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Reforming Physician Payments To Achieve Greater Value in Health Care Spending

American College of Physicians

Position Paper

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American College of Physicians

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I. Introduction

The problems inherent in the system we use to pay physicians for furnishing health services are well documented. Prominent among them is that most physicians are compensated principally on the basis of the volume of services they provide. Fee-for-service payments create incentive for physicians to provide more services, not necessarily the services that are most effective for a particular patient. Further, the fee-for-service system involves substantial inequities in how payment rates are determined, which have contributed to a decline in interest in the practice of primary care specialties that is at crisis level. This supply problem is especially troubling because primary care is consistently associated with better outcomes and lower costs. The October 2008 ACP paper, *How is a Shortage of Primary Care Physicians Affecting the Quality and Cost of Medical Care?: A Comprehensive Evidence Review*, documents the value of primary care that has been established by over 100 studies over the past two decades.

This dysfunctional system extends beyond direct payments to physicians. It also lacks incentives to facilitate coordination among the different providers in the health care system. It rewards episodic, acute care by individual clinicians rather than coordinated, comprehensive, longitudinal care provided by physicians working in collaboration with other health care professionals. Specific reform proposals aim to change the broader payment system to align incentives across providers to reward efficient, high-quality, coordinated care.

Comprehensive reform of the payment system must involve improvements to physician payments and changes to improve coordination of care across providers. Both are urgent and essential to meeting patient needs and maintaining a sustainable health care system. This paper contains the ACP recommendations aimed at realizing comprehensive payment reform. The College's recommendations involve two main components:

- The need to design, test, and evaluate new payment models that align incentives with appropriate, high-quality, efficient, coordinated, and patient-centered care, followed by rapid expansion of the models shown to be most effective. The ACP-recommended changes would provide expanded testing of the promising Patient-Centered Medical Home (PCMH) reform model while facilitating steps that optimize the ability to learn from these tests and rapidly extend the model as appropriate. The College recommends elements that should be included in the other innovative payment reform models to be tested to determine their ability to replace the current volume-based payment system with a system that fosters the above attributes. It recommends a process by which multiple innovative models can be developed, pilot-tested, and then rapidly expanded, should the initial results of the pilots support such expansion.
- The urgent need to improve payments made under the existing fee-for-service system that is based on the Resource-Based Relative Value Scale (RBRVS). The ACP-recommended changes would generate increased interest in the practice of primary care specialties by increasing primary care physicians' compensation to a level that is competitive with the earnings of physicians practicing in other specialties. They would improve the accuracy of fee-for-service payments—removing the potential for clinical decisions to be influenced by factors other than the patient's best interest. They would provide relief from the Sustainable Growth Rate formula system used to annually update Medicare physician payments—a long-broken system which generates uncertainty that harms the ability to operate a physician practice and provides updates that lag behind medical inflation. These changes should be made concurrent with the development, testing, and expansion of new payment models. ACP views them as essential to transition to more comprehensive payment reform.

II. New Payment Models Are Needed to Increase Value in Health Care Spending

Recommendation

1. **ACP strongly supports the need to develop new payment models that align physician incentives with effective and efficient care instead of paying on the basis of the volume of services.**

III. Recommended Elements for New Physician Payment Models

Background

New payment models that policymakers are considering include continued expansion of the PCMH model and testing of the PCMH in the context of alternative payment models, Accountable Care Organizations, paying for bundles of services for an episode of care on the basis of past treatment patterns, paying for bundles of services associated with care that would be provided according to evidence-based guidelines, making a capitation payment to primary care physicians for the full range of primary care services, and others. Some of these models preserve an element of fee-for-service and others would entirely replace fee-for-service with a bundled payment structure.

Most of these alternatives are in the early stages of testing and some are still conceptual and lack definition. This lack of real-world experience poses a challenge to policymakers. The will to act is rivaled by the number of reform options. Facing a similar dilemma, ACP is articulating elements it believes should be included in payment reform models. These elements, identified below, are supported by literature and other information. The College intends for these elements to contribute to the reform debate by guiding policymakers in crafting payment reform proposals. They also provide ACP with a framework for evaluating existing and new proposals.

Recommendations

1. **New payment models should support specific policy objectives to ensure accuracy, predictability, and the appropriate valuation of physician services**

- Recognize the value of primary care physicians and services
- Provide immediate/short-term payment increases to signal that primary care is valued
- Recognize services provided outside of face-to-face encounters with the patient
- Improve accuracy in the valuation of physician services
- Recognize the value of patient-centered, longitudinal, coordinated care services and the cost of providing these services
- Recognize the value of critical elements of chronic care delivery, such as disease self-management and follow-up, and the cost of providing these services
- Recognize the value of quality improvement and performance measurement on the basis of evidence-based quality, cost efficiency, and patient experience of care, and recognizing the cost of obtaining these data

- Provide, at a minimum, a transition to a unit of payment that diminishes the incentive to increase volume, ensures appropriateness, and promotes greater accountability
- Recognize and appropriately value the complexity, time, and costs associated with sicker-than-average patients, avoiding a potential disincentive for physicians to treat patients with more complex conditions
- Recognize quality and efficiency and reward appropriate stewardship of resources while promoting and maintaining high quality

These elements are largely derived from the recommendations to improve payments under the current fee-for-service system that we present later in this paper. The rationale supporting those recommendations justifies the use of these elements to guide payment reform.

Efforts to link payments to quality of care and resource use are underway. Medicare has maintained a program since 2007 that pays physicians a bonus for reporting on quality measures. The Centers for Medicare & Medicaid Services (CMS) is working to formulate a complete plan for being a more active purchaser of health care services. The agency intends to submit its Value-Based Purchasing plan to Congress by May 2010. Numerous private sector initiatives are also underway. ACP encourages innovation and the testing of approaches to determine how to best effect improvement in a logical and sustainable manner. Other ACP-identified essential reform elements provide guidance on how physician quality and resource use can be incorporated into payment reform.

2. New payment models should increase value to the health care system

- Promote comparative/cost-effectiveness research
- Foster coverage policies that reflect clinical evidence related to treatments
- Promote transparency in reporting on the quality and cost of care in a manner fair to physicians
- Promote increased transparency for all stakeholders and health care sectors

ACP supports comparative effectiveness research on available health care interventions and the dissemination of results to all stakeholders. Further, the College supports the availability of explicit and transparent cost-effectiveness information because it is vital to obtaining the most value for our health care expenditures (1).

ACP supports the availability of information on the quality and cost of care physicians furnish to patients because it has the potential to guide informed consumer decisions. This information must be derived from a process that is fair and acceptable to stakeholders (2).

If organizations that represent consumers, employers, unions, physician organizations, and health plans agree on a set of principles to guide reporting on physician performance, this would provide confidence that a diverse set of stakeholders can agree on a process. ACP has supported this effort to promote transparency, fairness, and external review of programs that rate physicians (3).

The same transparency regarding the quality and cost of physician care is appropriate for other health care stakeholders. For example, it is estimated that nearly 10% of private health plan revenue is consumed by administrative costs, with approximately 8% attributed to billing and insurance-related functions (4). Health plans should detail their administrative and other non–medical care expenses in addition to information on other business practices. ACP expects to release a paper on the role of transparency throughout the entire health care system late in 2009.

3. New payment models should support patient-centered care and patient engagement in shared decision-making

- Engage and empower patients; promote shared decision-making
- Ensure that patient financial liability in obtaining evidence-based treatments is reasonable
- Include the expectation that patients assume some degree of responsibility for their health
- Encourage team-based care in which a physician directs and/or collaborates with other health care professionals, as well as office-based staff and other personnel, to meet the needs of patients
- Structure payments to reward physicians for providing care that reflects the needs and preferences of the patient (patient-centered care), with emphasis on activities that satisfy requirements for the practice to be recognized as a Patient-Centered Medical Home
- Provide incentives that support care to all patients on a physician panel and avoids patient segmentation by condition and/or type of care, which requires multiple delivery models that are overly disruptive to practice
- Provide for ongoing input from patients and organizations that represent them.

The idea that patients should be more informed and active participants in their health care is widespread. The AARP identifies patients partnering in decisions about their care, increasing their self-management ability, and living healthier lifestyles as components of reform (5). The readiness of patients to participate actively, especially those with low income, is unclear (6). AARP calls for patient financial contributions, in the form of premium expenses and out-of-pocket costs, to be capped at 10% of income (7). These factors illustrate the challenge of increasing patient involvement without imposing unreasonable demands on patients.

ACP supports the PCMH delivery model to facilitate better care and increased satisfaction and recommends that it be supported by an enhanced payment structure that recognizes its value. The College commitment to team-based care is reflected in its 2009 position paper on the role of nurse practitioners in medical care (8). In addition, ACP is working with multiple stakeholders through the Patient Centered Primary Care Collaborative to maximize the role of pharmacists in providing care through a PCMH and is interested in the Veterans Administration's effort to identify the optimal primary care team. Whether members of the team are employed by the practice or the practice has access to them through arrangements, care from an interdisciplinary team that addresses the comprehensive needs of the patient—medical, psychological, and social—is the goal.

As new payment models are developed, the emphasis should be on approaches, like the PCMH, that support a holistic approach to patient-centered care. For instance, proposals for different care and payment systems for prevention, acute minor illness, acute serious illness, and chronic conditions would likely lead to further fragmentation.

4. New payment models should encourage appropriate expenditures on physician services

- Provide, at a minimum, a pathway to eliminate the Sustainable Growth Rate formula system and do so in a way that is sustainable and politically viable
- Provide predictable and stable updates to Medicare physician payments through a mechanism that enables all services to realize positive updates but ensures a positive update for primary care services
- Examine the appropriateness of growth in expenditures on physician services at a sub-aggregate level; for example, by type of service
- Assess the impact of changes in expenditures on physician services, such as Part B spending, in the context of the overall Medicare program, such as Part A or Part D spending
- Assess cross-system physician expenditure impacts at a sub-aggregate level; for example, on Part A spending
- Recognize the value of primary care services and the urgent need for action that can redistribute expenditures toward primary care services

Discussion later in this paper supports the need for Medicare payments that are maintained and updated in a manner that is fair, predictable, and stable; recognizes the value of primary care; and accounts for the impact that physician expenditures have on other health system sectors. Utilization, spending, and impact should be monitored over time to ensure that the physician payment system remains viable and to determine needed adjustments.

5. New payment models should align incentives across the health care system

- Encourage hospitals, physicians, and other health care professionals and providers to work toward shared objectives
- Ensure that the data and other informational element needs inherent to a model, such as attributing patients to physicians or identifying an episode of patient care, can be achieved in a manner that is accurate and understandable to stakeholders
- Provide fair policies and/or formulae for distributing money if payments are intertwined—either as a single payment for a bundle of services or through a shared savings fund
- Provide a clear indication of the expected impact of any mechanism aimed at aligning incentives across the health care system by addressing:

  1. Timing, including whether testing is prudent;
  2. Whether the model is predictable in a way that enables essential business planning;
  3. Whether the model is sustainable;
  4. Whether the model is practical for physicians and other stakeholders; and
  5. The degree, if any, to which physicians and other stakeholders are at financial risk

Payment system changes to facilitate improved coordination between health system sectors can be instituted in a variety of ways, including through incentives that are:

- In the physician payment system, to encourage communication and coordination with other settings, such as a hospital;
- In the hospital (or other sector) payment system, to encourage communication and coordination with other settings, such as physicians in ambulatory practice;
- Intertwined into multiple payment systems, such as physician and hospital; and/or
- Included in a new, comprehensive, cross-sector payment system.

The CMS has launched demonstration projects and is taking other steps related to promising payment reform models. It is conducting a demonstration that allows hospitals to share savings that result from efficiencies with the physicians who helped to achieve them. In the Medicare Hospital Gainsharing demonstration, hospitals can reward physicians for a direct portion of the savings generated through collaborative efforts. Outside of the demonstration project sites, the law prohibits hospitals from paying physicians for reducing services to beneficiaries even if those services are duplicative or generate improved quality (9). Also, the agency has initiated an effort to broadly change Medicare regulations to provide clearer guidance as to acceptable gainsharing arrangements, which is being informed by public comments.

The agency is engaged in a bundled payment demonstration project called the Acute Care Episode demonstration. In January 2009, CMS announced six hospitals that will participate in a demonstration that will provide bundled payments for inpatient services paid by Part A and Part B that are related to certain cardiac and orthopedic procedures. The bundled payment will be shared among the hospital and the physicians participating in each patient's care. Hospitals will receive savings generated through improved coordination and efficiency and have the ability to share them with the physicians or teams that participate in the provision of care. Thus, the bundled payment demonstration also incorporates the gainsharing concept. The beneficiary will also share in any savings through reduced copayments (10).

Medicare hospital re-admissions are frequent and costly (11). Accordingly, policymakers are increasingly interested in addressing avoidable hospital re-admissions, potentially through changes in payment policy. As decreasing preventable readmissions would greatly benefit patients and reduce expenditures, this is an appropriate area on which to focus. The physician payment system could be modified to provide a direct payment to physicians for treating a patient in the ambulatory setting within a specified period of time after discharge. Providing a direct incentive to conduct a specific set of real-time activities—such as discussion with hospital or attending hospitalist, review of discharge summary, or medication reconciliation—to promote a better transition is another alternative. A more comprehensive approach would be to measure hospital re-admission rates on certain conditions for which they are common over a certain time frame and reward the hospitals and the physicians involved for improvements compared with an established baseline.

ACP is encouraged that innovative payment reform ideas, in addition to those discussed above, have the attention of policymakers and aim to improve coordination across sectors. These include establishing Accountable Care Organizations and other, more comprehensive approaches to bundling payments. Because of the likely magnitude of the change and its disruptive impact on affected stakeholders, the process, expected impact, and intent must be made clear.

6. New payment models should encourage the optimal number and distribution of physicians in the workforce

- Have as an explicit payment policy goal that the numbers of physicians who enter primary care and the proportion of those who remain are sufficient to meet the expected increased demand for adult primary care
- Provide a mechanism to assess the extent to which reforms achieve primary care workforce or environment improvement goals

As described earlier, payment and earnings expectations play a prominent role in physician career choices, and improvements to primary care payments are imperative. ACP further documents the dire primary care workforce situation and provides recommendations for attracting and retaining primary care physicians in areas other than payment, such as debt relief and practice environment improvements, in its "Primary Care Solutions" position paper.

7. New payment models should encourage the use of health information technology that has the capabilities needed to support clinicians' efforts to improve the quality and effectiveness of care

- Provide positive financial incentives to facilitate the adoption and use of Health Information Technology (HIT) that are, at a minimum, of a sufficient amount and duration to ensure physician interest
- Apply payment penalties for failure to adopt or use HIT only after a foundation is established that involves appropriate standards, provides reasonable functionality, and ensures interoperability
- Include a mechanism to monitor the foundational elements described above, if the policy penalizes failure to adopt or use HIT through payment reductions after a phase-out of payment incentives. Planned payment reductions should be halted if it is determined that the foundational elements have yet to be realized
- Recognize that the realization of widespread use of interoperable HIT extends beyond acquisition and maintenance costs and addresses the need for appropriate industry standards, technical support, and physician practice workflow changes

ACP is pleased with the funding included in H.R. 1, the American Recovery and Reinvestment Act of 2009 (ARRA), and commends President Obama and the Congress for their commitment to promote the adoption and use of Electronic Health Records (EHRs). ACP strongly supports the positive Medicare payment incentives the law makes available.

The College believes, however, that it is imperative that the overall environment be hospitable to the purchase of EHR systems before penalties are imposed that would reduce baseline payments to physicians not using certified systems beginning in 2016. Although the planned penalties will not adversely affect physicians for some time, small and/or rural practices, which are in the greatest need of assistance, stand to lose the most if penalties take effect before the barriers to their HIT adoption and use are addressed. ARRA requires or sets in motion activities to create an environment in which EHRs that harness the potential of the technology—including the establishment of standards and processes—are commonly available. However, there is no guarantee that the challenges will be met in the time frame envisioned.

Although Congress could pass legislation that delays payment penalties or otherwise amends the current law (and the current law does permit exemption from penalties for yet-to-be-defined hardship cases), it is prudent to identify goals that must be met, with associated time frames, and to establish a process

by which penalties are reassessed when these goals are not met. Specific benchmarks that reflect the needed progress include but are not limited to certifying the sufficient availability of HIT, including at reasonable cost, and certifying that technical capabilities, including functionality and interoperability, are applicable to small and/or rural practices. Imprudent HIT purchase in the face of impending penalties would be devastating to these practices.

Further, the situation of a recently trained physician starting a new practice must be addressed as the HIT incentive program rules are developed. It is important to avoid disadvantaging physicians who establish a practice during either the positive incentive phase or the subsequent penalty stage.

This process for monitoring progress against established benchmarks to avoid unwarranted penalties is appropriate for any Congressional or other policy action that aims to achieve a policy objective by providing a positive financial incentive for a period of time followed by a financial penalty.

8. New payment models should recognize differences in practice characteristics, including the prevalence of small practices

- Recognize the specific challenges of small physician practices—where most patients receive their care
- Recognize challenges patients have in receiving care in rural and other underserved areas, which are typically served by small practices
- Limit or otherwise clearly define the extent to which physician payment is "at risk," because the acceptance of risk as incurred by an insurer is an insurmountable obstacle for most physician practices
- Provide physicians the ability to participate in a payment approach that best suits the needs of their practice. This element is essential during the testing phase and likely to remain necessary even after successful models are identified and made a permanent part of the Medicare program.

A report describing ambulatory care visits provided in physician offices states that ambulatory medical care is the largest and most widely used segment of the health care system, with more than 900 million visits in 2006. The report found that approximately 82% of office visits are furnished in practices with five or fewer physicians. Whereas about 31% of office visits are provided in solo practices, 46% are furnished by single-specialty groups and another 22% by multispecialty practices (12).

A recent Commonwealth Fund report finds that bundled payments can prompt physicians and other providers to organize better. It states that the more organized the provider organization (with independent physician practices and hospitals being the least organized), the greater the extent to which it is feasible to bundle payments. It identifies a bundled payment on a continuum that lists fee-for-service payments as the least bundled and global payment per enrollee as the most bundled (13). Many of these bundled payment concepts differ from the capitation model that was once prevalent during the managed care movement; for example, bundled payments would account for services furnished by multiple providers and payment amounts would be determined based on specific conditions or episodes.

Although ACP supports using payment policy to facilitate better care coordination and more accountability, the Commonwealth Fund finding, which it expresses as a graph, demonstrates the challenges faced by small and nonintegrated physician practices. The large physician practices participating in the Medicare Group Practice demonstration project, which allows the practices to share in system-wide Medicare savings they generate over a baseline, have invested in the capability to better coordinate care to patients. These organizations

have not only made the investment to improve patient care but have done so with the expectation that this better care will generate efficiencies that generate savings, from which their share will at least equal costs (14).

Small physician practices are generally hesitant to make up-front investments in hopes of generating a return. EHR adoption provides an example. Depending on the size of the practice and its applications, EHR acquisition costs an average of $44,000 per physician. The average annual ongoing costs of maintenance and support are about $8,500 per physician (15). Physicians cite these costs as the largest barrier to EHR adoption (16). Costs are also associated with training and lost productivity; a 2005 study found that 14 small practices that implemented a HIT system experienced a decline in revenue of $7,500 per physician because of lost productivity (17). Collectively, investment and maintenance is a financial commitment that spans the life of the practice. This obstacle is especially acute for physicians in small practices, where three-fourths of all Medicare recipients receive outpatient care (18).

Large practices and integrated delivery systems may find programs that provide back-end reward through a shared-savings model viable. Small practices generally lack the up-front capital to make the personnel and infrastructure investments needed to generate efficiencies that would bring shared savings rewards. Accordingly, a model that provides some resource assistance to small practices to invest in increased capability is likely needed to make back-end shared savings possible.

9. New payment models should seek to minimize the imposition of new administrative tasks and costs on physician practices and seek to reduce the cumulative burden of existing requirements that detract from patient care.

- Assess the impact of the new payment model on the administrative tasks and costs required of physicians and physician practices and have an explicit goal to not impose additional tasks that are unnecessary
- Ensure that the cost of any new administrative requirements inherent in new models, such as achieving PCMH recognition, be recognized in the payment structure
- Ensure that inherent new administrative requirements be designed to minimize burden and are facilitated through technology when possible
- Have an explicit goal of reducing existing administrative tasks and costs imposed on physicians and practices under the current, primarily volume-based payment system
- Replace medical review processes that involve Medicare personnel review of medical record documents to assess the necessity of services billed to the program with processes that encourage accountability on the basis of measurement of quality, effectiveness, and efficiency of care
- Recognize that primary care and principal care physicians—those with a longitudinal relationship with patients—have an especially heavy administrative workload

Practicing physicians are forced to navigate a myriad of regulations and requirements unrelated to direct patient care, which put a strain on their practice and adversely impact their satisfaction. A 2007 survey of fourth-year medical students found that they perceived internal medicine as requiring more paperwork, which was, among other considerations, a factor in specialty choice (19).

10. New payment models should recognize the costs to physicians associated with the transition to the new payment structure

- Recognize the costs—in terms of lost productivity, training, and infrastructure—associated with transition to a new payment system.

Physicians affected by use of innovative payment models will experience a disruption in their operations. The magnitude of this disruption is likely to be commensurate with the extent to which the model deviates from the current system. Basing payments to physicians, in part, on their performance would likely require practices to provide additional information pertaining to the care they furnish. Basing payments, in part, on how an individual interacts with the larger delivery system is likely to require coordination with other entities, such as other physicians and hospitals. It is important to understand the impact on physicians to ensure that their practices can comply with the operational requirements imposed by new payment models.

11. New payment models should allow for on-going evaluation and assessment for change

- Provide mechanisms to monitor and assess the impact of reform, including individual elements, and make modifications as appropriate

IV. Process for Testing Innovative Payment Reform Models to Achieve Maximum Benefit

Background

Numerous reform proposals are being considered. However, most if not all are largely untested. Experience and evidence are needed to assess the feasibility, impact, and sustainability of these proposals. Multiple innovative models should be tested and evaluated, with an emphasis on the most comprehensive of models. Reform proposals should possess the elements defined earlier in this paper. ACP intends to use these recommended elements to evaluate proposals. An environment that provides for the design, implementation, and evaluation of reform models is needed to provide policymakers and other stakeholders with the information needed to determine the best payment reform path to achieving optimum performance from our health care system.

Recommendations

1. Congress should provide the Secretary of the Department of Health and Human Services (HHS) Secretary with the authority and funding to conduct voluntary pilots of innovative models to better align physician payment with desired outcomes pertaining to quality, cost-effectiveness, and efficient patient-centered care and to create a fast-track process and timeline for widespread adoption of the models that are shown to have the greatest positive impact on these desired outcomes. Congress should direct the HHS Secretary to take the specific steps below to guide this effort.

a. Establish criteria for determining which physician payment reform models should receive priority for fast-track funding and implementation. Such criteria should be determined in consultation with physicians, consumers, and other stakeholders, and specifically include the ACP-recommended reform elements articulated in this paper.

b. Select payment models, on the basis of the criteria referenced above, for fast-track funding, implementation, and evaluation on a pilot basis, not constrained by the usual requirements for research and development funding, such as the requirement that all pilots be implemented on a budget-neutral basis. The Secretary may prioritize and stagger the timeline for implementation, but highest priority projects should begin as soon as practicable. Priority should be given to piloting payment models that specifically aim to improve the primary care physician practice environment.

c. Establish a technical advisory panel of health policy experts, consumers, physicians (including primary care physicians), and other stakeholders to provide advice to HHS on design, implementation, and evaluation metrics for each pilot selected under such fast-track authority. This technical advisory panel shall also assist HHS in ongoing assessment of each pilot as data become available.

d. Create processes to allow for voluntary participation by a wide range of physician practices, primary care, and non–primary care practices alike to participate in the projects selected under the fast-track authority, recognizing that different models may be more or less applicable to specific types of physician practices and specialties. Direct the Secretary to make technical assistance and practice transformation support available to practices that elect to participate.

Medicare and other payers urgently need to develop, initiate, pilot, and then expand effective new models of physician payment that realign incentives from volume of services to effective, efficient, patient-centered, team-based, and coordinated care. The HHS Secretary should be given the funding and fast-track authority to identify the most promising models for reform, on the basis of policy criteria to be developed in consultation with outside experts, which should receive priority for pilot testing and subsequent expansion under fast-track authority. Timelines and benchmarks should be established to enable the Secretary to make decisions, also in consultation with outside experts, on which pilots have demonstrated the greatest potential to improve patient care to merit rapid expansion into the broader Medicare population. This effort should include continued expansion and evaluation of the PCMH, through standalone testing of the model by Medicare and other payers, and likely as part of more comprehensive innovative reform models. The Medicare Payment Advisory Commission (MedPAC) should also provide guidance throughout this effort.

Other ideas being discussed to improve the ability to test, evaluate, and expand reform models may supplement our recommended process. The potential establishment of a Medicare Chronic Care Practice Research Network provides an example. Congress has directed MedPAC to study the feasibility and advisability of such an undertaking (20). Establishing a mechanism that compiles and disseminates information on state-based payment reform efforts would be another contribution. A Rhode Island project that aims to provide benchmarks and strategies for improving private health plan payments for primary care is an example of an idea worthy of sharing broadly. The federal government and other states would benefit from this information-sharing mechanism.

V. Optimizing Benefit Related to the Patient-Centered Medical Home Model

Background

The PCMH is a promising reform model for improving the quality of patient care while restraining or reducing costs. ACP was instrumental in developing the delivery model and articulating a supporting payment structure (21). The College helped to establish a process to recognize PCMH practices and advocate for testing (22). These efforts were intended to define the PCMH and promote stakeholder confidence in the model.

The objective behind these efforts has largely been met; the PCMH enjoys the support of a wide range of health care stakeholders, including physician organizations, consumer organizations, employers, health plans, and quality-focused organizations (23). Policymakers view it as a promising reform model, with Congress authorizing the Medicare Medical Home demonstration project through a 2006 law and supplementing it with dedicated funding and increased ability for expansion through a 2008 law. The Medicare Payment Advisory Commission recommends a Medicare medical home pilot project to supplement the demonstration currently being developed that focuses on practices that use advanced health information technology (24). Other pieces of federal legislation have been or are likely to be introduced that would direct additional Medicare medical home test projects. Numerous states are incorporating PCMH tests into reform of their Medicaid and State Children's Health Insurance Program (SCHIP) programs (25). Numerous private payers are participating in PCMH test projects, many involving multiple health plans, that are underway or being developed across the country (26).

The enhanced payment that supports PCMH practices is intended to benefit primary care and other physicians who provide whole-person, longitudinal, patient-centered care of patients. The intent is to reward physicians for providing effective, efficient care, which is expected to result in overall savings. In addition to increasing compensation to these physicians, the payment structure is intended to provide physicians the ability to increase practice capability in terms of infrastructure and personnel that form a cohesive interdisciplinary team.

Recommendations

1. **ACP recommends that Congress expand and/or supplement the existing Medicare medical home demonstration with a national pilot project.**
2. **ACP recommends that Congress direct CMS to work with private-payer PCMH test projects to include Medicare beneficiaries to ensure that projects include the great majority of patients in a physician's panel.**
3. **ACP recommends that the HHS establish a PCMH "National Coordinator," housed in the Office of the Secretary, to lead an office with the resources to coordinate government involvement pertaining to all PCMH-related activities. These activities include:**

- **Coordinating PCMH efforts that pertain to Medicare, Medicaid, and SCHIP**
- **Considering proposals to expand and/or supplement the existing Medicare Medical Home demonstration project**

- **Assessing private payer PCMH test projects and related efforts**
- **Ensuring that the evaluation of government and, to the extent practicable, private test projects provide optimal information to assess the model**
- **Working to establish a payment structure to support practices that receive voluntary PCMH recognition and a timeline for implementing it during the period in which the Medicare Medical Home demonstration and other test projects are playing out, to be able to expeditiously transition to the model if it meets quality and cost benchmarks**
- **Linking other federal initiatives that complement PCMH test projects in areas in which there is overlap**
- **Facilitating technical assistance and other support to small practices interested in achieving PCMH capabilities and recognition**
- **Applying experience from other CMS demonstrations, including past projects involving similar goals**
- **Coordinating with the Agency for Health Research and Quality research agenda**
- **Coordinating with the Health Resources and Services Administration in its role in physician workforce issues**
- **Working with other federal agencies and departments as appropriate.**

Rewards for having and using high-level practice capability, as signified by PCMH recognition, should be available to physicians throughout the country through a national pilot. Although the current Medicare demonstration allows Congress to expand the project if quality increases but cost does not or if costs decrease but quality does not, CMS is not currently authorized to expand the demonstration nationally if it proves successful (27). A pilot would inherently provide CMS the ability to incorporate the PCMH as a permanent part of the Medicare program if it demonstrates success.

It is essential that PCMH test projects involve enough patients or payers to make participation worthwhile to practices. Physicians are unlikely to go through the process of receiving PCMH recognition and applying practice improvements to all patients if they will receive rewards tied to only a small number of patients in their total panel.

Addressing this problem requires collaboration between payers. CMS states that 86% of beneficiaries meet the eligibility requirements to participate in the Medicare demonstration. A physician in a PCMH-recognized practice must have at least 150 eligible patients on his or her panel to participate (28). Although panel size is difficult to determine with precision because of differing definitions, a 2003 ACP member survey indicated that internists typically have nearly 1,500 "active" patients, described as patients seen in the past 2 years (29). Beneficiaries included in the Medicare demonstration will represent a small percentage of the total panel, even if all eligible beneficiaries elect to participate.

Even a PCMH test project involving multiple private payers is limited in its ability to include a great majority of patients on a physician's panel in the project. The Colorado Multi-Stakeholder, Multi-State PCMH Pilot project will not come close to including nearly all patients in the project despite participation from six private health plans and the state Medicaid program (30). It is necessary for Medicare and private payers to join together to conduct a PCMH project that will be intuitively appealing to physicians and patients. Although CMS has identified the presence of private sector PCMH test activity as one criterion it is using for selecting the eight geographic states or sites for the Medicare demonstration (31), ACP perceives this as a secondary priority for the

agency. The federal government must be more proactive in jointly testing the PCMH in conjunction with private payers.

Understanding the impact that payment changes and support to participating practices have in determining test results is important. The various projects being conducted by Medicare, Medicaid, SCHIP, and private payers differ in the extent to which they enhance payment and other support, such as access to a patient registry to help manage patient population, to physicians in medical home practices for providing patient-centered care. Although ACP appreciates the willingness of payers to invest in testing the PCMH model, underfunding test projects could compromise the ability to accurately assess the model. The enhanced support in the various projects may need to be adjusted on the basis of each project's experience. Maintaining this information centrally would be invaluable.

The ability to centrally receive and assess information related to PCMH test projects would enable the federal government to develop a payment structure that supports the model while results are coming in and to establish a timeframe for broader implementation. Barring adjustments driven by information pertaining to projects, ACP has recommended that the payment structure include:

- A severity-adjusted, per-patient, per-month fee to cover care coordination efforts and needed infrastructure
- Continued fee-for-service payments
- A quality-based performance component.

Considering the dire primary care environment—and the contributing role played by the current payment system—as well as the demands of an aging population, it is prudent to be proactive regarding implementation of reform models that demonstrate success. The College recognizes, however, that other payment models might also prove to be effective in supporting care delivered through a PCMH and that several different PCMH payment models could be studied in innovative model pilot tests.

Practices must demonstrate that they have the structure and capability to provide patient-centered care to be recognized as a PCMH. The most recently used PCMH recognition module classifies a qualifying practice as one of three medical home levels, each indicating a progressive level of capability (32). Although practices must demonstrate capability beyond what is typical, they have some ability to reach the requisite PCMH recognition score in different ways. ACP is aware that government programs exist that address focused areas that are relevant to the PCMH. The current scope of work governing the Medicare Quality Improvement Organization (QIO) program involves 14 organizations that focus on improving transitions in care, such as inpatient-to-ambulatory setting, in certain geographic areas. HHS maintains a program that facilitates the ability of physicians to provide language translation services to patients. A National Coordinator could leverage activities such as these that are being conducted through government programs.

Establishing the position of a PCMH National Coordinator in a well-funded office would enable the federal government to be aware of the wide range of activities relevant to the PCMH; be directly involved in the activities of its choosing, to leverage all efforts to maximize the benefit of this promising reform model; and have a cohesive plan for broader implementation if the model proves successful. Of note, it would also raise the profile of the PCMH, consistent with the interest it has received from stakeholders.

Advancing the PCMH concept is an important step toward realizing more comprehensive payment reform. The PCMH can play an important role in innovative reform models that are worthy of testing.

VI. Immediate, Sufficient, and Sustained Improvements in Payments to Primary Care in the Current Medicare Fee-for-Service System

Background

For the purposes of this section of the paper, ACP defines "primary care physicians" as general internists, geriatricians, family physicians, and pediatricians. Our definition is largely consistent with definitions used in the references cited throughout this section. Although the College does not doubt that other specialties face looming shortages and other serious challenges, the primary care physician workforce is in crisis. Without urgent and significant action, it may be beyond repair.

The demand for primary care in the United States is expected to grow at a rapid rate, whereas the nation's supply of primary care physicians is declining. This divergence between supply and demand comes at a time when the value of primary care is increasingly documented and understood.

The Association of American Medical Colleges (AAMC) estimates a shortage of about 46,000 primary care physicians by 2025, which accounts for about 37% of the total physician shortfall (33).

Primary care physicians are leaving the field—through early retirement or career change—at a higher rate than colleagues in other specialties (34). Medical students' career plans are even more disheartening. Only 2% of fourth-year medical students indicated that they planned to enter a career in general internal medicine, according to a 2007 survey of 11 U.S. medical schools (35).

A 2008 ACP paper cites over 100 articles that show the value of primary care. The paper, which describes a review of literature over the past 20 years, highlights the critical importance of primary care in providing patients with better outcomes at lower cost (36). An example of the evidence cited in the paper is the description of a study showing that a 1% increase in the number of primary care physicians per 10,000 people in a state was associated with a rise in that state's quality ranking by more than 10 places and a reduction in overall spending by $684 per Medicare beneficiary (37).

The factors that contribute to the decline in the primary care physician supply are multifaceted and complex. They include the rise in medical education debt and the administrative hassles that have caused great dissatisfaction with the current practice environment. An ACP description of these issues and recommendations to address them are included in the College 2009 position paper "Solutions to the Challenges Facing Primary Care Medicine: Comprehensive Strategies from the American College of Physicians."

The recommendations in this section focus on the key—and perhaps predominant—factor driving the declining interest in primary care: Lower compensation relative to other specialties. Reliance on a payment system that rewards volume of services provided plays a significant role in this payment discrepancy.

The income gap between primary care and other specialties is real and growing (38). Currently, the average primary care physician earns approximately 55% of the average earnings for all non–primary care physician specialties (39). Over a 35 to 40-year career, the gap in income between primary care physicians and the midpoint income for other physicians is $3.5 million. The income of a radiologist or orthopedic surgeon, specialties at the higher end of the physician income scale, is nearly three times higher than that of a primary care physician (40).

The role of income in specialty selection is well documented. A 2007 survey of the perception of fourth-year medical students pertaining to internal medicine, compared with other specialties they had chosen or considered, is telling. Respondents perceived internal medicine as having lower income potential while requiring more paperwork and a greater breadth of knowledge (41). A recent study compared residency position fill rates with average starting salaries by specialty. It found a strong direct correlation between higher overall salary and higher fill rates with U.S. graduates. The specialties of pediatrics, family medicine, and internal medicine (all disciplines) have the three lowest starting salaries. In 2007, only about 42% of first-year family medicine residency positions were filled by U.S. medical school graduates, compared with approximately 94% in orthopedic surgery (42).

Patients will benefit if primary care physicians are paid commensurate with their value. As noted above, the availability of primary care is consistently associated with better outcomes and lower costs of care, yet the lack of competitiveness in primary care compensation compared with other specialties is a principal factor behind the growing shortage of primary care physicians. The shortage of primary care physicians will continue to grow, leading to poorer outcomes and higher costs of care, unless immediate steps are taken to make primary care compensation competitive with other specialties. It is illogical to maintain a payment system that discourages primary care practice at a time when need and demonstrated value are increasing. Dramatic and urgent action is needed. The minimum of 7 years required to train a primary care physician reinforces the need to act to improve pay before the primary care workforce cannot be revived.

ACP believes that the development of new payment models, as discussed earlier in this paper, will prove to be the most effective longer-term strategy for realigning payment policies to support comprehensive, longitudinal, and coordinated care by primary care physicians. Such new models, by providing compensation to primary care physicians consistent with the value they provide, will make primary care more attractive to new physicians and help retain the existing primary care physician workforce. In the meantime, however, most primary care physicians are likely to continue to be paid under traditional fee-for-service, and most patients will continue to receive their care from physicians paid under such a system. Accordingly, compensation for primary care physicians must be made competitive with other specialties, even as new and better payment models are developed that align payment directly with the value of services being provided. Making immediate and sustained payment improvements in the current system will help facilitate a primary care base that can serve as a foundation of our health care system under new payment models.

Recommendations

1. **As new payment models are developed, piloted, evaluated, and then implemented on a large-scale basis, the federal government and all purchasers and payers of health care must also make immediate improvements in existing payment systems, on the principle that compensation of primary care physicians should be competitive with that of physicians in other specialties.**
2. **The federal government should take the lead in working with other purchasers and payers to conduct a price and market sensitivity analysis—to which all payers should contribute—to determine the level of compensation needed to make primary care competitive with specialty and other career choices for physicians.**
3. **Until such a market sensitivity analysis is completed and its results are assessed, the federal government and other purchasers and payers should take the interim step of setting a target benchmark for annual compensation increases for primary care physicians, based on the best available current data, to close the percentage gap in the average annual compensation for primary care physicians compared with other specialists.**
   a. **As a starting point, ACP recommends that the target be set at 80% of the annual compensation received by the median or average compensation of all non–primary care specialties.**
   b. **Medicare fee-for-service payments to primary care physicians should be increased over a 5-year period to account for the program's proportional contribution to achieving the target annual compensation level. This should be implemented as soon as practicable through an adjustment to payments, as determined by the existing fee-for-service methodology. The adjustment each year should be no less than one fifth of the amount needed to reach the 80% threshold over the 5-year period.**
   c. **The initial 80% target could be adjusted once the results of the market and price sensitivity analysis are completed. Specifically, Congress should charge the Secretary of the HHS to determine whether the plan to make primary care competitive with other specialties needs to be revised once the market and price sensitivity analysis is complete.**
   d. **The HHS should conduct an annual analysis of the impact that each year's payment increase has on the primary care workforce to determine whether it—and changes in other factors that determine specialty selection and practice choice—is achieving the intended effect. This analysis should include comparison against benchmarks for the number, proportion, and availability of primary care physicians.**
   e. **Congress should provide a dedicated source of federal funding to support increases in Medicare payments to primary care physicians. The increase should not be accomplished in a budget-neutral manner, which entails redistributing money with the physician payment pool. This dedicated source should be funded by the decrease in costs in other parts of the Medicare program that are expected to result from more robust primary care and by other means deemed by the Congress or through authority provided to the Secretary of the HHS.**

4. The federal government should disseminate information pertaining to its efforts to adjust its payment system to make primary care specialties more competitive and viable to private health plans and other purchasers of health care, such as state governments and employers.

To eliminate differential income as a critical factor in medical student and resident choice of specialty, the average net income for primary care physicians needs to be raised to be competitive with the average net income for all other specialties. As a starting point, ACP recommends setting the target percentage of primary care physician income at 80% of the average income of all other specialties. ACP has calculated that Medicare and all other payers would need to increase their payments to primary care physicians by approximately 8% per year over a 5-year period, above the baseline for all other specialties, to bring the average of the median earnings for primary care physicians to 80% of those for all other specialties, all other factors being equal.

The plan to increase payment to primary care physicians by 8% per year above the baseline for other specialties should remain in place until data are available that justify modification. The results of a market competitiveness and price sensitivity analysis would be used—along with other emerging data—to adjust the plan. The market competitiveness and price sensitivity analysis should take into account the additional years of training associated with specialty training programs; any expansion of existing programs and development of new ones to reduce or eliminate student debt for physicians selecting primary care careers; and other relevant factors, such as any redistribution of payments that result from implementation of ACP recommendations to refine the RBRVS that are presented later in this paper. An annual study of the pay increase impact is prudent, even though it is unlikely that dramatic changes could be detected in the first year.

Achieving competitiveness with non–primary care specialties is warranted and essential to reverse the declining interest in primary care that has reached crisis. Addressing the unwarranted payment disparity will help physicians-in-training view primary care as a viable practice option.

ACP recognizes that calling for increased compensation for primary care physicians, especially at a time when the United States is in a severe economic downturn, may be difficult for some to accept. Yet the evidence is clear that unless primary care is compensated at levels that are competitive with other specialties, the numbers of physicians choosing primary care will continue to decline, leading to poorer access, higher costs, and worse outcomes for patients. Other countries have raised the incomes of primary care physicians and found this to be effective in reversing the movement away from primary care. The United States can learn from their experience. Increased payment to primary care should be linked to a process to monitor the adequacy of medical students and residents who select primary care specialties and the overall supply of primary care physicians to determine how long such a policy should be continued.

The Role of Medicare

Medicare, as the single largest purchaser of health care in the United States, has a particular responsibility to lead. A number of influential stakeholders are urging policymakers to take action to boost Medicare primary care payments. Although these recommendations fall short of the steps ACP is recommending, they represent an increasing call for action.

MedPAC recommends that Medicare pay a bonus for primary care services furnished by primary care–focused practitioners. Although MedPAC would yield to Congress to determine the precise bonus payment amount, it identifies the 10% bonus currently paid for services furnished in health professional shortage areas and the 5% bonus that was until recently paid for services in areas with a low physician-to-population ratio as a starting point for discussion. The Commission initially made this recommendation in June 2008—when it devoted an entire chapter in its *Report to Congress* to "Promoting the Use of Primary Care"—and reiterated it in its March 2009 *Report to Congress* "to emphasize its importance." The MedPAC rationale for the bonus payment is that primary care services are undervalued and that physicians focused on furnishing primary care services cannot increase the frequency with which they furnish these services—as could be more readily done for tests and minor procedures—to increase their revenue (43).

It is unclear whether MedPAC intends for its recommendation to represent a one-time adjustment or a sustained adjustment over several years until the compensation gap between primary care physicians and other specialists narrows significantly. Further, the MedPAC-recommended adjustment would enhance revenue to eligible primary care physicians by less than the decided-on amount of increase because the increase would apply only to specific evaluation and management services and not all the services. An adjustment of 10% using the MedPAC approach, whether for a single or even over multiple years, will be insufficient to make primary care competitive with other specialties. The inability of the bold MedPAC recommendation to result in competitiveness illustrates the severity of the discrepancy.

Although ACP appreciates MedPAC's attention to the payment disparity problem, its recommendation that the bonus payment not increase the overall amount that Medicare spends on physician services deviates from the College's position that the funding should not be restricted in this budget-neutral manner. Instead, funding should take into consideration the impact of primary care in reducing overall Medicare costs, including Part A cost avoidance associated with reductions in preventable hospital, emergency department, and intensive care unit services associated with increased or improved primary care. Other non–budget neutral funding may be required as a supplemental source.

The Commonwealth Fund, understanding the need for action to boost primary care, supports the MedPAC primary care bonus recommendation. The Commonwealth Fund also recommends that the adjustment be budget-neutral, projecting that it, coupled with other changes in the way Medicare updates payments for physician services that are beneficial to primary care services, will generate lower expenditures (44).

In addition, the amount of the adjustment should not be left up to Congress to decide and enact each year, but should instead be scheduled in advance so that annual compensation increases in increments until competitiveness with other specialties is reached. Such predictability is needed to influence the career decisions of medical students who are contemplating the current and future potential of primary care compensation, as well as to help established primary care physicians who may be considering a career change or early retirement.

Role of Private Payers

Recognition of the need for private payers to contribute toward closing the income gap is growing. MedPAC states that application of a focused Medicare bonus payment by private payers would have the benefit of promoting primary care throughout the health care system (45). The National Business Group on Health (NBGH), which represents over 270 large employers who provide coverage for 55 million Americans, recommends a focus on primary care as part of comprehensive health care reform. In addition to urging primary care as the foundation for an efficient, high-quality health care system, NBGH recommends that "payment policies should recognize the value of primary care and primary care-like services." The NBGH believes it is necessary to reduce payment for services that are overvalued and generate increased efficiency to avoid increasing overall expenditures (46).

Although we call for Medicare to lead, the need for private payers to improve primary care physicians is great. ACP estimates that Medicare patients make up 40% of the typical internist's patient panel, meaning that most patients are covered by other sources—most commonly private insurance.

The results of a 2006 American Medical Association (AMA) survey of private health plans, Medicaid plans, Workers' Compensation plans, and TRICARE show that most non-Medicare plans use the RBRVS to determine payments but convert the RBRVS relative value units (RVUs) in a manner that results in higher payment for non–primary care services (47). These findings are significant because the AMA survey involves payers that provide health insurance coverage to over 123 million enrollees, with private insurance plans accounting for 79 million of the total.

Specifically, the survey found that 85% of private payer respondents use the RBRVS. Private payers, like Medicare, use a conversion factor to convert RBRVS RVUs to payment amounts. Most of these payers, unlike Medicare under its current payment methodology, use multiple conversion factors. The number of conversion factors used by private payer respondents is below.

- One conversion factor: 41%
- Two conversion factors: 9%
- Three to five conversion factors: 13%
- Six or more conversion factors: 38%

Private payers that use multiple conversion factors often establish a conversion factor for specialties or major service types. The average payer specialty or type of service conversion factors are below. This information is the average of all payers, because private payer–only specialty or type of service–specific conversion factor amounts are not readily available. As a point of comparison, the Medicare 2006 single conversion factor was $37.90. Whereas the average single conversion factor maintained by non-Medicare payers is an amount similar to the Medicare 2006 factor, those who maintain multiple conversion factors do so to the detriment of primary care services.

- Other payer single conversion factor: $38.04
- Primary care or E/M service: $44.78
- Radiology: $48.91
- Surgery: $51.95

Medicare has historically undervalued payment for primary care services, such as evaluation and management services. Private payers use the Medicare methodology and then compound this effect by paying more for non–primary care services. To break this cycle, the government must disseminate information on its effort to increase primary care compensation to make primary care specialties competitive and enlist employers to urge health plan changes. Although we realize that market forces and other factors determine private payer rates, the contribution to the payment disparity is stark and must be addressed.

Other Relevant Efforts

The initiation of thoughtful efforts to analyze the primary care problem and develop potential solutions is a further sign of traction toward receptivity to our recommendations.

The Council on Graduate Medical Education (COGME), a government entity that advises the Administration and Congress on physician workforce issues, has contracted for a study to research the factors that influence specialty choice and distribution. The study is expected to analyze the impact of income on specialty choice, as well as other factors, to determine how to increase the number of primary care physicians by making those specialties more attractive and/or manipulating training slots. The Council intends for the study to trigger an official report (48).

Rhode Island, through its Office of the Health Insurance Commissioner, is engaging in a project to define affordability priorities and standards for health insurers in the state. The initial recommendation of a project Advisory Council is that the most effective action health plans can take to improve the affordability of the health care system in Rhode Island is to redirect a greater portion of their medical payments in the coming years to primary care. Primary care spending baselines, benchmarks, health plan–specific spending targets, and regulatory consequences are to be established as part of the project (49).

It is encouraging that other countries have achieved success in attracting more primary care physicians by increasing payments to be more competitive with other specialties. The physician compensation program introduced into the English National Health Service in 2004 with an emphasis on improving chronic care increased family physician income by 58% through 2006 and "helped increase recruitment into primary care (50)." Further, many countries that rank higher in quality and lower in cost than the United States structure their payment system to better support care coordination and team-based care and reward care that is furnished consistent with evidence. Although the differences in how countries finance and pay physicians for care make direct comparison difficult, the emphasis on primary care internationally is instructive (51).

Implications and Discussion

In addition to helping to reverse the declining interest in the practice of primary care, improving compensation will enable these primary care physicians to spend more time with patients—understanding their problems, making a diagnosis, and discussing treatment options, as opposed to rushing to see as many patients in a day as possible. This should result in improved physician–patient relationships and a more rational use of resources.

The expenditure required to boost primary care is an investment—an investment in a more solid foundation on which to build an improved health care system—that will yield a better quality of patient care at lower overall

system cost. Devising a methodology that projects the impact of primary care on other parts of Medicare/sectors of our health care system is prudent and provides a mechanism to fund increased payments for cost-effective primary care. Even if the funding source derived from projected savings needs to be supplemented by other non–budget-neutral sources, dedicating such funding is a wise expenditure for a necessary investment. Additional funding could be derived from other reforms. ACP has identified some potential changes, many of which are technical in nature, that could help fund the primary care increase. They are available at www.acponline.org/advocacy/events/state_of_healthcare/options09.pdf. This initial expenditure is small considering the high likelihood of success and the large cost of inaction.

As mentioned previously, boosting compensation to primary care physicians and other changes through the fee-for-service system is one component, to be accompanied by testing of innovative payment models intended to facilitate a move to a more rational payment system. The College believes that new payment models that align incentive with value will ultimately do more to support the value of primary care physicians than will making improvements in fee-for-service payments; however, even the most promising new payment models need further development, testing, and evaluation.

ACP recognizes that some may question the idea of benchmarking a payment increase to primary care physicians to the current average level of compensation to non–primary care physicians, because this could be viewed as reinforcing the current perverse incentives for volume. The reality, however, is that most patient care continues to be reimbursed under a fee-for-service system and improvements to payments under this system are a necessary step to reverse the growing shortage of primary care physicians. Such improvements in fee-for-service must not be viewed as a substitute for the need to design and implement new payment models that fundamentally alter incentives to bring greater value to patients; indeed, development and implementation of such new models is urgent and must go hand-in-hand with improving fee-for-service to recognize the value of primary care.

VII. Other Improvements to the RBRVS on Which the Fee-for-Service System Is Based

Background

Congress requires that the CMS use the RBRVS to determine Medicare fee-for-service payments to physicians. The RBRVS measures the resource costs required to provide each physician service, ranking each service relative to all other services. These resource costs are expressed in the form of RVUs. The total relative value assigned to each service is divided into three components:

- Physician work—consists of factors recognizing the time it takes to perform the service, the technical skill and physical effort, the mental effort and judgment, and the potential risk to the patient. On average, physician work accounts for 52% of the total RVU of a service.
- Practice expense—consists of factors recognizing the direct costs, such as for equipment, supplies, and administrative and clinical staff, and the indirect costs, such as office rent and utilities, that the physician incurs in providing the service. On average, practice expense accounts for 44% of the total RVU of a service;
- Professional liability insurance—reflects the cost of professional liability insurance associated with performing the service. On average, professional liability insurance accounts for 4% of the total RVU of a service.

Medicare adjusts the RVUs for each of the three components to reflect cost differences by geographic area, known as Geographic Practice Cost Indices (GPCI). It converts the geographically adjusted total RVU for each service into a payment amount by multiplying it by a dollar multiplier, called a conversion factor.

The Medicare payment formula is:

$$\text{Payment Amount} = [(\text{Work RVU} \times \text{Work GPCI}) + (\text{PE RVU} + \text{PE GPCI}) + \text{PLI GPCI})] \times \text{Conversion Factor}$$

The great majority of non-Medicare payers, including private health plans, use the RBRVS as the basis for determining payments (52).

CMS maintains the RBRVS through annual and periodic updates to RVUs assigned to each service and changes to the underlying methodology. It is imperative that these changes be appropriate because the RBRVS drives approximately $80 billion in annual Medicare payments for physician services and substantial amount in payments made by other payers. Recent reports from MedPAC (53) and the Center for Studying Health System Change (54) have highlighted the adverse effect of improperly valued services, or misvalued services, on our health care system. Misvalued services distort incentives and may result in the overuse or underuse of specific services on the basis of financial as opposed to clinical reasons. Inappropriate valuation of services also affects physicians' decisions to enter or remain in specialty fields that perform undervalued services.

The College included a series of recommendations in a 2006 position paper, "Reform of the Dysfunctional Healthcare Payment and Delivery System," aimed at improving the RBRVS. Some of the recommended changes have been made. However, more needs to be done to enhance the accuracy and fairness of the RBRVS system. Although there is significant interest in moving away from a system that pays for discrete physician services in an overarching system that provides incentive to increase volume, refining the RBRVS remains crucial

until new payment models are designed and implemented on a widespread basis. Innovative payment models are likely to be tested, and even models that dramatically change incentives may still, at least in part, be based on current fee-for-service payment rates that are built by RVUs. In addition, Medicare can make payment policy changes within the context of the RBRVS to facilitate a transition to models of care that focus more explicitly on improving care coordination.

Recommendations in this section of the paper aim to improve payments—and the larger practice environment—to primary care physicians and internal medicine subspecialists. Some recommendations benefit all physicians. Most important, the recommendations are intended to benefit patients by improving the quality, effectiveness, and efficiency of care provided in the United States.

Recommendations

Improving the Accuracy of Relative Value Units Assigned to Physician Services

1. **ACP recommends that the federal government improve the methodology for determining practice expense relative value units, including by revising the assumptions that overvalue high-cost equipment.** The federal government should establish mutually exclusive equipment categories for all services with each assigned its own percentage utilization rate. Any "savings" that result from these changes should be put back into the physician payment pool of dollars to be redistributed through payments for all other services, which would include primary care services. In addition, CMS should continue with its plan to update the specialty-specific practice cost data it uses in its practice expense methodology and consider other appropriate actions.

MedPAC recommends an increase in the percentage rate at which equipment is assumed to be operating (55). The use of a higher utilization rate assumption would spread the cost of the equipment over more units of service. This is because the physician payment for using the equipment for each service is based on the assumed use of the equipment over its lifetime. If the assumed utilization factor is less than the actual use of the equipment, the payment for that equipment is higher than warranted. CMS uses the 50% equipment use assumption rate it established in 1997 without access to specific equipment use information. A MedPAC 2006 survey of selected markets indicated that advanced imaging equipment use was significantly higher than the current 50% assumption. The RUC also recommends that CMS revise its assumed utilization rate to better reflect the use of high=cost equipment. Overpaying for advanced imaging services (e.g., CT, MRI) provides incentives that can contribute to rapidly rising utilization. Further, the high acquisition cost for advanced imaging equipment provides a strong incentive to optimize the amount of time it is in use (56).

In response to CMS interest, the AMA is facilitating a survey of physicians that collects practice cost data that will enable the agency to plug this more recent data, which is meant to capture a snapshot in time for all physician specialties, into the methodology it uses to determine practice expense RVUs. This is an important step toward ensuring the complex multistep methodology produces the fairest and most accurate RVUs possible. We encourage CMS to use the specialty practice cost data that AMA will soon provide and explore other changes to improve the methodology.

2. **ACP recommends that the federal government establish a group of independent experts to advise CMS in its process of reviewing relative value units. It should focus on identifying potentially overvalued services and data sources that can be used to improve the accuracy of relative value units.** The group should supplement the advice that is currently provided by the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC), an entity composed of representatives appointed by physician specialty organizations that makes relative value recommendations to CMS. Congress can direct CMS to take this action or the agency can use its existing authority.

In its March 2006 *Report to Congress*, MedPAC recommended that CMS establish an expert panel to guide review of RVUs assigned to physician services, citing concern that the RUC is ill-suited to identify and address services that may be overvalued. While the RUC has put processes in place to focus on misvalued services, ACP is not convinced that the RUC process is well-suited for taking decisive action to correct overvalued services. Accordingly, ACP continues to recommend that an expert panel be established and charged to focus on overvalued services. Including representatives without a direct financial stake in the fee-for-service payment system would enhance the ability of this panel to accomplish this mission. Specifically, the panel should include Medicare contractor medical directors; experts in economics, technology, and physician payment from the private sector; and patient consumer representation.

CMS should identify data sources that provide information on cost, time, and other factors involved in furnishing services. In addition to receiving guidance from the expert panel, CMS should work with other parties inside and outside government (e.g., Kaiser-Permanente or other staff model health maintenance organizations, hospital systems, the Department of Veterans Affairs, and the National Institutes of Health) to obtain real data. Examples of how data pertaining to services that have been furnished to patients could be used to promote accurate RVUs are below.

- A review of hospital logs that document surgical procedures indicates that the amount of time recorded to perform many procedures is generally lower than the amount of time assigned to the procedures in the RBRVS methodology, which are typically established through survey responses reporting by a relatively small number of physicians. As the amount of time a physician devotes to furnishing a service is a factor in determining its RVU, excessive times probably distort payments (57).
- Some physician specialty organizations maintain repositories of information pertaining to services/procedures furnished to patients. These specialty organizations are to be commended for compiling and using these data for quality improvement. The RUC has used these data to some extent in determining RVU recommendations pertaining to certain services; however, application of these data in this context has been somewhat selective. It may be possible to apply data from repositories that were collected for reasons unrelated to payment to maintenance of RVUs.

3. **ACP recommends that the federal government study the process by which CMS receives input on the appropriate relative value units for each physician service.** The study should assess the degree to which physician representation is commensurate with contributions toward care of patients, with an emphasis on primary care and treatment of the chronically ill; and how the current statutorily mandated budget neutrality requirement impacts recommendations to CMS.

CMS has historically accepted over 90% of the recommendations it has received from the RUC (58). ACP has participated in the RUC since its 1992 inception and commends the RUC for its many contributions. The College remains concerned, however, that the RUC composition is skewed toward physicians who predominantly perform procedures and/or focus on single organ systems. In its March 2006 *Report to Congress*, MedPAC noted that some medical specialties felt that primary care specialties were not well-represented at the RUC. MedPAC went on to identify alternative options for determining representation: "Representation on a panel such as the RUC can be defined by the percentage of total EM [evaluation and management] services furnished by a specialty or by the proportion of total Medicare physician expenditures, or in other ways." Studying the process by which CMS receives input on the appropriate RVUs for physician services would contribute greatly toward ensuring that the process is objective and includes balanced representation of the physicians, including those who have expertise and experience providing whole-person, comprehensive, and longitudinal care.

RBRVS Changes to Facilitate Improved Care Coordination

1. **ACP recommends that Medicare make separate payment for services that facilitate care coordination and promote patient-centered care, including:**

- **Comprehensive coordination of a patient's care, including care related to transition between settings**
- **Evaluation and management provided to an established patient by phone**
- **Evaluation and management provided to an established patient using Internet resources**
- **Collection and review of physiologic data, such as from a remote monitoring device**
- **Education and training for patient self-management**
- **Anticoagulation therapy management services**
- **Current or future services as determined appropriate by the Secretary of HHS.**

The Medicare fee-for-service payment system continues to be anchored to a face-to-face encounter with a patient. CMS has declined to provide separate payment for many discrete services that do not involve the physician seeing the patient face-to-face. CMS maintains this position despite the fact that, in most cases, procedure codes describing these services exist that would allow physicians to bill for them and that agency has assigned RVUs, with the assistance of the RUC, to these services. CMS must recognize the value in allowing care to be furnished in the most efficient manner. Patients would certainly benefit from Medicare payment policy changes that expand the options by which they receive needed care.

Paying for Services Currently Defined and Exercising Authority to Expand Needed Care Options

Making a separate payment for providing a clinical service to a beneficiary known to the physician that is unrelated to a face-to-face encounter, by phone or e-mail, would facilitate care that is more convenient for the patient. Paying for discussing whether care plan changes are needed as a result of clinical data derived from a remote monitoring device is likely to result in more timely care. Facilitating the ability of physician practices to educate patients to better manage their own condition is a sound investment.

Paying for some of these services would provide an incentive for physicians to be proactive in identifying and reaching out to patients in need of interventions instead of being reactive and waiting to be contacted by the patient when he or she needs care. The Secretary of the HHS could also use the authority we recommend to find innovative ways to reward timely, efficient care. For example, the agency could establish payment to physicians for using a registry, which is likely to be electronic but could be also be paper, to effectively manage their patient population by identifying patients who need interventions consistent with evidence-based guidelines and providing those services in a timely manner. Medicare must deviate from its position that payment is tied to in-person care because this often presents a barrier to optimal care.

Patients would benefit from having access greater access to physician services when face-to-face encounters are needed. Providing increased access through extended office hours, however, is a challenge as many practices are already stretched to capacity and maintaining longer hours involves real practice costs. Medicare could provide incentives for physicians to extend office hours by making an extra payment for service furnished during non-routine business hours. Existing procedure codes that indicate a service was provided during non-routine times (e.g., weekday evening, weekend) provide a mechanism CMS could use to make extra payments.

Implications and Discussion

These services are likely to result in care that generates savings in other settings. The misguided Medicare payment policy pertaining to billing for services to beneficiaries on the blood-thinning drug warfarin provides an example. The Medicare payment policy that requires the physician (or member of the clinical team) to see the patient face-to-face to bill for the careful management required for this dangerous drug provides an obstacle to optimal care. CMS should make separate payment for existing procedure codes that describe a bundle of anticoagulation management—including face-to-face and non–face-to-face services—to enable physicians to be paid for care furnished in the manner most efficient for the physician and the patient. The existing procedure code describes a small bundle of services furnished by a single physician over a relatively short period. Other procedure codes are structured this way (e.g., physician oversight of the care provided by a home health agency over a 30-day period). As the concept is already established and falls short of the "bundled payments" approached being considered as a more far-reaching innovative payment reform model, we view payment for the anticoagulation management bundle as covering a discrete service. The same concept would probably apply to the yet-to-be-established procedure code describing comprehensive coordination of a patient's care. Such a procedure code would probably describe all coordination-related services not currently adequately covered through payment for other services furnished over a 30-day period.

Medicare recognition of a better way to pay for anticoagulation management services is likely to reduce overall costs. It is estimated that there are more than 43,000 adverse drug events treated in the emergency department each year related to anticoagulation therapy (59). Many patients treated in the emergency department will be admitted to the hospital, further degrading the health of the patient and adding to unnecessary expense. A minimal investment in the outpatient setting would reduce expenditures in more costly settings.

Paying separately for these services would facilitate and reward efficient care. While many of the service would likely be provided by primary care physicians, all physicians, especially those who manage patients with serious or multiple conditions and thus frequently provide care between visits, would benefit.

Billing and collecting relatively small amounts associated with individual phone, e-mail, and other services may be cumbersome and potentially involve administrative costs that equal the payment. Another mechanism may be warranted, especially for physicians who frequently communicate with a patient about their care outside of a face-to-face encounter. Increased payment for an evaluation and management service related to a face-to-face encounter could provide a more accommodating billing and payment system.

The College recognizes that a sound argument can be made that it is best to tie payment for these services to a new payment model—be it through a PCMH, a bundled or capitation payment, or other model—that would link payment for a set of services to performance against quality, cost, and patient experience metrics. As discussed elsewhere in this paper, ACP strongly supports the development of new models of payment and delivery of services, including but not limited to the PCMH, that would incorporate payment for care coordination services that is bundled and tied to expected performance. At the same time, however, the College believes that there is a need to create mechanisms, at least on an interim basis, within fee-for-service to support the delivery of services related to improved care coordination. This recognizes that most physicians will continue to be reimbursed under a fee-for-service system at least in the near-term, while promising new models, including the PCMH, are pilot-tested. The ACP recommendations would also create a pathway for practices that may not yet be able to achieve the qualifications to be recognized as a PCMH. Rewarding these practices for more efficiently coordinating care at least for some patients will encourage them to expand their capability.

2. ACP recommends that Medicare make a separate payment for physician counseling related to beneficiary receipt of Medicare-covered preventive services furnished by another physician or entity.

While Medicare covers numerous preventive services, it fails to pay for physician discussions with patients about receiving preventive services furnished by another physician or entity. A general internist may urge an eligible beneficiary to receive a Medicare-covered colonoscopy to screen for colorectal cancer. The internist will need to explain why the colonoscopy is indicated, discuss the benefits, answer questions, and address concerns. Medicare does not pay for this type of counseling, making it challenging for physicians to find time to discuss clinically indicated preventive services during an encounter for an acute condition or ongoing treatment of a chronic problem. The payment could be a bundled amount that includes physician counseling for all the Medicare-covered preventive services furnished by others. As coverage for preventive services is defined by patient characteristics as determined by clinical evidence, a bundled amount could be established for the typical beneficiary in different gender and age categories.

This action would benefit the primary care physicians who frequently pro-

vide the counseling and benefit patients by ensuring that they receive preventive services. Non–primary care physicians who furnish these services would have increased opportunities to provide evidence-based preventive care to patients. It would also facilitate a practice's ability to improve care coordination.

ACP recommends that Congress direct the HHS to account for Medicare system-wide savings expected to result from payments for physician services that improve care coordination and provide patient-centered care and to use the amount of expected savings to increase the limit by which aggregate expenditures may rise before triggering an offsetting downward adjustment to maintain budget neutrality. The Medicare statute requires CMS to make a budget neutrality adjustment if RVU changes increase or decrease expenditures by at least $20 million. The statute should be modified to direct CMS to include Medicare system-wide savings that it expects to result from increased Part B expenditures for physician services that result from paying for additional services aimed at improved care coordination.

CMS would establish a mechanism to determine which services are eligible to trigger an increase in budget neutrality limits to reflect anticipated savings and how the savings should be calculated. The agency should use its efforts to project system-wide Medicare savings that the patient interventions and/or the application of technology can generate in its Medicare Medical Home and Electronic Health Record demonstration projects to guide its development of a mechanism to calculate expected savings.

Making this change will free CMS to invest through payments for new services and capabilities that can improve patient care and generate Medicare program efficiencies. The current budget neutrality adjustment requirement stifles innovation through the enormous barrier that paying for new services by lowering Medicare payments for all other services imposes. It would allow CMS to reward physicians who provide appropriate, efficient care without penalizing other physicians through budget neutrality–induced reductions in payments for the services they furnish.

ACP notes that provisions to accomplish the changes recommended above were included in H.R. 7192, the "Preserving Patient Access to Primary Care Act," which was introduced by Representative Allyson Schwartz in the 110th Congress (60). The College looks forward to working with the Congress to enact these provisions in the 111th Congress. It also will concurrently encourage CMS to implement the changes for which it has administrative authority.

The College emphasizes its position that payment reforms to make primary care more competitive with other specialties, to improve the accuracy of relative value units under the RBRVS, and to provide payment for care coordination services should not be dependent on showing that changes will result in immediate and "scoreable" budget savings. The methodologies to estimate budget impacts currently used by the Congressional Budget Office (CBO), Office of Management and Budget (OMB), actuaries, and others tend to discount the benefits—better outcomes and more effective use of services—associated with investments in improving health care delivery, including primary care, care coordination, and prevention. While the mechanism we recommend to identify the expected savings should be more dynamic than current methodologies, we understand that additional funding may be needed to pay for these services. As over 100 studies show that primary care is associated with better outcomes and lower costs, providing this funding is a prudent investment.

VIII. Improving the Process by Which Medicare Physician Fee Schedule Payments Are Updated on an Annual Basis

Background

The Sustainable Growth Rate (SGR) formula establishes an annual target for the growth in expenditures of physician services. The target is a mechanism to control growth in aggregate expenditures on physician services. The annual update to Medicare payments, implemented through an adjustment to the dollar multiplier figure, or conversion factor, for a year is determined by comparing actual expenditures to targeted expenditures in the previous year. If actual expenditures are less than targeted, the annual update is positive and the conversion factor for the next year is increased.

Under the current law, the update for a year is determined by comparing cumulative actual expenditures to cumulative target expenditures from April 1996 through the end of the year prior to the year for which the update is implemented. For example, the 2009 update reflects a comparison of cumulative actual to cumulative target expenditures from April 1, 1996, through December 31, 2008 (the 2009 update amount resulting from the SGR formula was not implemented as Congress enacted a law specifying an update amount, overriding the amount derived through the formula). Target expenditures for each year are equal to target expenditures from the previous year increased by the SGR.

The SGR is calculated based on the CMS estimate of the change in the following four factors:

- The estimated percentage change in fees for physicians' services
- The estimated percentage change in the average number of Medicare fee-for-service beneficiaries
- The estimated 10-year average annual percentage change in real gross domestic product (GDP) per capita
- The estimated percentage change in expenditures due to changes in law or regulations (61).

The change in fees for physician services is primarily determined by the Medicare Economic Index (MEI), which represents the growth in the cost of providing physician services (62). An assumption that physicians continually improve productivity is a factor built into the MEI calculation, resulting in a downward adjustment to the medical inflation figure (63).

Congress included GDP growth as a factor in the SGR formula, believing that would allow for reasonable growth in expenditures on physician services (64). In the past, MedPAC has recommended that GDP be increased by a small percentage (e.g., 1% or 2%) as a more reasonable yet affordable proxy. More recently, MedPAC recommends that Congress update physician payments consistent with medical inflation. For 2010, MedPAC recommends keeping the downward adjustment resulting from the assumption of increased productivity in the inflation calculation.

The comparison of actual expenditures to the growth allowance target determined by the SGR formula produces an "update adjustment factor." The update for a particular year is determined by multiplying the update adjustment factor and the MEI. The law specifies that an update adjustment factor cannot exceed 3% or be less than – 7% in a given year (65).

CMS includes Medicare expenditures for some services not paid under the physician fee schedule, including Part B–covered drugs. These Part B drugs fall

into three general categories: those typically administered in a physician office setting; those administered through durable medical equipment items; and those that are patient-administered as allowed by statute. CMS is not required to include these expenditures in the update calculation under the SGR formula system but it chooses to do so because physicians directly control the provision of these services (66).

1. **Congress should replace the unsustainable Sustainable Growth Rate formula with a system that provides fair, predictable, and stable updates for physician services. This change should provide a permanent solution or, at a minimum, a transition to a more viable system that provides predictable and positive updates for physicians going forward. To facilitate a permanent solution to the SGR:**
   a. **CMS should retroactively remove expenditures on Part B drugs from the SGR formula.**
   b. **Congress should rebase Medicare baseline spending to eliminate the accumulated debt created by the SGR since it was implemented in 1998.**

The SGR system has been a perpetual problem since early this decade. Congress acted to avert the annual negative update produced by the SGR system during this time frame in every year but 2002. Even with Congressional action to override the projected payment cut with a freeze or modest payment increase, Medicare payments to physicians have lagged well behind increases in practice costs.

The late decisions to override the SGR-induced payment cut, a nearly annual event that has become ingrained in the political process, place a tremendous strain on the ability of physicians to plan—in terms of whether to accept new Medicare patients, retain or expand personnel, or invest in technology. The sequence of events is maddening. Congress has retroactively overridden a cut after its effective date. It has averted a scheduled cut for only a 6-month period, requiring additional, essentially immediate action to avert the next scheduled cut. This entire ordeal has required legislators and physician organizations to devote an inordinate amount of time and energy that could have been spent pursuing more meaningful and lasting reforms. Most physician practices are small businesses. This creates an environment inhospitable to small business.

Congressional action to avert the nearly annual impending SGR cuts without it adjusting the underlying formula has stymied efforts to provide a lasting fix to the SGR problem. Each fix by Congress has essentially increased the debt that the law requires to be recouped under the cumulative SGR system. This dynamic has gradually and dramatically increased the cost of replacing the SGR. CBO determines the cost of legislative action by determining how expenditures that result from the action compare with expenditures that would occur absent the legislative change. The hypothetical case of Congress averting the approximately 21% cut in physician payments slated to occur in January 2010 by replacing it with a 1% increase from 2009 rates is illustrative. The cost associated with this change is not the amount of money required to increase physician payments by 1% for 2010--it is the amount required to fund the roughly 22% payment increase above what is determined by the law before any change. Further, the CBO would calculate a Congressional decision to avert the additional 5% annual cut projected for 2011 and beyond by comparing the required new expenditures to the cuts determined by current law.

The accumulated SGR debt has grown dramatically as a result of this vicious cycle. In December 2008, the CBO estimated that it would cost $318 billion over 10 years to replace the SGR cuts with a freeze in payments at their current level and $439 billion over 10 years to replace it with an annual update equal to medical inflation (67).

This situation is serious and will only get worse without dramatic action. Congress needs to eliminate the SGR-accumulated debt. The College commends the Obama Administration for its intent to dedicate funding to account for "additional expected Medicare payments to physicians" over the next 10 years that was specified in its 2010 fiscal year budget blueprint document (68). ACP is pleased that this policy is reflected in the Budget Resolution approved by the U.S. House of Representatives in April 2009. Accounting for the funds provides a foundation for an enduring solution. Congress must follow the lead of the President and act to end the SGR saga.

CMS should remove expenditures for drugs covered under Part B from the SGR formula, extracting spending attributed to these drugs going back to the first year the SGR was in use. Retroactive removal of the cost of drugs would dramatically reduce the cost of an overall SGR fix, which includes lowering the cost of eliminating the SGR-accumulated debt. According to a recent estimate by the AMA, retroactive removal of the cost of physician-administered drugs back to the base year for tracking expenditures under the SGR would reduce the 10-year cost of replacing the SGR going forward with updates based on MEI by $150 billion (69). Spending less to address the SGR problem could free up funds for more constructive efforts, such as helping to fund payment improvements to make primary care specialties more competitive with other specialties.

2. **In conjunction with elimination of the SGR, Congress should facilitate and fund the development of alternative physician payment models to introduce incentives for efficient and effective care, rather than paying solely on the basis of volume of services based on input prices. (The College's recommendations for promising payment models are discussed later in this paper).**

    a. **The College believes that such changes in Medicare payment policies to create incentives for more efficient and effective care at the practice and individual physician level, as will be discussed later, may eliminate the need to replace the SGR with a new Medicare expenditure targets(s).**

There is no evidence that physicians respond to a national target in making treatment decisions (70), but there is considerable evidence that payment methodologies that introduce incentives for effectiveness and efficiency at a more "micro" level can influence physician decision-making. ACP continues to prefer that Congress only institute volume or expenditure controls as a backup mechanism to the extent that other reforms in payment methodologies to improve quality and introduce greater efficiency are found to be insufficient. These other reforms include aligning Medicare payments with quality improvement, promoting adoption and use of health information technology, and providing patient-centered care through the PCMH. These innovative initiatives, combined with more accurate payments for physician services under the RBRVS, should result in more rational expenditures.

3. Should Congress decide that a national expenditure target(s) is required, it should consider the following adjustments/alternatives.

a. New Single National Target for All Services—any national target to replace the SGR should:

- **Separate Medicare payment updates from per capita GDP.**
- **Consider whether the components of the Medicare Economic Index still represent an accurate cost of medical inflation.**
- **Refrain from decreasing the Medicare Economic Index for assumed increases in productivity.**
- **Provide a full update that is not lowered by an amount attributed to assumed increased physician productivity.**
- **Establish a realistic floor on payments so that physician payment in any given year would not be subject to drastic cuts.**
- **Allow for expenditure increases resulting from new technologies.**
- **Account for instances when a service/procedure previously performed exclusively in the inpatient setting becomes available in the outpatient setting.**
- **Not be cumulative in nature.**
- **Require that HHS more expressly and consistently take into account expenditure growth associated with new and expanded Medicare benefits.**
- **Direct the HHS Secretary to take into account the impact of volume growth within physician services on substituting or reducing expenditures in other categories of Medicare.**
- **Give the HHS Secretary authority to exempt specific categories of services, such as primary care services, from any payment reductions resulting from the single target, providing flexibility to achieve policy objectives.**

Linking physician payment updates to GDP introduces volatility and has been demonstrated to be unsustainable. The U.S. recession early in this decade, shortly after the SGR system was implemented, contributed to negative updates. Physicians experienced a 5.4% payment reduction in 2002 as a result. The application of a downward adjustment for productivity is unwarranted, as the assumption that productivity increases regardless of the practice environment is dubious. It is unfair, as no downward adjustment is made as part of the methodology for updating payments to any other type of provider. The cumulative nature of the SGR and failure to fund the cost of short-term fixes to avoid cuts in subsequent years has put us in this untenable situation. Congress should learn from these lessons and make adjustments going forward if it retains a single aggregate expenditure target for physician services. ACP makes these recommendations in the spirit of using the collective troubling experience to improve a single target system.

b. Multiple Service Category-Specific Targets—any alternative that involves multiple targets by categories of service should:

- **Establish a new spending baseline that eliminates the need to recoup the SGR accumulated debt.**
- **Ensure that primary care services have a higher expenditure growth allowance than other services.**
- **Make information available on utilization and expenditures for service-specific categories available by geographic regions for informational purposes aimed at fostering local collaboration.**
- **Establish a mechanism to assess how the change in expenditures for physician services impact spending on other categories of physician services and other components of the Medicare program, including Part A expenditures. This information should be used to determine how best to eliminate the artificial divisions between components of the program that are barriers to effective coordination and policy.**
- **Give the HHS Secretary the authority to adjust a service category target upward should evidence show that increases in volume and expenditures for services included in that category have had a beneficial effect on reducing volume and expenditures in other physician service categories and on other parts of Medicare.**

Another alternative being considered by Congress would establish service-specific expenditure targets. A bill that passed the House of Representatives in 2007 would have established six service-specific expenditure targets in 2010. The six service categories would have been:

- Primary care (i.e., office visits, home visits) and Medicare-covered preventive services (e.g., screening colonoscopy)
- Other evaluation and management (E/M) services
- Imaging
- Minor procedures
- Major procedures (e.g., procedures with 10- and 90-day global periods)
- Anesthesia services.

Actual expenditures for each category of services would have been compared with category-specific target expenditures. Each category of service would have received an annual update—accomplished by modifying the conversion factor maintained for that category—based on this comparison. The annual growth allowance for each category would have been tied to GDP. The primary care service category would be the exception; however, as its annual volume growth allowance would be GDP plus 2%.

The intent was for these expenditure targets to curb the rapid growth in the provision of some advanced imaging services and tests in a way that would promote, among other things, adherence to evidence-based medicine, reduced variation, and less redundancy. Although the Senate failed to act on the House-passed bill, the separate targets would have been untenable in 2010 barring additional Congressional action because the bill required that physicians ollectively pay back the debt accumulated by the SGR system over many years beginning in 2010. This would have resulted in payment cuts for services in all six categories over multiple years before the debt was retired. Separate expenditure targets are not viable without rebasing the SGR.

The College believes that rebasing of the SGR and a higher growth allowance for primary care services are essential if category-specific targets are to be implemented. The ability of any service-specific expenditure target system to recognize the value of primary care services is essential. While the 2007 House-passed bill would have directed CMS to sign specific procedure codes to each service category, the relative low growth trend of primary care services as generally described in the bill would have generated updates above medical inflation for office visits and other primary care–oriented services if there was no requirement to pay back the accumulated debt. This approach is likely to have a positive impact on all physicians who predominantly provide these types of services and patients who benefit from having access to primary and preventive care.

The College recommends that Congress consider the following to ensure that any system fosters an environment that allows expenditures on primary care services to grow at a reasonable pace without adversely harming payment rates:

- Setting the E/M service conversion factor higher than the baseline for all other categories at the outset of the implementation of multiple targets to retroactively account for how primary care services have been historically disadvantaged under the current system. Kevin Grumbach, MD, Director, University of California San Francisco (UCSF) Center for California Health Workforce Studies Professor and Chair, UCSF Department of Family and Community Medicine, made this recommendation in his February 2008 statement to the Senate Health, Education, Labor, and Pensions Committee (71). MedPAC has conducted an analysis along these lines but it has not made a recommendation in this area.
- Explicitly prohibiting the primary care services expenditure category from incurring any cut as part of a separate service-category target system and updating that category to reflect medical inflation.' The primary care service category would not be subject to an absolute cut as a result of comparing actual expenditure growth to an expected target. Primary care services would be designated for fair, predictable, and stable positive updates, while monitoring the comparison of actual to target expenditures would be used to monitor for potential overutilization. Potential problems could be detected through such monitoring, which could trigger educational or other efforts unrelated to direct payment adjustments, with a payment reduction being reserved only for a sustained and inappropriate utilization increase. The CBO modeled the impact of a similar option in a December 2008 report (72).

ACP believes that providing utilization and expenditure data by geographic areas for informational purposes will encourage local and regional collaboration. While ACP does not support tying annual payment updates to geographic targets—nor does the College expect that Congress would establish a payment system that creates winners and losers explicitly by geographic area—providing information by geographic area would be a new, direct mechanism to highlight utilization and expenditure trends and to serve as further impetus for quality improvement and cost-constraint projects. The CBO modeled a concept that would group physicians together in high-cost areas and decrease payments to those physicians if higher-than-typical costs persisted. The CBO notes in its review that the intent of the focus on high-cost areas would be to increase physician accountability and spur local collaboration (and peer monitoring). ACP does not support the payment concept that the CBO modeled but it does believe that geographic area–specific utilization and expenditure information can foster collaboration without it being linked to payment.

The local and regional collaboration these informational data would foster may help to address persistent regional variation in care. Fisher and colleagues explain that high-cost/high-utilization areas have outcomes that are the same or worse than low-cost/low-utilization areas. They discount the availability of technology and the prevailing payment system as driving forces, instead citing the greater propensity to use discretionary services (e.g., referrals for services and tests, hospital admissions, in high-cost/high-utilization areas). In addition to recommending that payment systems provide physicians time to carefully make treatment decisions and to reward hospitals for optimal care, they cite physician leadership as a key to reducing unwarranted variation (73). Specific information on regional utilization/expenditures would help physicians to collectively lead.

2. **Congress should establish a mechanism to assess how the change in expenditures for physician services impacts spending on other components of the Medicare program. This information should be used to determine how to best eliminate the artificial divisions between components of the program that are barriers to effective coordination and policy.**

Maintenance of health care sector silos in the Medicare program is illogical. Physician interventions have a large impact on spending in other Medicare program components. Appropriate physician-provided care, especially when furnished by primary care physicians, can have a positive impact on quality and cost for ambulatory sensitive conditions. A payment system should reward physicians by allowing them to benefit from savings they generate and to foster direct collaboration between physicians and other health providers (e.g. hospitals). CMS efforts to assess the system-wide impact of physician services through a number of Medicare demonstration projects, including the Physician Group Practice demonstration—which measures the cost and quality of large practices and shares savings with them above a minimum threshold—can help achieve this goal. Congress should take this action whether using a system of single or multiple targets.

The results of an assessment of how spending on physician services impacts other Medicare program components could be incorporated into a physician-service-expenditure target(s) approach until a more comprehensive shared-savings model is established.

IX. Administrative Simplification Recommendations Aimed at Supporting an Improved Payment Environment

1. Physicians who are participating in projects that involve practice-capability requirements, performance measurement, and/or other accountability for the quality and effectiveness of care should be subjected to fewer administrative requirements.

Requiring physicians to adhere to very specific guidelines for documenting office encounters (and other evaluation and management services) with patients and to navigate prescription drug prior authorizations and cost containment processes may be unnecessary and even redundant when a physician is participating in a project that provides accountability through measurement.

The Medicare medical home demonstration project that is scheduled to start in January 2010 provides a testing opportunity. The requirements for a physician to have his or her practice recognized as a PCMH, supplemented by the likely metrics that Medicare and other health plans will use to assess the effectiveness of the PCMH model, provide an example. Practices need to be able to track patients by condition and other factors; coordinate among the practice team, other providers, and family and other caregivers; and use e-prescribing technology to be recognized as a PCMH. Medicare, and nearly all plans testing the PCMH, expect increased appropriate use of generic drugs and will assess their pharmacy expenditures as part of the project.

Congress and/or CMS should find opportunities to reduce administrative activities in tests of innovative payment reform models. Recognizing the government's need to ensure that federal funds are spent appropriately, ACP recommends the development of program integrity mechanisms that are less burdensome to physicians and patients.

X. Options to Assist in Funding Payment Reforms

Below is a summary of the recommendations ACP has included in this paper aimed at finding the necessary funding to execute the two main components needed to realize comprehensive payment system reform, with a notation of the specific context within which it was made.

- Use the expected decrease in costs in other parts of the Medicare program calculated to result from more robust primary care to help fund a program of immediate and sustained increases in payment to primary care physicians for primary care services.
- Use the expected decrease in costs in other parts of Medicare program calculated to result from separate Medicare payment for discrete physician services that improve care coordination and provide patient-centered care. The intent is to use these expected savings to correspondingly increase the amount by which Part B expenditures can rise—to accommodate newly valued services and services for which values increase—without CMS having to make a downward adjustment to maintain budget neutrality.
- Establish a mechanism to assess how the change in expenditures for physician services impacts spending on other components of the Medicare program. The intent is to use this information to determine how to best eliminate artificial divisions between different parts of the program and to help determine optimal funding for increasing payments for physician services through an annual update process.

ACP has cataloged some options that could be used to fund payment reform, including the primary care payment increase. These options, many of which are technical in nature, are available at www.acponline.org/advocacy/events/state_of_healthcare/options09.pdf.

ACP notes that the CBO report that models the cost associated with over 100 reform options, including many that aim to constrain costs, is a valuable resource as policymakers consider options. The College has not taken a position on many of the reform options listed in the CBO report but finds it helpful in gauging impact of many reforms. The complete CBO report is available at www.cbo.gov/ftpdocs/99xx/doc9925/12-18-HealthOptions.pdf.

Conclusion

ACP recommends a two-component process to realize the comprehensive payment reform that will result in better value for health care spending in the United States. The first component is to develop, test, and evaluate innovative payment models that align incentives with quality, effective, and efficient care instead of paying on the basis of the volume of services. The second, concurrent and complimentary component is to improve the current fee-for-service payment system, which is largely based on the RBRVS. This involves changes to reverse the declining interest in the practice of primary care that is on the verge of making these specialties extinct and to provide a better environment for physicians to respond to patient needs. Refinement of the fee-for-service system is needed because it is likely to remain in effect until new, more effective payment models are identified and implemented and it may serve, at least in part, as the basis for determining payments under these new models.

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