ 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;¹⁰ 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.¹¹

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

2. Patient-Centered Medical Home – Neighborhood

The importance of involvement of the “medical neighborhood” to the ultimate success of the PCMH model to fully achieve its quality and efficiency goals has been highlighted by recent policy papers by ACP¹² and the Agency for Healthcare Quality and Research (AHRQ).¹³ Specialty and subspecialty practices, hospitals, and other health care professionals and entities that provide treatment to the patient need to be recognized and provided with incentives—both non-financial and financial—for engaging in patient-centered practices that complement and support the efforts of the PCMH to provide high quality, efficient, coordinated care. The above cited College policy paper outlines a model using care coordination agreements to promote a functioning PCMH-Neighborhood. Reciprocal recognition of professional MOC standards and activities that focus on these same skills and systems, including implementation of such agreements, is a potent lever.

The NCQA, acknowledging the importance of the involvement of the “medical neighborhood” in support of PCMH (primary) care, is in the process of developing a “medical neighbor” recognition process that identifies specialty and subspecialty practices that engage in activities supportive of the PCMH model—with particular emphasis on care coordination and integration. This decision was made following the conclusion of a comprehensive feasibility study in which this concept was strongly supported by multiple health care stakeholders—including physician groups, employers, health plans, state and federal payers, and patient advocates. In addition, the American Board of Internal Medicine and the NCQA are, collaborating to align aspects of Maintenance of Certification and the new “medical neighbor” recognition process.

Efforts to promote processes to coordinate care between primary care practices and the other physicians and health care professionals providing treatment to the patient have been an integral part of both private and public integrated care systems (e.g. Kaiser, Department of Veterans Affairs) and are an important component of the developing Accountable Care Organization (ACO) models. This new NCQA program, and similar efforts, can serve to encourage specialty/subspecialty practices and other “neighborhood” health care entities currently not involved within an integrated system—settings in which most care is currently being delivered—to implement these important processes. This is already happening in several areas of the country. For example:

¹⁰ Agency for Healthcare Research and Quality. Care Coordination and Measures Atlas. Accessed at <http://www.ahrq.gov/qual/careatlas/>

¹¹ 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

¹² American College of Physicians. The patient centered medical home neighbor: The interface of the patient centered medical home with specialty/subspecialty practice. 2010. Accessed at http://www.acponline.org/advocacy/where_we_stand/policy/.

¹³ 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.

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

INCORPORATING HIGH VALUE CARE INTO PAYMENT POLICIES

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

ACP’s High Value, Cost-Conscious Care Initiative (HVCCC), which includes clinical, public policy, and educational components,¹⁴ was designed to help physicians and patients understand the benefits, harms, and costs of an intervention and whether it provides good value, as well as to slow the unsustainable rate of health care cost increases while preserving high-value, high-quality care.

For the clinical component of the HVCCC Initiative, ACP has released materials focused on three areas: low back pain, oral pharmacologic treatment of type 2 diabetes, and colorectal cancer. Furthermore, as part of this initiative, ACP convened a workgroup of physicians that identified, using a consensus-based process, 37 common clinical situations in which screening and diagnostic tests are used in ways that do not reflect high-value care.¹⁵ Furthermore, on July 10, ACP and the Alliance for Academic Internal Medicine (AAIM) unveiled a high-value, cost-conscious care curriculum to help train internal medicine residents about how to avoid overuse and misuse of tests and treatments that do not improve outcomes and may cause harm. The free curriculum, available at www.highvaluecarecurriculum.org, is designed to engage internal medicine residents and faculty in small group activities organized around actual patient cases that require careful analysis of the benefits, harms, costs, and use of evidence-based, shared decision making. The flexible curriculum consists of ten, one hour interactive sessions that can be incorporated into the existing conference structure of a program.

ACP has also joined other leading professional medical organizations in the Choosing Wisely campaign,¹⁶ which complements our HVCCC Initiative. An initiative of the ABIM Foundation, the goal of the Choosing Wisely campaign is to promote thoughtful discussions among physicians, patients, and other stakeholders about how to use health care resources to improve quality of care. In April 2012, ACP unveiled our list of “Five Things”¹⁷ internists and patients should question in internal medicine.

On April 19, ACP and Consumer Reports announced a new collaborative effort to create a series of *High Value Care* resources to help patients understand the benefits, harms, and costs of tests and treatments for common clinical issues. The resources will be derived from ACP’s evidence-based clinical practice recommendations published in *Annals of Internal Medicine*. The initial pieces of the *High Value Care* series will be two patient brochures about diagnostic imaging for low back pain and oral medications for type 2 diabetes. The *High Value Care* resources will be available on the websites of ACP (ACPOnline.org), Consumer Reports (ConsumerReports.org), and *Annals of Internal Medicine* (Annals.org).¹⁸

¹⁴ Additional information can be found at: http://www.acponline.org/clinical_information/resources/hvccc.htm.

¹⁵ Qaseem A, Alguire P. et al. Appropriate Use of Screening and Diagnostic Tests to Foster High-Value, Cost-Conscious Care. *Ann Intern Med*. 2012;156:147-149. Accessible at <http://www.annals.org/content/156/2/147.full.pdf+html?sid=10a2df33-7fa3-45c1-a01d-dc7ecd1b9f6c>

¹⁶ More information on this initiative can be found at: <http://choosingwisely.org/>.

¹⁷ This document can be found at: http://choosingwisely.org/wp-content/uploads/2012/04/5things_12_factsheet_Amer_College_Phys.pdf.

¹⁸ More information on this effort can be found at: http://www.acponline.org/pressroom/high_value_care_ed_materials.htm.

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

IMPROVING MEDICARE FEE-FOR-SERVICE TO SUPPORT CARE COORDINATION

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

Specifically, ACP support the development and recognition under Medicare fee-for-service payment of two new CPT codes—(1) for chronic, complex care and (2) transition care following a facility-based discharge. These new codes have been developed by a CPT Panel workgroup and approved by the CPT Editorial Panel during their May 2012 CPT Meeting. These codes are currently undergoing a survey process in order to be assigned recommended values by the Relative Value Update Committee (RUC), and then receive a final valuation by the Centers for Medicare and Medicaid Services (CMS). These codes are designed to allow physicians to report their non-face-to-face time, and the clinical staff (team) time spent on patient cases—an important element of the overall Patient Centered Medical Home (PCMH) model, which was discussed earlier. The College is also encouraged by the inclusion of a similar new transition of care code applicable to post-hospital discharge situations in the recently released Medicare 2013 Physician Fee Schedule proposed rule.

LEVERAGING EXISTING QUALITY IMPROVEMENT/VALUE BASED PAYMENT MODELS

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

Major improvements in the MU, eRx, and MU programs are needed, though, if they are to be part of a transitional VBP program. Currently, there is no true alignment among these programs in their measures, reporting requirements and payment incentives, and. CMS has been unable to provide timely feedback to physicians regarding whether they are successfully satisfying program requirements, leading to frustration and distrust. ACP has been deeply involved in the national policy issues surrounding the use of health information technology to facilitate effective clinical data sharing—including the EHR Incentive Program as initiated with the HITECH act. In our most recent comments on the notice of proposed rulemaking from both CMS¹⁹ and ONC²⁰ on Stage 2 Meaningful Use, we highlighted our support of the government's vision to use EHRs and health IT to improve care, but believe that more needs to be done to align the measures across all of the initiatives currently underway including CMS PQRS and e-prescribing programs. While CMS has made strides in aligning the measures, at a high level the technical requirements in each of the programs are different enough that dual processes must be undertaken. We are also concerned about the approach that CMS has taken when structuring the penalty phases of the EHR Incentive Programs, e-Prescribing Incentive Program, and Physician Quality

¹⁹ These comments can be found at: http://www.acponline.org/advocacy/where_we_stand/health_information_technology/cms_nprm.pdf.

²⁰ These comments can be found at: http://www.acponline.org/advocacy/where_we_stand/health_information_technology/onc_nprm.pdf.

Reporting System (PQRS) by requiring that the activity to avoid the penalty must be completed in the prior year or even two years in advance of the legislated deadline. As a result, CMS has effectively moved up the legislated deadline beyond what the market can bear.

In addition, ACP recommends that measures and measure strategies be thoughtfully aligned with – and where possible leverage – the regular practice assessment, reporting and quality improvement activities that individual physicians already are required to undertake as part of their specialty board Maintenance of Certification (MOC).

SUGGESTIONS ON A LEGISLATIVE FRAMEWORK TO TRANSITION TO BETTER PAYMENT MODELS

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

Specifically, ACP envisions two phases in the SGR reform process. During the first stage, Medicare would stabilize and improve payments under the current Medicare fee schedule for at least the next five years by eliminating the SGR as a factor in establishing annual updates and by ensuring higher payments and protection from budget neutrality cuts for undervalued primary care, preventive and care coordination services.

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

The Physician Payment Innovation Act of 2012, H.R. 5707: Reps. Allyson Schwartz (D-PA) and Joe Heck (R-NV) recently introduced legislation, consistent with ACP’s core principles above, outlines the pathway to full SGR repeal and implementation of new value-based models of care that focus on quality of care, as opposed to volume of care, as occurs under the current payment system.

H.R 5707 achieves five key policy goals: it repeals the Sustainable Growth Rate (SGR), it eliminates a nearly 30 percent cut on January 1, 2013, it stabilizes payments through 2018 with no cuts for the next six years and positive updates to all physicians during 2014 -2017 and then extend 2017 rates through 2018, it provides higher updates for undervalued primary, preventive, and coordinated care services, whether delivered by primary care physicians or by other specialists, accelerates development, evaluation, and transition to new payment and delivery models, developed with input by the medical profession and external validation.

ACP recognizes that there may be variations on the framework proposed by H.R. 5707 that could achieve the same goals of eliminating the SGR, stabilizing payments, recognizing the importance of improving payments for undervalued primary, preventive and coordinated care services, and establishing a clear pathway to patient-centered, value-based models. We are open to discussion of how best to achieve a transition consistent with the above goals, while recognizing that H.R. 5707 is the first and only bipartisan bill that we are aware of that translates the above critical policy goals into a practical legislative framework.

SUMMARY AND CONCLUSION

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

1. Congress and the Medicare program should work ACP and other physician organizations to develop a transitional QI/VBP initiative, which would provide higher updates to physicians who successfully participate in a transitional QI/VBP initiative, consistent with the principles discussed above.
2. Congress should look to the PCMH as being one of the most promising models for improving outcomes and lowering costs; learning from the extensive and growing experience in the private sector and through the CMS Innovation Center, as well as from private sector recognition and accreditation programs. We are confident that the PCMH model, and the related PCMH-Neighborhood, can be scaled up in the more immediate future, as part of a transition to better payment and delivery systems to replace the SGR and pure fee-for-service.
3. Congress and CMS should work with the medical profession on reducing barriers to the PCMH model, including facilitating the coordination of care among physicians and across settings; facilitating the use of health IT in meaningful ways; aligning the multiple federal initiatives with the goal of health care transformation, including timely payment to those physicians that meet the requirements of these initiatives; recognizing existing professional quality reporting and improvement activities where applicable, and facilitating participation in these initiatives by all payers.
4. Medicare should adopt payment policies that support the efforts by ACP and other physician membership organizations to provide guidance to physicians on high-value, cost-conscious care, including payment policies to support shared decision-making strategies to engage patients in making decisions with their physician on their care, informed by evidence on value and effectiveness.
5. Medicare should make improvements in the existing Medicare physician fee schedule to create incentives for care coordination.
6. The Senate Finance Committee should report legislation to repeal the SGR, provide stability in payments for all physicians, higher updates for undervalued care coordination, preventive, and primary care services, and transition to new payments and delivery models, working from the bipartisan Medicare Physician Payment Innovation Act, H.R. 5707.

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

