Statement for the Record

American College of Physicians

Hearing before the House Ways and Means Health Subcommittee

On

Developing a Viable Medicare Physician Payment Policy

May 7, 2013

My name is Charles Cutler. I am Chair of the Board of Regents of the American College of Physicians (ACP), the nation's largest medical specialty organization, representing 133,000 internal medicine physicians who specialize in primary and comprehensive care of adolescents and adults, internal medicine subspecialists, and medical students who are considering a career in internal medicine. I reside in Norristown, PA, and am a full-time, board-certified practicing internist. I am a member of Fornance Physicians, a multi-specialty group practice consisting of 85 doctors.

On behalf of the College, I want to express our deep appreciation to Chairman Kevin Brady and Ranking Minority Member Jim McDermott for convening this hearing and for your shared commitment to finding a bipartisan solution to the broken Medicare physician payment system. I also wish to thank Chairman Dave Camp and Energy and Commerce Chairman Fred Upton for their leadership in advancing a draft proposal to move toward a more stable and effective physician payment system. I also wish to acknowledge our appreciation for the contributions of Representative Allyson Schwartz, a member of the Ways and Means Committee, and Representative Joe Heck, in crafting a bipartisan bill, the *Medicare Physician Payment Innovation Act of 2013*, H.R. 574, which has the same goals and similar approaches as Mr. Camp's and Mr. Upton's draft proposal. ACP continues to support this legislation but also recognizes that there are different approaches to achieving the same objectives of repealing the SGR, providing stable updates, and transitioning to value-based payment (VBP) programs. Our testimony today will focus on how legislation to repeal the SGR can facilitate the ability of physicians to embrace new models of delivery and payment that provide greater value to patients.

RECOMMENDED KEY ELEMENTS OF A NEW MEDICARE PHYSICIAN PAYMENT SYSTEM

A permanent solution to the SGR problem should facilitate a transformation of the Medicare physician payment system from one that incentivizes volume to one that rewards high-quality and efficient care. Therefore, the College supports a phased approach to repealing the SGR and progressing to better, value-based payment and delivery models that include the following seven key elements:

1. Eliminate the SGR, effective with enactment of the authorizing legislation.

2. Provide stable and positive baseline annual payment updates for all physicians, during which physicians would begin to transition to VBP models over the next five years. The baseline updates should be set by statute, and provide higher baseline updates for undervalued evaluation and management services (without regard to the specialty of the physician providing such services).
3. During the period of guaranteed baseline updates described above, create opportunities for physicians to have their baseline update increased, on a graduated scale, for participating in an approved/deemed transitional VBP model or program.
4. Allow reasonable but not unlimited time for all physicians to get on a transitional VBP pathway that works for their specialty, practice setting, and patient population served, without holding back those who have already begun the journey. Those who are ready now to begin delivering care in models or programs that have shown the potential to result in better clinical outcomes, with more efficient and effective use of resources, should be able to qualify for higher VBP updates as early as January 2014.
5. The pathways to qualify for transitional VBP updates should consist of designated payment/delivery system models—including Patient-Centered Medical Homes (PCMHs), PCMH-Neighborhood (PCMH-N) specialty practices, ACOs, and bundled payments—based on specified criteria, and deemed private sector quality improvement programs. Such a deeming process must ensure that deemed programs have core capabilities to advance quality and effectiveness and can produce measurable results on performance.
6. Performance measures used in transitional VBP programs should go through a transparent, multi-stakeholder review and validation process, regardless of the source of the measure.
7. At the end of the five year transitional period, the expectation would be that most physicians would be in or on well on their way to participating in an approved program. We believe it would be appropriate to consider a mix of positive incentives but also potential reductions in payments, *after a reasonable transition period with pathways for all physicians and specialties to participate in an approved VBP program*, for physicians who decline to participate in a meaningful program by a specified date. However, there should be hardship exemptions for physicians (such as those in smaller practices, late career physicians, and physicians in underserved areas) who will be particularly challenged in making the transition. We note that a similar approach of positive incentives and penalties with hardship exemptions is included in the Medicare Physician Payment Innovation Act, which we have endorsed.

We also note that in our previous testimony before the House Ways and Means Health Subcommittee on July 24, 2012[i]—and described further in our responses to the February 7th and April 3rd draft proposals by Chairmen Camp and Upton to repeal the SGR and reform the Medicare physician payment system[ii]—we outlined a set of principles for developing a transitional quality improvement (QI)/value-based payment (VBP) program. Our testimony today reflects and provides more detail on how the principles we offered could be incorporated into a legislative framework consistent with the Camp-Upton draft proposal. Although the methodology and actual percentage updates to be specified in statute for establishing the baseline payment for physician services, including establishing a higher baseline for undervalued evaluation and management services, are important elements of the College's recommended approach, we will focus our

testimony on how to design and implement a program that transitions from the current flawed payment system to one that is aligned with the value of care provided to patients (incorporating elements 3 through 7 above).

APPLYING ACP's KEY ELEMENTS TO THE COMMITTEE CHAIRS' DRAFT PROPOSAL

We believe that the approach suggested in the above principles could be incorporated into the second draft of Chairmen Camp's and Upton's proposal by:

1. Establishing positive baseline updates, with a higher baseline for evaluation and management services, by statute, for a period of five years. Negative updates, cuts or withholds would act as substantial barriers for physicians to transition to value-based models by denying practices the resources needed to successfully transition to new models and likely would force many physicians out of Medicare.
2. Allowing physicians in phase 1 to qualify for additional VBP allowances for participating in an approved or deemed transitional VBP program, starting as early as January 1, 2014—essentially, advancing phase 2 into phase 1 for those physicians who are ready to make the transition, while continuing to provide stable and positive baseline payments for others who are just getting started.
3. Establishing a graduated VBP allowance structure (or Update Incentive Program) for physicians to qualify for higher FFS payment updates, above their baseline, for participating in an approved/deemed program, with the amount of the VBP/UIP allowance being based on how much the program or programs they are participating in incorporate core elements associated with better outcomes and effectiveness of care.
4. Developing standards and criteria to be used by the Secretary for selecting and deeming programs that would be eligible for each level of graduated VBPs.
5. Specifying that approved/deemed/accredited PCMH and PCMH-N practices that meet standards for selection/deeming would qualify for the graduated VBP/UIP FFS payment allowances effective on January 1, 2014, including recognized/deemed PCMH and PCMH-N practices—including (and especially) those that are not part of one of the CMS Innovation Center initiatives and therefore have no other reimbursement support from Medicare other than FFS and the annual update applied to it. Practices that are participating in Innovation Center programs or other Medicare payment reform pilots (e.g. Comprehensive Primary Care Initiative, Accountable Care/Shared Savings, Advanced Primary Care, and bundled payments programs) also should qualify for the graduated VBP/UIP allowances at the highest levels, since FFS payment will continue to be the principal source of Medicare payments for such practices, and excluding them from the graduated VBP/UIP allowances would have the unintended effect of penalizing physicians and practices that are doing the most to advance quality and effectiveness while accepting greater accountability for results. Essentially, this means allowing physician practices in models that would qualify for the Provider Opt-Out for Alternative Payment Models to qualify for value-based payment increases as early as next year.

In this context, physicians who are in designated Alternative Medicare Payment Models including Patient Centered Medical Homes *that are part of a CMS approved and funded program* would receive (1) the appropriate level of graduated VBP/UIP update allowance for their fee-for-service payments and (2) the underlying payment support structure

for their particular program, discussed in more detail later in this testimony. However, because many PCMHs, ACOs, and other innovative payment models are not formally part of a CMS-approved and funded program, even though they are delivering care to large number of Medicare patients, there needs to be a way for such practices to qualify in a graduated VBP/UIP update incentive program since that is the only support they receive from Medicare, as discussed in more detail later in our testimony.

Also attached to this statement is an appendix with excerpted responses to the questions we addressed in our response to the second version of the Camp-Upton draft proposal.

More details of ACP's suggested value-based transition program are discussed below.

A GRADUTATED APPROACH TO REWARDING QUALITY AND EFFECTIVENESS

The College believes that the groundwork is already in place for Congress to begin to facilitate a broad transition to value-based delivery and payment approaches, including PCMH, PCMH-N specialty practices, and other models as discussed in more detail later in this testimony, using a clearly laid out set of criteria for selecting/deeming programs that would qualify for additional VBP updates during a five year transition period. Such a transition must recognize that physicians are starting out in different places on incorporating best practices to achieve greater value for their patients, with some physicians already being very far down the road in redesigning their practices to achieve better value, while others are just getting started on the entrance ramp to value-based payments and delivery models. Physicians at all points along this spectrum need to have models available to them that are appropriate and realistic for their particular stage of development, but with the opportunity for them to *earn additional VBP updates* (above the baselines to be set in the statute) on a graduated VBP payment scale that *provides greater rewards for those who are doing more to improve outcomes and effectiveness of care.* Such a graduated VBP scale should be based on the extent to which a particular deemed or approved program has demonstrated core capabilities to achieve better clinical outcomes, with more effective use of resources. Studies suggest that the most effective programs have some or all of the following components associated with better outcomes and more effective care:

- Reporting on *validated* clinical performance measures appropriate for the specialty of the physician patient population being served.
- Coordinated, interdisciplinary and team-based care "best practices" to overcome fragmentation of medicine into distinct "silos" of care.
- Tracking of patient outcomes through patient-registry systems.
- Patient engagement and shared decision-making.
- Commitment to evidence-based practice guidelines to reduce ordering of marginal, ineffective, low value or even harmful care, such as ACP's High Value Care Initiative[iii], described later in this testimony and the *Choosing Wisely* effort[iv] organized by the American Board of Internal Medicine.

- Informed and pro-active clinical care management teams and empowered patients, as described in the Chronic Care Model (CCM),[v] within a practice or across a group of practices. The CCM has proven itself over the past decade as a meaningful framework for practice redesign that leads to improved patient care and better health outcomes.[vi]
- A strong emphasis on primary care and appropriate valuation of primary care services as being critical to delivering high value, coordinated care for the whole person, including programs that incorporate the elements of PCMH (primary care model) and PCMH-N (specialty practice model) practices, described in more detail later in this testimony.

Although many of the above elements may be found in integrated delivery models, they can also be incorporated into independent physician practices in a fee-for-service environment. For example, an independent FFS physician practice might employ a nurse as a care coordinator to help patients with chronic illnesses take control of their own health, develop protocols to ensure that all clinicians involved in a particular patient's care are sharing information among themselves, reporting on measures of quality appropriate to that practice and specialty, and tracking patient outcomes through a registry system.

Each level of graduated VBPs could reflect how many of the above elements each particular approved or deemed program has, as well as other criteria that may be appropriate for a particular specialty program or type of practice. Physicians who successfully participate in a program with more of the required elements would qualify for a higher graduated payment than those who participate in a program with fewer elements.

Some illustrative examples of how such a graduated VBP structure might work are outlined below. The items in each column would not all be required for a practice to qualify for that level, but are intended to propose some alternative pathways that may be available to practices of different make-ups and sizes and/or physicians of different specialties. Working across the rows, achievements at each level could be considered additive or could each be done on their own. Again, it is important to reiterate that this is illustrative—there could be fewer or more tiers of graduated VBPs aligned with participation in a program that meets the criteria applicable to each category. An important element to reiterate about these tiers is that they should allow for every physician/specialty and practice to have a pathway that works for their own specialty, practice setting, and size.

Level 1 VBP Program 0.25% VBP update above baseline*	**Level 2 VBP Program 0.50% VBP update above baseline***	**Level 3 VBP Program 0.75% VBP update above baseline***	**Level 4 VBP Program 1.00% VBP update above baseline***
Implements ACP's High Value Care Initiative	Level 1 PCMH	Level 2 PCMH	Level 3 PCMH
Implementing care coordination agreements, in line with the PCMH-N with other physicians	Level 1 PCMH Specialty Practice	Level 2 PCMH Specialty Practice	Level 3 PCMH Specialty Practice
Reporting on a limited performance measure set, primarily focused on processes; and showing	Reporting on a more robust set of performance measures, including a mix of process and outcome	Reporting on a more robust set of performance measures that are more focused on outcomes (either within a	Reporting on a more robust set of performance measures, focused on outcomes, (either within a

Level 1 VBP Program 0.25% VBP update above baseline*	Level 2 VBP Program 0.50% VBP update above baseline*	Level 3 VBP Program 0.75% VBP update above baseline*	Level 4 VBP Program 1.00% VBP update above baseline*
improvement in those measures over time	measures (either within a PCMH program or independently); and showing improvement in those measures over time	PCMH program or independently); and showing improvement and/or consistently high quality in those measures over time	PCMH program or independently) that includes composite, population, outcomes, and cost measures; and showing improvement and/or consistently high quality in those measures over time.
			Participation in an ACO or other alternative delivery model that involves robust measurement

**Baseline update assumes a positive annual update for all services and a higher baseline update for undervalued evaluation and management services. The suggested graduated VBP percentage updates are for illustration only.*

However, it is critical that these different pathways do not result in an uneven playing field, where some specialties, physicians, or practices are disadvantaged by being held to more robust standards due to the availability and comprehensiveness of relevant measures for their specialty. Additionally, it will be important to allow more time for smaller practices, those that provide care to underserved populations, and late-career physicians to fully advance into alternative models, likely through the provision of hardship exemptions; however, there should be no free pass for anyone.

The updates described in these illustrative tiers are proposed to be applied to Medicare FFS services in the Medicare Physician Fee Schedule. The College recognizes that these updates would likely need to be modest given the current fiscal environment and would not be the true or only driver behind the efforts of the physicians in those alternative delivery models. Physicians participating in PCMH, PCMH-N, and ACO models, in particular, are often—but not always—receiving risk-adjusted care coordination payments, shared savings based on quality metrics, etc. However, even in those cases, it is important that the Medicare FFS payments also continue to provide positive incentives by allowing them to qualify for the higher levels of graduated VBP FFS updates. There are a number of reasons for this:

- As noted earlier, FFS still remains an underlying tenet for most of the alternative delivery and payment models, such as PCMHs and ACOs—some of which may be built entirely on FFS payments.
- Alternative revenue streams for formal PCMH programs typically are not entirely from Medicare—and in many cases, Medicare is not an official participating payer at all (other than providing some regular FFS payments), rather the program is funded entirely by private payers. However, the practices still need to transform the way they provide care for all of their patients regardless of payer, which involves significant investment in infrastructure improvements, workflow changes, staff team roles, etc. For example, although there are thousands of recognized (by accreditation bodies and/or private payers) PCMHs around the country, very few of them are receiving any increased reimbursement from Medicare. Medicare is supporting only a few hundred PCMH practices nationwide that have been selected for its Comprehensive Primary Care Initiative or one of the few other PCMH programs that have been launched by CMS. Allowing PCMHs that have achieved recognition through an independent evaluation process to

qualify for the higher graduated payments is necessary to allow the PCMH model to grow. Conversely, if such practices were unable to qualify for higher VBPs during the transition, Congress would actually be *disadvantaging* physicians who have taken the biggest steps into incorporating the PCMH model into their practices.

- There are a number of practices across the country that are interested in, or working toward transforming to a PCMH or PCMH-N model—or are taking on other robust quality improvement activities, such as the ACP High-Value Care Initiative—and do not have a formal payment program in their region to support their efforts. Thus they are relying entirely on FFS—and a reformed FFS system should be structured to incentivize this work.
- Physicians and practices that are involved in PCMH and ACO programs are already taking on significant financial risk, both directly and via the infrastructure investments required to participate, so it is important that the underlying FFS payments involved in those programs include positive incentives and updates.

DISCUSSION OF MODELS THAT SHOULD QUALIFY FOR GRADUATED VALUE PAYMENTS

Patient-Centered Medical Home (PCMH)/ PCMH Neighborhood

ACP strongly believes that the PCMH and PCMH-N models are ready to be a part of a new, value-based health care payment and delivery system, given all of the federal, state, and private sector activity to design, implement and evaluate these models and the growing amount of data on its effectiveness in improving care and lowering costs.[vii]

The CMS Innovation Center's Comprehensive Primary Care Initiative (CPC Initiative) provides an appropriate starting point for discussing how the PCMH model could be more immediately incorporated into the Medicare physician fee schedule. The five comprehensive primary care functions that serve as the framework for the CPC Initiative project—risk-stratified care management, access and continuity, planned care for chronic conditions and preventive care, patient and caregiver engagement, and coordination of care across the medical neighborhood—are in line with the PCMH and PCMH–N concepts, championed by ACP and other national membership organizations representing physicians and other clinicians and are supported by thousands of business, consumer, and payer groups represented in the Patient-Centered Primary Care Collaborative (PCPCC).

Physician practices that were selected for the CPCI are supported by a Medicare payment structure that consists of: (1) risk adjusted per patient per month Medicare payment to cover the extensive costs and work associated with care coordination; (2) fee-for-service payments as determined by the Medicare fee schedule (RBRVS and conversion factor as affected by the SGR); and (3) opportunities to share in Medicare savings. Participating practices will be accountable for achieving substantial milestones and performance metrics.

Physicians and practices that transition to the PCMH model should be measured by distinct measures that are focused on delivery of patient-centered care, such as the core measures recommended by the PCMH Evaluators' Collaborative established by the Commonwealth Fund, which includes measures in the following domains: clinical quality (process and outcome), utilization, cost, and patient experience of care. In addition, the Agency for Healthcare Research and Quality (AHRQ) has available an atlas of care coordination measures.[viii] 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.[ix]

ACP believes that the advancement of the PCMH model also is being facilitated through several recognition and accreditation programs including the National Committee for Quality Assurance's (NCQA) Patient-Centered Medical Home Recognition Program (2011)[x], URAC's Patient-Centered Health Care Home's Accreditation Program[xi], and The Joint Commission's Primary Care Medical Home Option.[xii] ACP supports the idea of CMS basing its determination of accreditation as a PCMH through a national accreditation organization (via a deeming approach for the purposes of Medicare payment, discussed further below). The standards included in each of these programs are already well known and widely used and, while not identical, do include very similar concepts.

Additionally, NCQA has recently released a Patient-Centered Specialty Practice Recognition Program[xiii], which now creates a pathway for non-primary care practices to be formally acknowledged and incorporated into a new, value-based health care payment and delivery system based on the PCMH-N concept. Several areas of the country are already 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. It is likely other accreditation programs will follow suit and also start to develop programs that are relevant for non-primary care practices.

Also, ACO development is rapidly occurring throughout the country in both the public and private sector. The Medicare shared savings program has contracted with dozens of physician practices and hospitals, including ACO practices that involve ACP members. Although the financial model for each ACO varies depending on the type of ACO program in which it is participating, all are paid under the usual Medicare fee-for-service basis with the opportunity to share in savings to the program from more effective management of the Medicare patients attributed to them. Variations of the shared savings programs involve more or less financial risk and reward for the participating practices. Therefore, while not discussed in detail in this testimony, ACOs should also be considered part of a new value-based payment and delivery system.

Other Physician-led Programs to Promote High Value Care

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 transitional quality improvement/value-based payment model. ACP's High Value Care Initiative, which includes clinical, public policy, and educational components, 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.[xiv] 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.

Another alternative, largely physician-led quality improvement approach that could be considered by Medicare for higher updates over time would be the development and implementation of patient registries. Patient registries involve a systematized method for collecting patient-based data that are often used to help clinicians understand and improve their practice—some physician societies have already implemented extensive and robust registry programs while others are still in the development phase.

The bottom line is that 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 FFS system to incentivize improved care coordination and better reflect the quality of care provided, particularly because FFS still remains an underlying tenet for most of the alternative delivery and payment models. Physicians should not be limited to only one payment model—the focus should be on the right mix of incentives that support the ability of physicians and patients to spend more appropriate clinical time together.

Deeming of VBP programs and Validation of Performance Measures

The Department of Health and Human Services has a long history and tradition of deeming non-profit private sector accreditation organizations to satisfy compliance with federal regulations in a way that relies on the accreditation organization's expertise, while still ensuring that the process meets federal standards relating to transparency. We believe that CMS can learn from those relationships and work with the accreditation organizations and national specialty societies, including ACP, to design a deeming program for PCMH and PCMH-N recognition that appropriately balances the interests of the non-profit, private sector accreditation organizations and CMS' responsibility to establish and maintain transparency in its decision-making processes. CMS could deem a program as meeting the standards to qualify for a graduated VBP update allowance as long it can demonstrate that it includes one or more of the core elements associated with effective programs, as described previously in our testimony. Such deemed programs could include:

- PCMH and PCMH-N practices as recognized or accredited by a nationally recognized accreditation organization.
- PCMH and PCMH-N practices as recognized and offered to enrollees of one or more private health insurance programs, and/or as recognized by state government programs including Medicaid.
- Programs developed by national specialty societies, state medical societies, county medical societies, community-based physician groups, or other entities that would apply directly to CMS to be deemed as an approved initiative.

Robust and aligned performance measurement approaches and a stable infrastructure to develop, test, validate, and integrate performance measures into practice are essential. Although ACP agrees with the goal of encouraging the development of performance measures applicable to all specialties, it is essential that this not result in specialty specific "siloed" efforts, but one that is part of a national strategy for quality improvement. The development, validation, selection,

refinement, and integration of performance measures should be a multilevel process that takes advantage of the most recent scientific evidence on quality measurement and have broad inclusiveness and consensus among stakeholders and in the medical and professional communities. This entire process should be transparent to the medical community. Measures should be field-tested to the extent possible prior to adoption. All measures, whether developed by a specialty society or other experts, accordingly should go through a multi-stakeholder evaluation process, a role that is performed by the National Quality Forum as a trusted evaluator of measures. ACP encourages the committees to ensure that there is stable and sustainable financing for the NQF as the trusted validator for quality measures. Deeming of private sector specialty programs, such as patient registry programs, might be considered as another way of qualifying specialty society quality improvement programs, although the clinical performance measures used by such programs should go through the NQF validation program.

In addition, in order to maximize physician engagement and promote quality, the SGR repeal and Medicare physician payment reform proposal should explicitly acknowledge the role of the physician specialty certification community. The American Board of Medical Specialties (ABMS) maintenance of certification (MOC) is a multi-source assessment program that addresses competencies for good medical practice and provides a program of continuous professional development and a platform for quality improvement. In this regard, the SGR proposal should include participation in ABMS MOC as a quality metric, include ABMS MOC as a reporting pathway, and allow physicians choice in reporting so that they can align their quality improvement activities in ways that are relevant to their practices.

CONCLUSION

In conclusion, ACP strongly supports a phased approach to repealing the SGR and progressing to better, value-based payment and delivery models. As outlined above, this approach should establish *positive* baseline updates, with a higher baseline for evaluation and management services, by statute, for a period of five years; allow physicians in the Camp-Upton draft proposal's phase 1 to qualify for additional VBP allowances for participating in an approved or deemed transitional VBP program, starting as early as January 1, 2014; establish a *graduated* VBP allowance structure (or Update Incentive Program) for physicians to qualify for higher FFS payment updates, above their baseline; and develop standards and criteria to be used by the Secretary for selecting and deeming programs that would be eligible for each level of graduated VBPs. Such standards should define the core elements associated with effective programs. ACP strongly believes that the PCMH and PCMH-N models are ready to be a part of this new, value-based health care payment and delivery system—as early as phase 1 for those practices that have made or are ready to make the transition to these models. It is also critical that robust and aligned performance measurement approaches and a stable infrastructure to develop, test, validate, and integrate performance measures into practice be incorporated into all of the VBP programs. Additionally, all measures, whether developed by a specialty society or other experts, accordingly should go through a multi-stakeholder evaluation process, a role that is performed by the National Quality Forum as a trusted evaluator of measures. The College looks forward to working with the Subcommittee on developing a viable Medicare physician payment system consistent with the Camp-Upton draft approach and the ideas presented in today's testimony and would be pleased to answer any questions.

[i] The full testimony from this hearing can be accessed at: http://www.acponline.org/acp_policy/testimony/medicare_value_based_payment_2012.pdf.

[ii] These letters, responding to the House Ways & Means and Energy & Commerce Committees' staff proposals to repeal the SGR can be accessed at: http://www.acponline.org/acp_policy/letters/gop_sgr_framework_proposal_as_released_by_the_ways_means_energy_commerce_committees_2013.pdf and http://www.acponline.org/advocacy/where_we_stand/assets/eliminating_sgr.pdf.

[iii] Additional information on ACP's High Value Care Initiative can be accessed at: http://hvc.acponline.org/.

[iv] Additional information on the Choosing Wisely effort can be accessed at: http://www.choosingwisely.org/.

[v] Additional information on the Chronic Care Model can be accessed at: http://www.improvingchroniccare.org/index.php?p=The_Chronic_Care_Model&s=2.

[vi] Katie Coleman, Brian T. Austin, Cindy Brach and Edward H. Wagner. Jan/Feb 2009. "Evidence On The Chronic Care Model In The New Millennium" Accessed at: http://content.healthaffairs.org/content/28/1/75.short.

[vii] A sampling of recent data on the effectiveness of PCMH programs can be accessed at: http://www.pcpcc.net/guide/benefits-implementing-primary-care-medical-home, http://content.healthaffairs.org/content/29/5/819.full, http://www.bcbsm.com/content/dam/public/Providers/Documents/help/R007532_2012PartnersReport_01WEB.pdf, http://content.healthaffairs.org/content/31/9/2002.full.html, and http://content.healthaffairs.org/content/31/9/2010.full.html.

[viii] Agency for Healthcare Research and Quality. Care Coordination and Measures Atlas. Accessed at http://www.ahrq.gov/qual/careatlas/.

[ix] 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.asp

[x] More information on NCQA's PCMH Recognition program is available at: http://www.ncqa.org/tabid/631/Default.aspx.

[xi] More information on URAC's PCHCH Accreditation program is available at: https://www.urac.org/healthcare/prog_accred_pchch_toolkit.aspx.

[xii] More information on the Joint Commission's Primary Care Medical Home Option is available at: http://www.jointcommission.org/accreditation/pchi.aspx.

[xiii] Additional information on the NCQA Patient-Centered Specialty Practice Recognition Program can be found at: http://www.ncqa.org/Programs/Recognition/PatientCenteredSpecialtyPracticeRecognition.aspx.

[xiv] Additional information on ACP's High Value Care Initiative can be accessed at: http://hvc.acponline.org/.

Appendix: Excerpts from ACP's Responses to Questions on the Second Version of the Camp-Upton Draft Framework (ACP's letter can be found at http://www.acponline.org/advocacy/where_we_stand/assets/eliminating_sgr.pdf)

Questions for Phase II:

How should the Secretary address specialties that have not established sufficient quality measures?

ACP believes that all specialties need to be engaged in programs that will result in measurable improvements in quality. To ensure a level playing field, no specialty should be exempted from having its performance measured or held to a higher or lower standard than any other. Dozens of externally validated measures already are applicable to and are widely in use for internal medicine specialists. Specialties that have not developed or incorporated such clinical measures and/or obtained external validation for them should be given reasonable but not open ended time to incorporate or create such measures; in the interim, the Secretary should ensure that in order to qualify for higher updates, such specialties be able to participate in robust programs to achieve measurable gains in patient safety, quality, and effectiveness, such as by participating in patient registry programs that meet certain standards to ensure that they meaningfully "raise the bar" on quality, programs to reduce medical errors, programs to encourage high value care and cost conscious care, or programs aligned with their own specialty board's Maintenance of Certification performance and practice improvement efforts.

Is it appropriate to reward improvement in quality over time in addition to quality compared to peers?

Yes, we believe that it is appropriate to reward improvement in quality over time in addition to quality compared to peers, although we also believe that those physicians who have shown that they are able and willing to achieve an even higher level of performance, earlier than some of their peers, should be able to qualify for appropriately higher updates. Any comparison of performance compared to peers must be carefully adjusted to reflect differences in the complexity of the patient population being treated and especially, to ensure that it does not disadvantage physicians who are taking care of underserved patient populations who may be at greater risk of poor health and outcomes.

Are there sufficient clinical practice improvement activities relevant to your specialty? If not, does your organization have the capability to identify such activities and how long would it take?

As noted above, there are many dozens of externally validated measures that apply to internal medicine and its subspecialties. While ACP does not independently develop performance measures, the College is deeply involved in the critical review of and provision of comments on performance measures developed by other organizations. The goal is to ensure that the measures are based on high quality clinical evidence.

Should small practices have the ability to aggregate measurement data to ensure that there are adequate numbers of patient events to reliably measure performance? If so, how?

Yes, ACP is supportive of small practices having the ability to aggregate their data in order to ensure the validity of their data. The committees should take advantage of the experience being gained in how to reliably measure performance in small practices through both public and private patient-centered medical home programs. The CMS Innovation Center is heading up the Comprehensive Primary Care Initiative (CPCi) which is a collaboration between private and public payers and primary care practices to support patient centered primary care. The CPCi currently involves nearly 500 practices in 7 regions across the country. The application for payer participation in the CPCi suggests an approach to data sharing between practices and CMS and other participating payers that could be more made more broadly applicable by extension to other efforts of smaller practices to reliably measure and report on performance.

Questions for Phase III:

How much time is needed to refine the methodology for determining and attributing efficient use of health care resources?

Is it preferable to only have a payment implication based on efficiency for providers that meet a minimum quality threshold?

With regard to the specific measurement of efficiency by clinicians, the College recommends that measure sets must primarily focus on improving patient outcomes, gauging the patient-centeredness of a practice, and improving the coordination of care across all providers. The College maintains that efficiency —or "value of care" measures must be based on an objective assessment of evidence on the effectiveness of particular treatments, with both cost and quality taken into consideration. Value of care measures must appreciate the nuances of physician care and must not compromise the patient physician relationship. Stakeholders must also work to develop population health measures designed for specific populations.