Section-By-Section Crosswalk: May 28 Energy & Commerce Discussion Draft and ACP Proposal
June 19, 2013

The committee's discussion draft, as released on May 28, 2013, would repeal the current Sustainable Growth Rate (SGR) system with the intent of replacing it with a fair and stable system of physician payment in the Medicare program.

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Stabilizing fee updates	Sec ___(p.1): Repeals SGR. Update rates for period of stability not specified, Update for period of stability not specified, conversion factor not specified	ACP supports this provision with recommendations for improvement: Insert the following language from Medicare Physician Payment Innovation Act, H.R. 547, Section 2, (a) through (c), establishing baseline updates for primary care and non-primary care services defining the service codes to be included in the primary care update and qualifying primary care practitioners, and the period of stability. 2014—baseline update for all services is equal to 2013 Conversion factor (zero update) 2015-18: Annual primary care baseline update shall be 2.5%. Annual non-primary care update shall be 0.5%.	The necessity of providing higher updates for undervalued evaluation and management services has broad support within the medical community and from independent experts, including the National Commission on Physician Payment Reform, National Coalition on Health Care, and The Commonwealth Fund. The undervalued E&M services at issue are often those that provide preventive health and wellness care, address new or undiagnosed problems, and manage chronic illnesses.
Fee schedule competency incentive program	Sec 1848A: Defines peer cohorts. Secretary shall approve and publish a final quality measure set for each cohort. Each fee schedule provider self identifies with a peer cohort, provide information on each quality measure within the final measure set for purposes of determining a quality based payment update adjustment applicable to each provider, beginning on ___ (year not specified). Secretary shall develop and apply methodologies	ACP supports this provision with recommendations for improvement: Supports testing of peer cohort program described in Sec. 1848. Supports requirement to minimize administrative burden on providers. Add the following clarifications: Peer cohort program to become effective on 1/1/15 and continue through 12/13/18 (period of stability). Physicians in approved designated or deemed Alternative Payment Models (APMs), including PCMHs, as described later, shall qualify for an "early adapter" differential (higher update—FFS baseline plus quality based payment update) effective 1/1/14.	ACP strongly believes that the Patient-Centered Medical Home (PCMH) and Patient-Centered Medical Home Neighborhood models are ready to be a part of a new, value-based health care payment and delivery system, given all of the federal, state, and private sector activity to design, implement and evaluate these models. This readiness is reflected through the significant amount of private sector payer activity in the area of the PCMH,

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	for assessing performance of providers with respect to such measures within the applicable measure sets and methods for collecting information for such assessments, which shall involve the minimum amount of administrative burden needed to ensure reliable results.		including test projects or roll-outs of the model in nearly all 50 states. Examples were provided in ACP's response to the original E&C and W&M framework in Feb. 2013. In addition to these pilot programs, a number of large insurers have announced their intent to roll the PCMH model out more widely. Additionally, it is important that any new approaches be studied closely by HHS to determine their overall success in increasing quality and reducing cost, improving physician and patient satisfaction, as well as their ability to potentially reduce or eliminate many administrative hassles faced by physicians that operate exclusively—or even partially—within the FFS system
Election for application at group practice or individual physician level.	Sec 1848A, (5) offers two options, specifically providing for group election opportunity or allow HHS to decide.	ACP supports this provision with recommendations for improvement: Secretary shall provide for election opportunity at either individual or group practice level.	
Quality measures for competency assessment	Sec 1848 A, (b) (1) Establishment of list of peer cohorts: Describes the method by which the Secretary shall identify peer cohorts and publish a list of peer	ACP supports this provision with recommendations for improvement: Supports including American Board of Medical Specialties (ABMS) as the basis for an initial list of peer cohorts. Add language to specify that cohorts can include condition or diagnosis based cohorts;	The Department of Health and Human Services has a long history and tradition of deeming non-profit private sector accreditation organizations to satisfy compliance with federal

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	cohorts with respect to which fee schedule providers will self-identify. Such list shall include as a peer cohort the provider specialty in each specialty in which the ABMS offers certification and any other cohort classifications of providers across such specialties.	cohorts formed by condition, diagnosis, or ABMS certified specialty at a regional or community level (e.g. physicians in a metropolitan area could propose and self-identify with a cohort formed by them at a regional or community level to improve outcomes and effectiveness of care rendered for a particular condition, diagnosis, or specialty. Specify that cohorts, at national or regional/community level, may be cross-disciplinary, cross specialty. Add language that the Secretary shall deem cohorts proposed and organized by providers (specialty societies, state medical societies, local/regional community-based physician associations) based on criteria relating to the core competencies included in such cohorts. Allow for deeming of private sector accreditation of PCMHs, PCMH-neighbor practices to be deemed and recognized by the Secretary as a cohort for the purpose of the quality incentive update adjustment.	regulations in a way that relies on the accreditation organization's expertise, while still ensuring that the process meets federal standards relating to transparency. CMS can learn from those relationships and work with the accreditation organizations and national specialty societies, including ACP, to design a deeming program for PCMH, PCMH-N recognition, and other programs developed by national specialty societies, state medical societies, county medical societies, community-based physician groups, or other entities that would apply directly to CMS to be deemed as an approved initiative that appropriately balances the interests of the non-profit, private sector accreditation organizations and CMS' responsibility to establish and maintain transparency in its decision-making processes.
Establishment of core competency categories	Sec 1848A (b) (2) requires the Secretary to convene multi-stakeholder groups to establish core competency categories and identification of areas of need for quality measures. Secretary shall establish a process for the	ACP supports the ideas within this provision but proposes an alternative means of addressing them: Modify by requiring that all measures, regardless of source, go through a multi-stakeholder evaluation process (NQF). Allow the Secretary to deem specialty-based registry programs that meet certain criteria relating to effectiveness; specify that all	Measures that have gone through the NQF, multi-stakeholder process do make a difference – a subset of this evidence is cited in recent NQF testimony before the W&M Health Subcommittee. If multiple pathways for evaluation

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	development of such quality measures. Secretary shall request from individual specialty societies and other relevant stakeholders best practices and clinical guidelines for the development of quality measures. I Secretary shall provide for a quality measures process to approve final quality measure set for peer cohorts. Secretary shall establish, and make publicly available, criteria for selecting such measures. A quality measure may be quality measures that have been endorsed by a consensus based entity, a quality measure that is developed by a national medical specialty society or other relevant stakeholder based on best clinical practices	clinical measures used in such registry programs must go through the same multi-stakeholder evaluation process.	and selection of measures were established – even if they are all multi-stakeholder, the result could be greater redundancy, administrative burden, and multiple "look alike" measures.
Provisional core measure sets	Sec 1848A, (D) and (E) specifies that the Secretary shall select quality measures and make them publicly available, including publishing in specialty-appropriate peer reviewed journals and providing for a reasonable public comment period.	ACP supports the ideas within this provision but proposes an alternative means of addressing them: Specify that all core measures selected by the Secretary go through a multi-stakeholder and transparent evaluation process (NQF). Eliminate requirement relating to peer review journals. Support public comment period with the following clarification: Before a provisional core measure set may be approved as a final quality measure set, the Secretary shall provide for a reasonable public comment period on the provisional core measure set. In considering	See above for rationale behind the NQF process. Evidence on the core competencies described include: • Berenson, Pronovost, and Krumholz. "Achieving the Potential of Health Care Performance Measures: Timely Analysis of Immediate Health Policy Issues." May 2013. Published by The Robert

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		such comments, the Secretary shall ensure that any revisions in the core quality measures that are made as a result of the public comment period are supported by evidence on clinical effectiveness and appropriateness of the measure and suggested revisions. Specify that the Secretary shall evaluate peer cohorts based on the extent by which they have core competencies and measure sets that evidence indicates are associated with better clinical outcomes, more effective and efficient use of resources, and that contribute to physicians' achieving the competencies needed to participate in new APMs. The Secretary shall consider inclusion of the following such core competencies: • Reporting on validated clinical performance measures appropriate for the specialty of the physician patient population being served, including process, structural and outcome measures, with particular emphasis on measures that improve clinical outcomes and patient experience with the care provided at an organizational/system level, rather than process measures at the individual physician level • Coordinated, interdisciplinary and team-based care "best practices" to overcome fragmentation of medicine into distinct silos of care. •Tracking of patient outcomes through patient-registry systems. •Patient engagement and shared decision-making. •Commitment to evidence-based practice guidelines to reduce ordering of marginal, ineffective, low value	Wood Johnson Foundation and the Urban Institute. Accessed at: http://www.urban.org/publications/412823.html • ACP's High Value Care Initiative: http://hvc.acponline.org/' • Choosing Wisely effort: http://www.choosingwisely.org/ • Chronic Care Model: http://www.improvingchroniccare.org/index.php?p=The_Chronic_Care_Model&s=2 • Katie Coleman, Brian T. Austin, Cindy Brach and Edward H. Wagner. Jan/Feb 2009. "Evidence On The Chronic Care Model In The New Millennium" Accessed at: http://content.healthaffairs.org/content/28/1/75.short

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		or even harmful care, such as ACP's High Value Care Initiative, described later in this letter and the Choosing Wisely effort organized by the American Board of Internal Medicine. •Informed and pro-active clinical care management team and empowered patients, as described in the Chronic Care Model (CCM), within a practice or across a group of practices. The CCM has proven itself over the past decade as a meaningful framework for practice redesign that leads to improved patient care and better health outcomes. •A strong emphasis on primary care and appropriate valuation of primary care services as being critical to delivering high value, coordinated care for the whole person, including programs that incorporate the elements of PCMH (primary care model) and PCMH-N practices (specialty practice model).	
Initial Feedback Period	Sect. 1848A (b) (5) (A) Each fee schedule provider self-identified with respect to a peer cohort shall, before any assessment of the fee schedule provider under subsection (d) for determining the applicable update adjustment under subsection (e) for such provider and the year involved, have a [__] period during which the provider shall report on the applicable quality measures and receive feedback on the	ACP supports this provision with recommendations for more specifics and improvement: Specify that physicians should receive quarterly feedback reports on their performance, with limited exceptions made for measures where it is more clinically appropriate to review the performance data only every 6 months or 1 year (e.g., cancer screenings, colonoscopy rates, and incidence of stroke in patients with atrial fibrillation). Physicians should have a key role in helping to determine the appropriate timeframes for review of performance information—and the decision-making process should be transparent so that physicians, consumers,	The Robert Wood Johnson Foundation (RWJF) by Berenson, Pronovost, and Krumholz noted the importance of using "measurement to promote the concept of the rapid-learning health care system."[1] Further stating that the dissemination of quality measure data should be viewed as one prong in a multi-pronged strategy to improve health care quality.

[1] Berenson, Pronovost, and Krumholz. "Achieving the Potential of Health Care Performance Measures: Timely Analysis of Immediate Health Policy Issues." May 2013. Published by The Robert Wood Johnson Foundation and the Urban Institute. Accessed at: http://www.urban.org/publications/412823.html.

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	performance of such provider with respect to such measures.	and payers are fully aware of the data sharing expectations. The Secretary shall also evaluate data sharing approaches being tested in CMMI projects and the private sector to determine if shorter timeframes for providing feedback are feasible and clinically appropriate—and be given the authority to implement shorter feedback timeframes if appropriate. Additionally, the Secretary shall establish a timely, fair, and accurate appeals process for clinicians to examine potential inaccuracies.	
General provisions applicable to adoption of all measures	Sect. 1848A (c) (1) RANGE OF MEASURES.—In carrying out subsection (b), the Secretary shall, to the greatest extent practicable and for each peer cohort, select a sufficient number of quality measures for potential inclusion of such measures. (2) (B) INPUT FROM STAKEHOLDERS.—For purposes of conducting the review under subparagraph (A), the Secretary shall request medical specialty organizations and other relevant stakeholders to, as needed, identify and submit to the Secretary updates to quality measures selected under subsection (b)(4) as well as any additional quality measures. The	ACP supports the ideas within this provision but proposes an alternative means of addressing them: As discussed earlier, Congress should specify that all measures, whether developed by a specialty society or other experts, accordingly should go through a multi-stakeholder evaluation process, a role that is performed by the National Quality Forum (NQF) as a trusted evaluator of measures. The NQF process does involve input from multiple stakeholders, including medical specialty societies and consumers. Therefore, the Secretary should be directed to select measures that have undergone the NQF evaluation process and to look to this process to provide annual reviews and updates. The Secretary shall provide adequate funding for NQF and the measure development and maintenance processes that feed into NQF's endorsement process to help with improving and streamlining the measure pipeline—allowing it to be substantive and nimble	See above for rationale behind the NQF process.

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	Secretary shall review submissions under this subparagraph. (2) (C) UPDATES.—Based on the review conducted under this paragraph for a year, the Secretary shall as needed—(i) select additional, and updates to, quality measures under subsection (b) for potential inclusion in final quality measure sets under paragraph (4)(F) of such subsection in the same manner as the Secretary selects such quality measures under such subsection; and(ii) modify final quality measure sets approved under subsection (b)(4)(F) in the same manner as the Secretary approves such sets under such subsection. In the case of a modification under clause (ii) that removes a quality measure from a final quality measure set, such modification shall not apply under this subsection unless notification of such modification is made available to all applicable fee schedule providers.	enough to meet the needs of the system. Additionally, the Secretary may allow for a public comment period on measures that will be linked to Medicare incentive payments. As noted earlier, this comment period should be supplemented with a thorough review of the evidence behind the measures being considered, and should not result in measures being altered, adopted, or rejected in response to public comments that are not supported by evidence.	
General provisions applicable to adoption of all measures—	Sect. 1848A (c) (3) The Secretary shall, as appropriate, coordinate the selection of quality measures under subsection (b) with existing measures and requirements, such	ACP supports this provision with recommendations for more specifics and improvement: The Secretary shall require CMS to harmonize (and reduce to the extent possible) the measures used in the different reporting programs (e.g., Medicare	While CMS has made strides in aligning the measures, at a high level, the technical requirements within each of the programs are different enough that dual

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Coordination with Existing Programs	as the development of the Physician Compare Website under section 1848(m)(5)(G). To the extent feasible, such measures should align with measures used under similar incentive programs of other payers and with measures in use under other provisions of section 1848. The Secretary shall explore options for combining performance data from incentive programs with similar commercial payer data to develop a more comprehensive picture of fee schedule provider performance that can be shared with consumers and providers to improve performance.	PQRS, e-RX, EHR Incentive/Meaningful Use, and Value-Based Payment Modifier (VBPM))—using the timeline CMS has established for this purpose as a starting point for program alignment[2]—and then work toward transitioning these aligned programs to using composite outcomes measures[3] rather than a laundry-list of process measures. Additionally, the Secretary shall consider the approaches being taken by the initiatives of the CMS Innovation Center and other efforts involving private sector payers, that are working to align federal, state, and private payer payment and delivery system reform efforts. The Secretary shall also gather information from the practices and physicians that are participating in the CMS Innovation Center efforts, who are also subject to the broader CMS reporting efforts, to obtain ideas for how those programs might be better aligned with reduced administrative burden and incorporated into a new set of alternative payment models over time. The Secretary shall consider how the infrastructure that has been built for these programs should be leveraged to the extent possible and not recreated. At that time, the Secretary may then consider sunsetting	processes must be undertaken. In the College's recent comments on the notice of proposed rulemaking from both CMS[4] and ONC[5] on Stage 2 Meaningful Use, we also noted our concern about the approach that CMS has taken when structuring the penalty phases of the EHR Incentive Programs, e-Prescribing Incentive Program, and PQRS by requiring that the activity to avoid the penalty must be completed in the prior year or even two years in advance of the legislated deadline. As a result, CMS has effectively moved up the legislated deadline beyond what the market can bear.

[2] This timeline can be accessed at: http://www.cms.gov/eHealth/ListServ_LearnMoreaboutTimingofQMA.html.
[3] Composite measures are defined as two or more measures that are combined into a single measure that results in a single score. More information on composite measures can be found at: http://www.qualityforum.org/Publications/2009/08/Composite_Measure_Evaluation_Framework_and_National_Voluntary_Consensus_Standards_for_Mortality_and_Safety%e2%80%94Composite_Measures.aspx.
[4] These comments can be found at: http://www.acponline.org/advocacy/where_we_stand/health_information_technology/cms_nprm.pdf.
[5] These comments can be found at: http://www.acponline.org/advocacy/where_we_stand/health_information_technology/onc_nprm.pdf.

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		the existing PQRS and e-RX programs, and potentially the VBPM and EHR Incentive programs, if a new quality incentive program is created that achieves the same objectives but in a more consistent way with consistent and harmonized measures, and fewer administrative burdens on physicians and practices.	
Assessing Performance with Respect to Final Quality Measure Sets for Applicable Cohorts	Sect. 1848A (d)(1)(A) IN GENERAL—The Secretary shall establish one or more methods, applicable to each year beginning with the first year after the period of stability, to assess the performance of a fee schedule provider with respect to each quality measure included within the final quality measure set approved under subsection (b)(4)(F) applicable for the performance period established under paragraph (3) for such year to the peer cohort in which the provider self-identified under subsection (b)(1) for such performance period and compute a composite quality score for such provider for such performance period. Such methods shall include methods for collecting fee schedule provider information in order to make such assessments.	ACP supports this provision with recommendations for improvement: The Secretary shall seek input from physicians to determine the methods used to develop and select measures (including the measurement evidence and any evidence grading methods used) for their cohorts, in collecting and aggregating the data on the measures used within their cohorts, and in advising on changes that may need to be made to their cohort based on the data review (e.g., additional differentiation, development of a cross specialty cohort).	The recent report from Berenson, Pronovost, and Krumholz states the following, "Drawing inferences about a physician's quality using a few measures peripheral to the physician's core professional activities may well be misleading and a diversion from the opportunity to engage physicians in substantive quality improvement activities. Here, again, policymakers should be more strategic, focusing on clinical areas where measures are meaningful and valid, and where concerted multi-party collaboration could materially improve the health of the population."
Assessing Performance	Sect. 1848A (d)(1)(B) METHODS— Such methods	ACP supports this provision with recommendations for more specifics and improvement:	The Department of Health and Human Services has a long

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with Respect to Final Quality Measure Sets for Applicable Cohorts (CONT.)	shall, with respect to a fee schedule provider—(i) *Review:* provide that the performance of such provider shall be assessed for a performance period established under paragraph (3) with respect to the quality measures within the final quality measure set for such period for the peer cohort of such provider and on which information is collected from such provider; and (ii) allow for the collection and utilization of data from registries or electronic health records.	The Secretary shall establish a process of deeming of private sector specialty programs, such as patient registry programs, as means of participating in a graduated, VBP approach. The clinical performance measures used by such programs should go through the National Quality Forum (NQF) endorsement process, as this will ensure that the measures are evaluated by a multi-stakeholder process. Additionally, the Secretary shall establish a deeming process for a number of different types of programs that meet certain standards, in order to qualify participants for a graduated VBP update allowance. These programs must be able to demonstrate that they include one or more of the core elements associated with effective programs, as described previously in our letter. Such deemed programs could include: • PCMH and PCMH-N practices as recognized or accredited by a nationally recognized accreditation organization. • PCMH and PCMH-N practices as recognized and offered to enrollees of one or more private health insurance programs, and/or as recognized by state government programs including Medicaid. • Programs developed by national specialty societies (e.g., registries), state medical societies, county medical societies, community-based physician groups, or other entities that would apply directly to CMS to be deemed as an approved initiative.	history and tradition of deeming non-profit private sector accreditation organizations to satisfy compliance with federal regulations in a way that relies on the accreditation organization's expertise, while still ensuring that the process meets federal standards relating to transparency. We believe that CMS can learn from those relationships and work with the accreditation organizations and national specialty societies, including ACP, to design a deeming program for PCMH and PCMH-N recognition that appropriately balances the interests of the non-profit, private sector accreditation organizations and CMS' responsibility to establish and maintain transparency in its decision-making processes.

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		Additionally, the Secretary shall have CMS rapidly certify patient decision aids that have been rigorously evaluated by independent researchers for the top 20 most expensive and/or most frequent, high priority performed procedures, particularly those that are considered preference-sensitive or are elective—and then require that the use of those aids be documented. CMS should allow physicians to indicate via a modifier to an E/M visit code (backed up with the appropriate documentation, which should ideally be facilitated by the electronic health record) that they have engaged their patients in shared decision-making, using a specialty society's clinical guidelines to reduce utilization of marginal and ineffective care, supported by certified patient decision aids as available and appropriate. Physicians who provide such documentation would receive a higher payment for that E/M visit.	
Assessing Performance with Respect to Final Quality Measure Sets for Applicable Cohorts (CONT.)	Sect. 1848A (d)(1)(C) WEIGHTING OF MEASURES.—Such a method may provide for the assignment of different scoring weights based on type or category of quality measure.	ACP supports this provision with recommendations for more specifics and improvement: Specify that the Secretary shall create a weighting system for core competencies and related applicable measures for each competency, so that competencies and measures that the evidence shows has the greatest impact on quality and effectiveness of care should be weighted more than those that the evidence indicates has less impact (i.e. outcomes measures and organizational measures versus physician level process levels). Physicians or practices that successfully participate in cohorts that have a higher overall weighted set of competencies and measures shall qualify for higher graduated quality incentive payments under the	The recent report from Berenson, Pronovost, and Krumholz includes an in depth discussion of structure, process, and outcomes measures, outlining the pros and cons of each type. The researchers conclude that the best approach is to "decisively move from measuring processes to outcomes."

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		competency-based incentive program, as specified later.	
Assessing Performance with Respect to Final Quality Measure Sets for Applicable Cohorts (CONT.)	Sect. 1848A (d)(3) PERFORMANCE PERIOD.—Not later than [__], the Secretary shall establish a period, with respect to a year, to assess under this subsection performance of fee schedule providers with respect to quality measures.	ACP supports this provision with recommendations for more specifics and improvement: As noted earlier, specify that physicians should receive quarterly feedback reports on their performance, with limited exceptions made for measures where it is more clinically appropriate to review the performance data only every 6 months or 1 year (e.g., cancer screenings, colonoscopy rates, and incidence of stroke in patients with atrial fibrillation). Physicians should have a key role in helping to determine the appropriate timeframes for review of performance information—and the decision-making process should be transparent so that physicians, consumers, and payers are fully aware of the data sharing expectations.	The Robert Wood Johnson Foundation (RWJF) by Berenson, Pronovost, and Krumholz noted the importance of using "measurement to promote the concept of the rapid-learning health care system."
Update Adjustment Taking Into Account Assessments with Respect to Quality Measures	Sect. 1848A (f) TRANSITION FOR NEW FEE SCHEDULE PROVIDERS.—(1) IN GENERAL.—In the case of a new fee schedule provider [there shall be __] (2) NEW FEE SCHEDULE PROVIDER DEFINED.—For purposes of this subsection, the term 'new fee schedule provider' means a physician, practitioner, or other supplier that first becomes a fee schedule provider (and had not previously submitted claims under this title as a person, as an	ACP supports this provision with recommendations for more specifics and improvement: Specify that the Secretary shall create a value-based payment (VBP) structure that rewards physicians and other providers with modest payment updates above the baseline. These updates should be determined by participation in an approved/deemed VBP program, including reporting on performance measures, achieving PCMH recognition, achieving PCMH specialty practice neighbor recognition, and participation in an ACO. More information on this approach is detailed in ACP's letter to the Committee dated June 10, 2013.[6] Additionally, the Secretary shall determine how to	Studies demonstrate that the most effective programs have some or all of the following components associated with better outcomes and more effective care: • Reporting on *validated* clinical performance measures appropriate for the specialty of the physician patient population being served, with particular emphasis on measures that improve clinical outcomes and patient experience with

[6] This letter can be accessed at: http://www.acponline.org/acp_policy/letters/energy_and_commerce_legislative_proposal_repeal_sgr_2013.pdf.

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	entity, or as part of a physician group or under a different billing number or tax identifier). (h) OPT OUT FOR PROVIDERS PAID UNDER ALTERNATIVE PAYMENT MODELS.—(1) IN GENERAL.—Payment for services that are provided by a fee schedule provider under an approved Alternative Payment Model shall be made in accordance with the payment arrangement under such model instead of in accordance with the update incentive program. Beginning with [___], the Secretary shall identify and publish in the Federal Register such models applicable under this subsection for such year.¿	risk adjust based on differing patient populations across specialties and geography and a differentiation of clinicians that primarily provide outpatient care from those that largely provide inpatient care. The cohort data should be regularly reviewed during the years of stability—and payments tied to them should be fairly modest during this time (along the lines of what the College proposes in its graduated payment approach)—to determine if they are effective and if more or less differentiation may be necessary. If it becomes clear that cross-specialty cohorts may be appropriate, like a cohort for primary care that would include internal medicine, family medicine, and pediatrics, then the Secretary may apply additional differentiation to the cohorts—specifying adult vs. pediatric primary care, for instance.	the care provided at an organizational/system level, rather than process measures at the individual physician level • Coordinated, interdisciplinary and team-based care "best practices" to overcome fragmentation of medicine into distinct silos of care. • Tracking of patient outcomes through patient-registry systems. • Patient engagement and shared decision-making. • Commitment to evidence-based practice guidelines to reduce ordering of marginal, ineffective, low value or even harmful care, such as ACP's High Value Care Initiative[7], described later in this letter and the *Choosing Wisely* effort[8] organized by the American Board of Internal Medicine. • Informed and pro-active clinical care management team and empowered patients, as described in the

[7] Additional information on ACP's High Value Care Initiative can be accessed at: http://hvc.acponline.org/.
[8] Additional information on the Choosing Wisely effort can be accessed at: http://www.choosingwisely.org/.

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			Chronic Care Model (CCM),[9] within a practice or across a group of practices. The CCM has proven itself over the past decade as a meaningful framework for practice redesign that leads to improved patient care and better health outcomes.[10] • A strong emphasis on primary care and appropriate valuation of primary care services as being critical to delivering high value, coordinated care for the whole person, including programs that incorporate the elements of PCMH (primary care model) and PCMH-N practices (specialty practice model).
Alternative Payment Models	Sect. 1848A (h) (2)(A) APPROVED ALTERNATIVE PAYMENT MODEL.—The term 'approved Alternative Payment Model' means an Alternative Payment Model that is developed by the Secretary under paragraph (3) or proposed by an entity and approved by the Secretary under	ACP supports this provision with recommendations for more specifics and improvement: The Secretary "shall" include PCMHs as one of the Alternative Payment Models. The College encourages the Committee to incorporate language from the Medicare Physician Payment Innovation Act of 2013 (H.R. 574) that	The College believes that the groundwork is already in place for Congress to begin to facilitate a broad transition to value-based delivery and payment approaches, including the Patient-Centered Medical Home (PCMH), PCMH-Neighbor specialty practices, and

[9] Additional information on the Chronic Care Model can be accessed at: http://www.improvingchroniccare.org/index.php?p=The_Chronic_Care_Model&s=2.
[10] Katie Coleman, Brian T. Austin, Cindy Brach and Edward H. Wagner. Jan/Feb 2009. "Evidence On The Chronic Care Model In The New Millennium" Accessed at: http://content.healthaffairs.org/content/28/1/75.short.

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	paragraph (4). (B) ALTERNATIVE PAYMENT MODEL.—The term 'Alternative Payment Model' or 'APM' means a mechanism by which payment under this title is made to a fee schedule provider for most or all of the items and services furnished by such provider. Such a mechanism shall have appropriate protections to assure that changes in care associated with the application of the APM will not reduce the quality or access to care for individuals enrolled under this part. Such a mechanism may include, but not be limited to, any of the following: (i) Accountable Care Organizations. (ii) Medical Homes. (iii) Bundled payments. (3) DEVELOPMENT BY SECRETARY OF ALTERNATIVE PAYMENT MODELS.—The Secretary shall develop and annually review and update Alternative Payment Models to be applied under this subsection. (4) APPROVAL OF PROPOSED ALTERNATIVE PAYMENT MODELS.—The	directs the Secretary to evaluate and then make recommendations for adoption of different models of payment and delivery systems on a defined timeline. Specifically, see section 2 (d) of H.R. 574—PROMOTING TESTING AND EVALUATION OF NEW PAYMENT AND DELIVERY MODELS (PHASE I). Additionally, as discussed earlier, the Secretary shall establish a deeming process for a number of different types of programs that meet certain standards, in order to qualify participants for a graduated VBP update allowance. These programs must be able to demonstrate that they include one or more of the core elements associated with effective programs, as described previously in our letter. Such deemed programs should include: • PCMH and PCMH-N practices as recognized or accredited by a nationally recognized accreditation organization. • PCMH and PCMH-N practices as recognized and offered to enrollees of one or more private health insurance programs, and/or as recognized by state government programs including Medicaid. • Programs developed by national specialty societies (e.g., registries), state medical societies, county medical societies, community-based physician groups, or other entities that would apply directly to CMS to be deemed as an approved initiative. Additionally, the Secretary shall ensure that	other models as discussed in more detail later in this letter, using a clearly laid out set of criteria for selecting/deeming programs that would qualify for additional VBP updates during a five year transition period.

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	Secretary shall develop a process by which physicians, medical societies, health care provider organizations, and other entities may propose Alternative Payment Models for consideration for approval by the Secretary to apply under this subsection.''.	physicians participating in PCMH, PCMH-N, and ACO models, also receive Medicare FFS positive payment incentives via the graduated VBP program, as FFS still remains an underlying tenet for most of these alternative delivery and payment models.	
Reports on Modified FFS and Payment System Alternatives	Sect. 1848A (c) (1) BIANNUAL PROGRESS REPORTS BY SECRETARY.—Not later than [__], and every 6 months thereafter, the Secretary of Health and Human Services shall submit to Congress and post on the public Internet website of the Centers for Medicare & Medicaid Services a biannual progress report on the implementation of the update incentive program under section 1848A of the Social Security Act, as added by subsection (b)(2). Each such report shall include an evaluation of such update incentive program and recommendations with respect to such program and appropriate update mechanisms. (A) GAO REPORT ON INITIAL STAGES OF PROGRAM.—Not later than [__], the Comptroller General of the United States shall submit to Congress a report analyzing the extent to which	ACP supports this provision with recommendations for more specifics and improvement: The College encourages the Committee to incorporate language from the Medicare Physician Payment Innovation Act of 2013 (H.R. 574) – see section 2 (d) (6) GAO REVIEW AND STUDY and (7) PUBLICATION OF LIST OF SUCCESSFUL MODELS Additionally, Congress should specify that PCMH and PCMH specialty neighbor practices shall be included as Alternative Payment Models and then studied to ensure their ongoing effectiveness.	

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	such update incentive program under section 1848A of the Social Security Act, as added by subsection (b)(2), as of such date, is successfully satisfying performance objectives, including with respect to— (etc.)		