American College of Physicians Statement for the Record Hearing on "Improving Quality, Lowering Cost: The Role of Health Care Delivery Reform"

Senate Committee on Health, Education, Labor and Pensions

November 10, 2011

The American College of Physicians (ACP) is pleased to submit the following statement for the record of the above referenced hearing. ACP is the largest medical specialty organization and the second-largest physician group in the United States. ACP members include 132,000 internal medicine specialists (internists), related subspecialists, and medical students. Internists specialize in the prevention, detection, and treatment of illness in adults. Our membership includes physicians who provide comprehensive primary and subspecialty care to tens of millions of patients. ACP appreciates the Committee's interest in efforts to improve the quality and efficiency of healthcare delivery. Our current Fee-for-Service (FFS) payment system rewards physicians for increasing the volume of visits and procedures rather than on the quality of care delivered and health outcomes; it does not provide incentives for physicians to coordinate care; and it provides no incentive for physicians to transform their care delivery to better meet the needs of a growing, older population characterized by multiple chronic illnesses. In addition, our current system undervalues the importance of primary care; the type of care that research clearly indicates is the foundation of a high performing healthcare system ---- higher quality at lower cost.[1]

There are already a number of significant initiatives being implemented and/or tested throughout the country to address the need for improvements within our healthcare payment and delivery system.

The American College of Physicians, along with the American Academy of Pediatrics, the American Academy of Family Physicians and the American Osteopathic Association, offered the Patient Centered Primary Care (PCMH) model[2] as a means of promoting higher quality, better coordinated, less costly care. This model, through a payment approach that includes a monthly care coordination fee, promotes the delivery of comprehensive primary care characterized by increased care access, improved care coordination and integration, and increased care quality and safety. This model has received the support of multiple other physician organizations, as well as the Patient Centered Primary Care Collaborative, a coalition composed of over 900 major employers, consumer groups, patient quality organizations, health plans, labor unions, hospitals, clinicians and others. In addition, PCMH programs are currently being implemented within both

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[1] American College of Physicians. Reforming Physician Payments to Achieve Greater Value in Health Care Spending. Philadelphia: American College of Physicians; 2009: Policy Monograph. http://www.acponline.org/advocacy/where_we_stand/policy/reforming_pp.pdf

[2] http://www.acponline.org/pressroom/account_care.pdf

the public and private sectors in almost every state.[3] The College strongly supports continued efforts to expand this model throughout the healthcare system.

The Center for Medicare and Medicaid Services (CMS) implementation of the Physician Quality Reporting System (PQRS), Electronic Prescribing, and Electronic Health Record "Meaningful Use" programs all serve to promote higher quality, safer and better coordinated care.

The Affordable Care Act of 2010 provided a foundation to promote needed changes within our healthcare payment system to promote care delivery aligned with improved quality, coordination and efficiency. While this legislation provides for a number of positive and notable changes, the College wants to particularly highlight the following components that are specifically related to the focus of this hearing:

- **Provisions to Promote Primary Care:** These include the Primary Care Incentive Bonus that provides designated primary care physicians and other healthcare professionals with a 10 % bonus on select primary care services from 2011-2015; the Medicaid Comparability Program that provides supplements to state Medicaid programs to increase physician payments for primary care services to be at least at parity with related Medicare payments for 2013 and 2014; and the establishment of loan programs, scholarships, and training funding priorities to promote primary care.
- **The Medicare Shared Savings (ACO) Program:** This program, particularly with the many changes included in the recently released final rule that eliminate multiple barriers to participation, facilitates the establishment of primary care as the foundation of the healthcare system, promotes care coordination and patient-centered care among all medical providers, and is based on a payment system that is strongly aligned with care quality and efficiency.
- **The Patient Centered Outcomes Research Institute (PCORI):** This quasi public-private institute was established to conduct research to provide information about the best available evidence to help patients and their health care providers make more informed decisions and has the potential to lower cost through providing information to promote more effective healthcare. [Note that the ACP has recently implemented a related initiative -- *High-Value, Cost-Conscious Care Initiative* -- to assess benefits, harms, and costs of diagnostic tests and treatments for various diseases to determine whether they provide good value -- medical benefits that are commensurate with their costs and outweigh any harms.[4]]
- **The Establishment of the Center for Medicare and Medicaid Innovation:** This new Center has the specific mandate to test innovative payment and service delivery models to reduce program expenditures, while preserving or enhancing the quality of care for those who get Medicare, Medicaid or CHIP benefits. In addition, this initiative provides the Health and Human Services Secretary with substantial authority to incorporate rapidly into federal programs those models found to be effective.

The College believes that these particular provisions within the ACA serve as important elements for the establishment of a more effective, high value healthcare delivery system and their continued federal support is imperative.

The College has been particularly pleased with the initial activities of the Center for Medicare and Medicaid Innovation (the Innovation Center, or CMMI). In a relatively short period of time, this Center has implemented programs that have the potential to significantly change the healthcare system. These initiatives include:

- **The Comprehensive Primary Care Initiative:** This multi-payer initiative fosters collaboration between public and private health care payers to strengthen primary care throughout the healthcare system. This initiative serves two functions; it promotes multi-payer cooperation and provides the

[3] http://pcpcc.net/pcpcc-pilot-projects
[4] http://www.acponline.org/clinical_information/resources/hvccc.htm

opportunity for primary care practices delivering services consistent with the Patient Centered Medical Home model access to a monthly management fee and potential shared savings to further assist them in the delivery of high value care.

- **The Advance Payment Model within the Medicare Shard Savings (ACO) Program:** This initiative makes it specifically more feasible for small to medium physician-owned and rural practice collaboratives to participate within the Medicare ACO program. It provides access to the capital needed by such groups to develop infrastructure and service delivery capabilities necessary to effectively succeed as an ACO. The College commends both CMS and the CMMI for the inclusion in the recently released final rule of the Medicare Shared Savings Program of many additional recommendations offered by ACP and other physician organizations. These changes from the proposed rule removed many significant barriers to physician participation within the program.
- **Accelerated Development Learning Sessions and Innovation Advisors programs:** These programs provide opportunities for physicians and other healthcare professionals to learn the skills necessary to function successfully under new payment and delivery models aligned with higher quality, lower cost care.
- **Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration:** This initiative tests the effectiveness of implementing the Patient Centered Medical Home model within the FQHC system including the provision of a monthly management fee per beneficiary to promote high quality, coordinated, patient centered care.

This is clearly an already impressive portfolio. The College recommends the following additional areas for the CMMI to consider under its mandate: additional initiatives to specifically encourage small practices (1-5 physicians) that provide the majority of care to Medicare beneficiaries to join into virtual and/or real collaborative efforts to more effectively provided value oriented care; initiatives, in addition to the ACO model, that provide incentives for specialty and subspecialty practices (the "medical neighborhood) to promote improved communication and care coordination with primary care practices; further initiatives that provide a strong incentive for multiple payers to join together to promote increased value-oriented care; and bundled/episode-based payment specifically to promote the delivery of primary care.

The administration also recently initiated the Partnership for Patients, a new public-private partnership to help improve the quality, safety, and affordability of health care for all Americans. This initiative brings together leaders of major hospitals, employers, physicians, nurses, and patient advocates along with state and federal governments in a shared effort to make hospital care safer, more reliable, and less costly. The College is a participant and supporter of this initiative.

The College believes there is a strong connection between being able to promote value-oriented delivery reform and the current, adverse effects of the Sustainable Growth Rate (SGR) methodology currently employed under Medicare. The SGR methodology, which currently mandates cuts of over 27 percent in physician fee schedule payments for 2012, serves to decrease both patient and physician confidence within this important federal program and has the potential to substantially reduce physician participation within Medicare. It also serves as a disincentive for physician practices to make the necessary financial and time commitments toward service delivery change. While the intent of using the SGR target to control healthcare costs is understandable, it has been made clear year after year that this target approach has not been effective---with federal healthcare cost continuing to grow at an unsustainable rate. The SGR approach must be eliminated!

What is needed is to promote effectively higher quality, lower cost care throughout the healthcare system is a transition away from the current volume-driven FFS payment model to models similar to those outlined above that are better aligned with value-oriented care. The College has previously offered an approach to eliminating the SGR update methodology, while stabilizing physician payments and transitioning to broader

payment models aligned with value. This approach, submitted by request of the House Energy and Commerce Committee[5], would:

- Repeal the SGR and set the annual update for non-evaluation and management (E/M) services at no less than zero percent and primary care-related E/M services at no less than 2.0 percent in calendar years 2012 through 2016.
- During this time, new payment and delivery models aligned with value would be developed, pilot-tested and evaluated, and the most effective models would be selected for broad implementation. Physicians would be expected to transition to the new payment models by a set timetable; if they did not in sufficient numbers, Congress could re-impose spending targets.

The success of this proposal depends on the further development and testing of these broad payment and delivery models aligned with the delivery of valued care. Thus, government's continued support through mandatory funding of CMII ensures that it has the resources necessary to partner with physicians and others to develop and evaluate innovative models. This modest investment of $12 billion could be the best investment the government makes, because these are the models that have the greatest potential to improve outcomes and reduce per capita health spending.

The College commends the Committee for addressing this very important subject, and offers its support in helping to implement improvements in our healthcare delivery and payment system that will promote the type of care our patients desire, the type of care our members want to provide and the type of care that should be promoted by both the federal government and healthcare stakeholders ---- high quality, coordinated, patient-centered, cost effective care. Please contact Neil Kirschner at 202-261-4535 or nkirschner@acponline.org if you have any questions regarding this testimony of if we can be of any further assistance.

[5] http://www.acponline.org/advocacy/where_we_stand/phys_pay_pro_cl.pdf