

Bending the Health Care Cost Curve

A goal of the Affordable Care Act (ACA, P.L. 111-148) is to reduce unnecessary healthcare costs, while improving or at least preserving the quality of the care delivered. This cost saving effort is often referred to as “bending the cost curve.” **The ACA has several essential “cost bending programs” that need to be adequately funded and supported, including but not limited to:**

Patient Centered Outcomes Research Institute (PCORI)-Section 6301: is a non-profit, tax exempt corporation established by the ACA to develop and provide comparative effectiveness information to assist patients, clinicians, purchasers, and policy makers in making more informed and effective healthcare decisions. The Institute will focus on clinical comparative effectiveness research, defined as research evaluating and comparing health outcomes and the clinical effectiveness, risks, and benefits of 2 or more medical treatments or services. The Institute will prioritize the healthcare areas to address, engage in research and evidence synthesis efforts, and disseminate its findings to all stakeholders in an understandable manner. While the function of the Institute is solely informational, it is expected that the information produced by this entity will assist all healthcare stakeholders in making better, more value-based decisions regarding their healthcare needs and purchases.

Center for Medicare & Medicaid Innovation (CMMI)-Section 3021: is established within the Centers for Medicare and Medicaid Services (CMS) to test models that promote broad payment and practice reform within Medicare, Medicaid and the Children’s Health Insurance Program (CHIP) while preserving or enhancing the quality of care. The provision provides the Secretary of Health and Human Services (HHS) significant leeway regarding the specific models to be tested. It specifically suggests the consideration of models that promote broad payment and practice reform in primary care. The projects conducted within the new Center have at least three advantages over the demonstration projects traditionally implemented by CMS:

- Budget-neutrality is not a requirement for project approval and implementation.
- The Secretary has significant authority to broadly implement into the Medicare, Medicaid and CHIP programs aspects of projects that have been found to be successful without the necessity of further legislative approval.
- The Center has substantial funding to help ensure that the projects chosen by the Center can be effectively developed, implemented and evaluated.

Payment and Delivery System Reforms to Support Primary Care Workforce Capacity: multiple research studies indicate that a strong primary care workforce relates to higher quality care and lower cost. Unfortunately, there is a crisis in primary care in this country; with few medical students choosing this medical specialty and many current primary care practitioners reaching the age of retirement. The ACA contains a number of “mandatory” provisions to encourage entrance into primary care and help maintain the current primary care workforce. These include a 10 % payment bonus under Medicare for defined primary care services delivered by primary care physicians and related healthcare professionals (the Medicare Primary Care Incentive Program-Section 5501), an increase in primary care payments under Medicaid to be in parity with Medicare payment-Section 1202) and a redistribution of residency slots favoring primary care—Section 5503. The ACA also authorizes many “discretionary” programs focused on encouraging entrance into primary care. These are summarized in a separate fact sheet on workforce capacity.

Medicare Shared Savings Program-Section 3022: allows for various collaborations of physicians and health providers to voluntarily establish Accountable Care Organizations (ACO) that can contract directly with Medicare and share in any cost saving achieved while meeting specified quality thresholds. These legal entities will be accountable for services delivered to a defined Medicare fee-for-service (FFS) patient population with the goals of

increasing the quality and efficiency of services delivered. These collaboratives can consist of physicians and other healthcare practitioners; networks of individual practices; partnership or joint venture arrangements; hospitals that employ accountable care professionals and other arrangements approved by the HHS Secretary.

Identifying and Correcting Misvalued Services Paid Under the Medicare Physician Fee Schedule-Section 3134: the current Medicare payment system primarily used to pay physicians and other healthcare professionals is based upon a Resource Based Relative Value System (RBRVS) that takes into account the amount of physician work, practice expense and professional liability costs associated with a given clinical service. This provision in the ACA legislation is based upon a belief that too little attention is devoted to monitoring whether services have become misvalued over time; with particular concern regarding those services that are overvalued and unnecessarily expensive. The current RBRVS procedures have also been found to significantly undervalue primary care services. The legislation provides the Secretary of HHS with the requirement to establish a process to validate these relative values, and outlines a roadmap to most effectively identify and correct misvalued services. The College further believes that this process should help ensure the accurate valuation of primary care services.

Medicaid Health Homes for Enrollees with Chronic Conditions-Section 2703: provides a Medicaid state plan option, called Health Homes, to address specifically the needs of beneficiaries with chronic conditions beginning in January, 2011. Current research from various Medicaid, Medicare and commercial sectors reflect the ability of the health home (also called Patient-Centered Medical Home) to improve care quality and lower healthcare expenditures. The federal government will provide 90 percent of the cost of this initiative to each participating state for the first two years of implementation. In addition, state planning grants are available to assist states in program development. The programs can be focused on specific high-need chronic care populations or within specific geographic areas of the state. Services provided under this program include comprehensive transitional care, including appropriate follow-up, from inpatient to other settings; patient and family support; referral to community and social support services, if relevant; and use of health information technology to link services, as feasible and appropriate.

ACP's Recommended Improvements to the ACA Regarding Healthcare Costs:

- A. **Congress should enact a permanent solution to the Sustainable Growth Rate (SGR) Formula that recognizes and supports the value of primary care:** the ACA did not address the SGR issue. The SGR, which attempts to control growth of healthcare expenditures under Medicare, has proven to be ineffective. In addition, the recent large annual cuts to physician payments required under the invalid SGR formula, which have been routinely overruled by Congress, only leads to confusion and uncertainty in both physicians and Medicare beneficiaries. Congress should discontinue the use of the current SGR methodology, and reach consensus on an approach or set of approaches to address unwarranted cost increases, recognizes the need to provide physicians with annual, predictable payment updates that reflect real increases in their costs, and also ensures the delivery of quality and efficient care. Furthermore, any solution to the SGR problem must protect and improve on the already undervalued payments to primary care. Primary care services must be protected from experiencing cuts in payments due to increases in utilization in other physician services. This can be accomplished in a number of ways including the: (1) exempting of primary care services from negative budget neutrality adjustments resulting from changes in relative values, (2) setting a floor on payment updates for primary care services, (3) providing higher spending targets for primary care than other category of services, should Congress decide to replace the SGR with separate spending targets for distinct categories of services and (4) exempting practices that are organized as Patient Centered Medical Homes and that are recognized as such by a process established by HHS from spending reductions in any given calendar year.

B. Congress should provide increased Congressional oversight under the Independent Payment Advisory Board-Section 3403: ACA established an Independent Payment Advisory Board (IPAB), which must submit recommendations to Congress, beginning in 2014, to reduce the growth of Medicare expenditures while maintaining or improving the quality of care delivered. The Secretary of Health and Human Services (HHS) would be required to implement these recommendations unless Congress passed an alternative proposal that provided an equivalent amount of budgetary savings. While the College understands the need to contain the growth of medical expenditures and believes that such an independent board can assist in addressing this issue, its current formulation places too much authority in a group of non-elected individuals. The College believes that recommendations from the IPAB should be open for review and debate by duly elected members of Congress, and should be able to be voted down by a simple majority of members in both houses of Congress.

Additional Considerations

Congress should preserve funding authorized under the American Recovery and Reinvestment Act (ARRA) that supports implementation of Electronic Health Records (EHR) throughout the healthcare system: The preservation of funding to promote EHR implementation is critical, not only for cost savings, but also for improvements in care quality and safety. These funds are being used to provide incentives to physician practices to implement EHRs, to establish Regional Extension Services to help practices accomplish this implementation, and to establish regional Health Information Exchanges to promote the communication of healthcare information among providers. The benefits of increased adoption of EHRs, besides lowering costs, include increased healthcare quality and safety through improved communication and coordination among providers, reduced unnecessary and inappropriate tests and procedures, and the increased availability of current evidence-based information at the point-of-service to help inform clinical decisions.