Reform of the Dysfunctional Healthcare Payment and Delivery System

American College of Physicians
A Position Paper

Reform of the Dysfunctional Healthcare Payment and Delivery System

Executive Summary

The American College of Physicians (ACP), which represents over 119,000 physicians who specialize in internal medicine and medical students, recently released both a workforce policy paper, "Creating a New National Workforce for Internal Medicine: Recommendations of the American College of Physicians" and a January 2006 "State of the Nation's Health Care" report. These documents provide substantial evidence of a looming crisis in primary care. The pool of primary care physicians (e.g. internists, family practitioners) is rapidly decreasing at a time when there is a growing demand for their services due to a rapidly aging population with increased incidence of chronic disease. This collapse of primary care will result in our health care system becoming increasingly fragmented, overly-specialized, and inefficient – and lead to lower quality, higher costs, reduced access and increased patient dissatisfaction.

Inadequate and dysfunctional payment and delivery policies are key drivers behind the impending collapse of primary care. Medicare, as the single largest purchaser of health care in the United States and as the standard for health plan payment policies in the private sector, has a particular responsibility to replace policies that are antithetical to primary care with policies designed to encourage and support its importance and growth. Examples of current Medicare policies that adversely affect primary care include:

- Undervaluing the evaluation and management (E/M) clinical services that are predominately provided by primary care physicians.
- Using methodologies to determine the relative value units (RVUs) for each service that overvalue some services/procedures to the detriment of other services in Medicare's budget neutral system.
- Not paying for those services required to allow the primary care physician to provide patient-focused, longitudinal, coordinated care.
- Using a yearly fee update formula – the sustainable growth rate (SGR) – that projects annual cuts in physician fees of approximately 5 percent through 2011and has a disproportionately adverse impact on primary care physicians.
- Providing incentives for volume of services with no regard to the quality or efficiency of the clinical service provided.

This policy paper builds on analyses and positions presented in recently released ACP position papers to develop a series of recommended changes to the current Medicare payment and delivery system that, if implemented, will improve the system and help mitigate the collapse of primary care. ACP recommends short term strategies to modify the current payment system until more fundamental reform can be enacted. The types of changes recommended include: ensuring that the value Medicare assigns to each physician service is accurate; providing separate Medicare payment for services that facilitate accessible and coordinated care; and transitioning

to a system that links a portion of Medicare payment to how well a physician adheres to evidence-based guidelines.

This policy paper also takes the position that these relatively modest modifications of the current physician payment and service delivery system will not be sufficient to permanently maintain and foster a thriving primary care workforce. ACP recommends that Congress replace the SGR formula with an alternative that is aligned with the goals of achieving quality and efficiency improvements and sustaining a sufficient supply of primary care physicians. Replacing the SGR would also maximize the impact of our recommendations to improve the current system. Further, ACP believes that a new model needs to be developed that recognizes the value of primary care delivery, is less likely to induce inappropriate service volume increases, and rewards care that is evidence-based and efficient. Thus, ACP calls on Congress to initiate a comprehensive study of reform options that meet these criteria. While ACP will analyze options and make recommendations for replacing the current physician payment and service delivery system in a future position paper, the College recently introduced a delivery model, the Advanced Medical Home, that it believes could achieve these goals if supported by appropriate financing. ACP recommends that CMS work with the College to further develop and test this model.

I. Recommendations to Ensure the Accurate Valuation of Physician Services

The College calls on policymakers to make immediate reforms in the way that Medicare determines the value of physician services under the Medicare Resource Based Relative Value Schedule (RBRVS).

Position 1: The Centers for Medicare and Medicaid Services (CMS) should substantially increase the work relative value units (RVUs) for evaluation and management (E/M) services based on evidence showing increased physician work.

Position 2: CMS should re-examine its methodologies for determining practice expense RVUs to ensure that the practice expenses assigned to specific services reflect true resource costs.

- CMS should implement a "bottom-up" methodology for using practice expense inputs to determine practice expense RVUs.
- CMS should facilitate a survey of all physician specialties to identify practice costs to include in the practice expense methodology.
- CMS should review its assumptions on the utilization and depreciation of service/procedure-specific equipment.

Position 3: CMS should establish a better process for identifying potentially misvalued RVUs and redistributing any savings into the budget neutral RVU pool.

- The Secretary should establish a group of independent experts to advise CMS in its process of reviewing RVUs.

- The Secretary should automatically review services that have experienced substantial changes in length of stay, site of service, volume, practice expense, and other factors that may reflect on the amount of physician work.
- The Secretary should automatically review the work RVU for recently introduced services after a specified period of time or based on other evidence that the work has changed over time.
- The Secretary should establish a process by which every service is reviewed periodically.

<u>Position 4</u>: CMS should request that the RVS Update Committee (RUC) examine its composition to assure that it is reflective of each specialty's relative contribution to providing services to Medicare patients.

<u>Position 5</u>: The College recommends that MedPAC examine modifying the RBRVS definition of work to more adequately reflect those processes related to the improving of clinical quality, efficiency and patient experience.

II. Recommendations to Provide Separate Medicare Payments for Services that Facilitate Accessible and Coordinated Care

The College calls on policymakers to make immediate reforms so that Medicare can pay physicians for providing patient-focused, longitudinal, coordinated care.

<u>Position 6</u>: CMS should provide separate payment for services employing e-mail, telephonic, and related technology that could facilitate timely communications between physicians and patients and reduce the need for face-to-face visits for non-urgent care.

<u>Position 7</u>: CMS should provide Medicare payment to physicians for the overall provision of defined care coordination/care management services, and/or provide specific codes for those activities that facilitate care coordination/care management services (e.g. care coordination across treatment settings, intensive care follow-up, use of patient registries and population-based treatment protocols, patient disease management training.)

<u>Position 8</u>: CMS should provide an add-on to Medicare payments for office visits that are facilitated by the use of HIT, such as electronic health records, electronic prescribing and clinical decision support tools, and reimburse accordingly. Furthermore, to ensure that the use of this technology is primarily to facilitate improved healthcare quality/safety, payment should be contingent on participation by physicians in reporting related data to approved quality improvement and measurement programs.

III. Recommendations to Add a Quality Component to the Medicare Payment System

<u>Position 9</u>: Congress and CMS should provide sustained and sufficient financial incentives for physicians to participate in programs to continuously improve, measure and report on the quality and efficiency of care provided to patients.

- The current payment system should be modified to allow new methods of reimbursement that reward those who follow evidence-based standards.
- Rewards should reflect the level of work and commitment to quality, which will differ among physicians and across specialties.
- Pay for performance (P4P) systems should rely on valid and reliable clinical measures, data collection and analysis, and reporting mechanisms.
- The value of health information technology (e.g. electronic health records, decision-support tools) should be financially recognized for its ability to assist physicians to do well on quality measures and report their progress.
- Potential P4P rewards should be significant enough to support continuous quality improvement, directed at positive rewards, not negative penalties, and be balanced between rewarding high performance and substantial improvement over time.
- Medicare P4P should enable physicians to share in system-wide savings (such as from reduced Part A hospital expenses) resulting from quality improvement.

IV. Recommendations to replace the sustainable growth rate formula (SGR) and introduce alternative payment and delivery models

<u>Position 10</u>: Congress must replace the sustainable growth rate (SGR) with an alternative that will assure sufficient and predictable updates for all physicians and be aligned with the goals of achieving quality and efficiency improvements and sustaining a sufficient supply of primary care physicians.

<u>Position 11</u>: Congress should enact legislation to require a comprehensive study and report on alternative Medicare physician payment and delivery models that would recognize the value of the patient's relationship with a primary care physician, be less likely to induce inappropriate service volume increases, reward care that is evidence-based and efficient, reduce inappropriate geographic variations in cost and quality, and facilitate physician-guided care coordination of patients with chronic diseases. The study should be conducted by nationally recognized experts in health care financing and delivery (including experts on regional variations in cost and quality, quality improvement, and management of chronic diseases) and representatives of physician specialties that serve the most Medicare patients, including national medical specialty societies representing primary care physicians. The Medicare Payment Advisory Committee should review and comment on the study and report.

<u>Position 12</u>: Medicare and other payers should work with the ACP to design a new model for financing and delivering primary or principal care called the Advanced Medical Home.

- A pilot or demonstration of the Advanced Medical Home financing and delivery model should be implemented by CMS.

Introduction

> "We learn early in our medical training about the importance and joy of having a continuous, ongoing and personal relationship with a patient, which is the hallmark of general internal medicine and family medicine. Unfortunately, we also learn ...that there is no economic future in primary care." (Vineet Arora, MD, 2006)[1]

A Looming Crisis in Primary Care

The American College of Physicians (ACP), which represents over 119,000 physicians who specialize in internal medicine and medical students, recently released both a workforce policy paper "Creating a New National Workforce for Internal Medicine: Recommendations of the American College of Physicians"[2] and a January 2006 "State of the Nation's Health Care" report[3] providing substantial evidence for a looming crisis in primary care. Primary care, the backbone of the nation's health care system, is at grave risk of collapse due to a dysfunctional healthcare payment and delivery system. Immediate and comprehensive reforms are required to modify or replace this system that undermines and undervalues the relationship between patients and their personal physicians. If these reforms do not take place, within a few years there will not be enough primary care physicians to take care of an aging population with increasing incidence of chronic diseases. The consequences of failing to act will be higher costs, increased inefficiency, lower quality of care and increased patient dissatisfaction.

At a time when there is a growing demand for primary care physicians (e.g. internists, family practitioners) due to a rapidly aging population with increased incidence of chronic disease, the pool of these practitioners is rapidly decreasing.

- Demographic projections reflect an aging population for Medicare and the United States in general. Within only six years, the first of a wave of 76 million baby boomers will begin to be eligible for Medicare. The number of adults aged 65 and older, currently numbered at 36.3 million, is expected to grow 54 percent between 2000 and 2020. The population age 85 and over will increase 50 percent from 2000 to 2010.[4]
- Approximately two-thirds of Americans age 65 and older have multiple chronic conditions. Among adults ages 80 and older, 92 percent have one chronic condition, and 73 percent have two or more. [5]
- In 2000, physicians spent an estimated 32 percent of patient care hours providing services to adults age 65 and older. If current utilization patterns continue, it is expected that by 2020, almost 40 percent of a physician's time will be spent treating the aging population.[6]
- Primary care physicians and general internists in particular, are at the forefront of managing this increasing aging, chronically ill population. According to the Health Resources and Services Administration (HRSA) 2003 Changing Demographics Report, adult patients' need for primary care physicians increases dramatically as they age.[7]
- There has been a dramatic decline in the number of graduating medical students entering primary care. In 2005, only 13 percent of first-year internal medicine residents planned to pursue careers in general medicine. Among third-year internal medicine residents, only 20 percent planned to practice general internal medicine compared to 54 percent in 1998.[8]

- Large numbers of physicians who had chosen a general medicine practice are leaving the field. A 2005 survey of internal medicine physicians who received their board certification in the early 1990s found that 21 percent of those who were practicing general (primary care) internal medicine have left internal medicine practice entirely, compared with only 5 percent of subspecialty internists who reported that they have left their subspecialty.[9]
- It is anticipated that the demand for general internists will increase from 106,000 in 2000 to nearly 147,000 in 2020, an increase of 38 percent.[10]

The Collapse of Primary Care will Cause Higher Costs, Lower Quality, Reduced Access, and Increased Dissatisfaction

The primary care physician's ability to evaluate and clinically manage the whole patient in a patient-centered, longitudinal, coordinated manner has direct positive healthcare consequences. This is particularly true for the treatment of chronic conditions. The collapse of primary care will result in our health care system becoming increasingly fragmented, over-specialized, and inefficient – and lead to poorer quality, higher costs, reduced access, and increased patient dissatisfaction.

- States with higher ratios of primary care physicians to population have better health outcomes, including mortality from cancer, heart disease or stroke.[11] [12]
- Areas with more specialists have higher per capita Medicare spending,[13] and that an increase in primary care physicians is associated with a significant increase in quality of health services, as well as a reduction in costs.[14]
- Studies of ambulatory care–sensitive conditions have shown that hospitalization rates and expenditures are higher in areas with fewer primary care physicians and limited access to primary care.[15]
- Cross national comparisons indicate that nations with stronger primary care infrastructures have lower rates of premature births, deaths from treatable conditions, and post neonatal mortality.[16] [17] [18]
- Studies have repeatedly demonstrated that the vast majority of Americans prefer a sustained relationship with a primary care provider.[19]

Inadequate and Dysfunctional Payment and Delivery Policies Contribute to the Collapse of Primary Care

Inadequate and dysfunctional payment and delivery policies are key drivers behind the impending collapse of primary care. Medicare, as the single largest purchaser of health care in the United States and as the standard for health plan payment policies in the private sector, has a particular responsibility to replace policies that are antithetical to primary care with ones designed to encourage and support its importance and growth. Examples of current Medicare policies that adversely affect primary care include:

- Undervaluing the evaluation and management (E/M) clinical services that are predominately provided by primary care physicians.

- Using methodologies to determine the relative value units (RVUs) for each service that overvalue some services/procedures—to the detriment of other services in Medicare's budget neutral system
- Not paying for those services required to allow the primary care physician to provide patient-focused, longitudinal, coordinated care.
- Using a yearly fee update formula – the sustainable growth rate (SGR) – that has a disproportionately adverse impact on primary care physicians.
- Providing incentives for volume of services with no regard to the quality or efficiency of the clinical service provided.

A series of modest changes to the current Medicare physician payment and delivery system can lead to improvements and help mitigate the collapse of primary care.

ACP Positions on the Reform of the Dysfunctional Healthcare Payment and Delivery Systems

I. Ensuring the Accurate Valuation of Physician Services

Recent reports from the Medicare Payment Advisory Commission (MedPAC)[20] and the Center for Studying Health System Change[21] have highlighted the adverse effect of misvalued services on our healthcare system. Misvalued services distort incentives and may result in the overuse and potential underuse of specific services on the basis of financial as opposed to clinical reasons. The inappropriate valuation of services also affects physicians' decisions to enter or remain in specialty fields that perform undervalued services. ACP contends that Medicare currently undervalues many of the E/M services and maintains methodologies for determining the RVU for each service that overvalues some services/procedures to the detriment of E/M and other services/procedures paid under the fee schedule. The cumulative effect of this misvaluing of primary care services is a key reason that new physicians are choosing specialties other than primary care practice and current practitioners are leaving the field prematurely.

The College calls on policymakers to make immediate reforms in the way that Medicare determines the value of physician services under the Medicare Resource Based Relative Value Schedule (RBRVS).

<u>Position 1</u>: CMS should substantially increase the work relative value units (RVUs) for evaluation and management services based on evidence showing increased physician work.

<u>Position 2</u>: CMS should re-examine its methodologies for determining practice expense RVUs to ensure that the practice expenses assigned to specific services reflect true resource costs.

- CMS should implement a "bottom-up" methodology for using practice expense inputs to determine practice expense RVUs.
- CMS should facilitate a survey of all physician specialties to identify practice costs to include in the practice expense methodology.

- CMS should review its assumptions on the utilization and depreciation of service/procedure-specific equipment.

Lower Compensation for Primary Care Specialties

At the most macro level, the evidence for the undervaluing of primary care services is demonstrated by the results of a recent (2004) survey of physician compensation by specialty[22]. The yearly compensation for the primary care specialties (i.e. Family Practice, General Pediatrics, and General Internal Medicine) is at least 40 percent lower than most other specialty physicians

A recent report of the Clerkship Directors in Internal Medicine highlighted earning considerations as a significant factor in student's choice of medical field.[23] Thus, it is understandable that new, incoming physicians, even those who originally entered into medical school for the type of personal, long-standing relationships that characterize primary care, eventually opt out and enter more financially rewarding specialties. Furthermore, in its March 2006 Report to Congress, MedPAC expressed concern about the disparity in remuneration between primary care and the other specialties, and the "implications of those disparities for the future workforce that will be necessary to meet the chronic care and other needs of Medicare beneficiaries." (p. 148) [24]

Undervalued Primary Care Relative Values

The reason for the marked difference between the compensation for primary care relative to the other medical specialties relates to the type of services provided by the different specialty groups and how these services are valued. Primary care practitioners predominately provide evaluation and management services, in which the physician must typically meet face-to-face with the patient, take a history, perform an exam, decide upon the nature of the presenting problem, counsel the patient and coordinate any required immediate follow-up care. This is a very time-consuming, cognitive process, and is in contrast with most of the other specialties, which provide predominantly time-limited, technical procedural services. ACP argues that the current Medicare payment system significantly undervalues the E/M services. This contention is reinforced by recent MedPAC data indicating slower than expected volume growth in E/M services relative to other types of services.[25] MedPAC has voiced concerns that differences in profitability (i.e. E/M services are undervalued relative to the other services) may be partly responsible for the observed volume growth differential. MedPAC has also determined that the slow growth of E/M services relative to some other types of services has effectively nullified any gains in the relative value of E/M services that initially resulted from implementation of the Resource Based Relative Value Schedule (RBRVS) in 1992.

Compensation for primary care physicians is disproportionately affected by undervalued E/M codes because primary care physicians utilize them more than procedurally-oriented specialties. The relationship between undervalued E/M services and lower physician compensation is further compounded by the time-consuming nature of the E/M activities (compared to more technical procedures) which greatly limits the number of services that can be provided over a period of time.

Undervalued Relative Work Values

There is strong evidence that the relative work values assigned to the E/M services are undervalued. The relative work value is one component of the RBRVS system that Medicare uses to determine physician fees. The RBRVS defines physician work as: "time; technical skill and physical effort; mental effort and judgment; and stress associated with concern about iatrogenic risk to the patient." (p.25)[26] (A brief description of the RBRVS is found in Appendix A). On average, the work RVU accounts for approximately 55 percent of the total RVU for each service. The relative work values for E/M services are currently undervalued due to the fact that their values have not been reviewed or increased since 1997. During this time period, there has been a significant change in the physician work required in the provision of E/M services that can be attributed to the following factors:

- Patients have more chronic conditions. [27]
- Hospital length of stay has decreased. [28]
- The complexity and intensity of physician work involved in furnishing E/M services has increased since 1995. Data from the National Ambulatory Medical Care Survey (NAMCS) reflects that patients are older, have more complex diagnoses, more discussion of treatment, and more mention of drugs used in treatment.[29]
- The documentation requirements for E/M services have increased. The implementation of the 1995 and 1997 Medicare E/M documentation guidelines has increased documentation demands related to stand-alone E/M services. These guidelines did not exist the last time the E/M codes were reviewed. This adds to the physician work of E/M services relative to other services, which are not subject to the same documentation standard.

ACP is currently engaged in an effort to increase the work RVUs assigned to E/M services under Medicare through the periodic review of the physician fee schedule. The Medicare statute requires CMS to review the accuracy of RVUs assigned to services in the fee schedule at least every five years, known as the Five-Year Review. In 2005, CMS agreed to include many E/M services in this current Five-Year Review process at the request of ACP and other cognitive-oriented specialties, which stated that changes in patient characteristics, such as those described above, and physician practice have resulted in increased work. Subsequently, ACP and other specialty organizations surveyed members asking them to quantify the amount of physician work that goes into performing the different E/M services included in the Five-Year Review. The survey data and other information support a significant increase in work RVUs for many E/M service codes. These data have been presented to the American Medical Association/Specialty RVS Update Committee (RUC). CMS will consider the RUC recommendations and other information, including public comments, to decide on the work RVUs for E/M services that result from the Five-Year Review process. CMS will implement those RVUs in 2007.

Misvalued Practice Expense Values

The practice expense component of the fee schedule recognizes the expenses that a physician incurs in furnishing a service. Medicare began to implement resource-based practice expense payments in 1999 and fully implemented resource-based practice expense RVUs in 2002. CMS

currently identifies direct and indirect practices expenses for each fee schedule service. CMS defines direct practice expense inputs as the physician-incurred cost of clinical labor, supplies, and equipment necessary to furnish the particular service. The agency defines indirect practice expense inputs as the physician-incurred costs for administrative labor, office supplies, and other equipment. Two main sources CMS uses for data to develop practice expense RVUs are:

- AMA Socioeconomic Monitoring System (SMS) survey data, from 1995-1999, to identify total practice expense costs per specialty; and
- Direct practice expense inputs identified by the Clinical Practice Expert Panels (CPEP)—multi-specialty panels of physicians that CMS used to identify direct inputs in the mid-1990s, subsequently refined by the RUC, and then accepted by CMS.

On average, the practice expense RVU accounts for approximately 40 percent of the total RVU for each service.

ACP believes that the CMS should make changes to its methodology for determining the practice expense RVU for each physician fee schedule service. The current methodology is unnecessarily complex, lacks a uniform, current source of data on physician practice costs, lacks a mechanism to identify the physician acquisition cost of supplies and equipment, and uses questionable assumptions on the utilization and depreciation of equipment. Overvalued practice expense RVUs distort payments. They provide financial incentive to furnish overvalued services and devalue the practice expenses assigned to other services through the single budget neutral pool of dollars from which Medicare allocates practice expense RVUs to specific services/procedures.

- **CMS should implement a "bottom-up" methodology for using practice expense inputs to determine practice expense RVUs.**

CMS currently uses a "top-down" methodology to derive practice expense RVUs. The top-down methodology begins with values for total direct and indirect practice expenses at the physician specialty level and then allocates these costs down to the physician service-specific level. ACP recommends that CMS replace the top-down methodology with a "bottom-up" methodology to calculate direct practice expense costs. Under the bottom-up methodology, CMS would sum the costs of the direct practice expense inputs assigned to each service—as identified by the CPEPs, refined by the RUC, and accepted by the agency—to determine the direct practice expense payment. ACP has supported a bottom up approach to establishing practice expense RVUs since CMS began to implement resource-based practice expenses in 1999. The bottom-up methodology will be more accurate as the inputs are more refined and more current. It will also be fairer because it assumes that the costs of the clinical labor, supplies, and equipment are the same for a given service, regardless of the specialty that is performing it. This assumption does not hold true under the top-down direct cost methodology, where the specialty-specific scaling factors create widely differing input costs for the same service.

- **CMS should facilitate a survey of all physician specialties to identify practice costs that can be used in the practice expense methodology.**

CMS uses 1995-1999 AMA SMS survey data to identify total practice expense costs per specialty. CMS uses these data to establish specialty-specific direct and indirect practice expense pools. The agency allocates these costs to specific services. It uses a weighted average based on the utilization frequency when a service is performed by more than one specialty. As directed by Congress, CMS has accepted supplemental practice expense survey data submitted by specialties that meet established CMS criteria to ensure consistency with SMS survey data to update their practice expense costs. CMS has accepted supplemental survey data submitted by 13 specialties. CMS is no longer considering supplemental survey data. Specialties had until March 1, 2005 to submit data for the agency's consideration.

ACP supports the use of current, reliable physician practice costs data. However, the College notes that the total practice expense costs generally increased significantly for specialties for which CMS accepted supplemental survey data. While some have suggested that CMS should establish a new timeframe in which it would consider supplemental survey data, it is unlikely that all specialties would participate. Therefore, ACP recommends an all-specialty practice expense survey to update the data that CMS currently uses, most of which reflects practice from the mid-1990s. This would be a fair process since it would be inclusive of specialties regardless of their respective professional organization's ability to conduct its own survey.

- **CMS should review its assumptions on the utilization of service-specific equipment.**

CMS may be underestimating physician use of service-specific equipment and, thus overpaying for the equipment portion of the practice expense payment.[30] As stated by CMS in the June 18, 1997 Federal Register, the agency assumes that all equipment is used 50% of the time and then derives a cost per-minute for that service based on the cost of the specific piece of equipment. CMS multiples that cost per-minute by the amount of time the physician uses the equipment to determine the service-specific equipment payment. If the equipment is used more than the 50% of the time assumed by CMS, then the equipment portion of the practice expense payment would be too high. A more accurate, realistic assumption on the utilization of equipment could lower the practice expense RVU for some services, resulting in an increase in the practice expense RVUs for other services under the CMS system of a budget neutral pool of practice expense dollar.

<u>Position 3</u>: CMS should establish a better process for identifying potentially misvalued RVUs and redistributing any savings into the budget neutral RVU pool.

- The Secretary should establish a group of independent experts to advise CMS in its process of reviewing RVUs. The CMS expert panel should include Medicare carriers, medical directors, and experts in economics, technology, and physician payment from the private sector. The group should supplement the advice that is currently provided by the RUC.
- The Secretary should automatically review services that have experienced substantial changes in length of stay, site of service, volume, practice expense, and other factors that may reflect on the amount of physician work.

- The Secretary should automatically review the work RVU for recently introduced services after a specified period of time or based on other evidence that the work has changed over time.
- The Secretary should establish a process by which every service is reviewed periodically. More specifically, ACP suggests that a process be established by which every service is reviewed no later than once every 15 years, with more frequent reviews of higher volume/higher expenditure services and less frequent reviews of low volume/low expenditures services.

<u>Position 4</u>: CMS should request that the RVS Update Committee (RUC) examine its composition to assure that its composition is reflective of each specialty's relative contribution to providing services to Medicare patients.

Changes in the Process of Determining Service Relative Value Units

The RUC makes work and practice expense recommendations to CMS when a code describing a physician service, primarily defined as Current Procedural Terminology (CPT) codes, is revised or established and during each Five-Year Review of the physician fee schedule. Each Five-Year Review, CMS has solicited public input on misvalued services. This input comes primarily from the medical specialties. MedPAC reviewed the work value recommendations of the RUC during the previous two Five-Year Reviews and found a predominance of recommendations to increase service work relative values.[31] This is despite the fact that there is no reason to expect that a code is more likely to become undervalued over time than overvalued.

CMS has been reluctant, at least in part because of resource limitations, to identify codes for services which the agency believes may be overvalued for inclusion in a Five-Year Review. Physician specialty organizations are likely to urge CMS to include only the services they believe are undervalued. This is compounded by the fact that the current process fails to include any parameters that could identify potentially overvalued codes. For example, CMS assigns a new CPT code value when the technique and/or technology is novel. There is no mechanism built into the current process to assess whether the value for that code is still appropriate after physicians gain experience with the technique and/or the technology matures.

MedPAC[32] has expressed concerns about this lack of diligence in avoiding overvaluing services. ACP shares the MedPAC concern. Maintenance of overvalued services—most likely to be procedures and tests—devalues the work of other services in a relative value system. CMS must maintain a process for establishing relative value units that ensures current, accurate prices to avoid underpaying services that are commonly furnished by internists and other primary care physicians.

The ACP believes that CMS should more regularly evaluate these RVUs and that an independent body of experts should assist CMS and the RUC in this task. The establishment of an expert panel would provide CMS with both a credible source of technical information and advice regarding the valuation of physician services, and a mechanism to focus on potentially overvalued codes, something that CMS and the RUC have not done effectively. Establishing an expert panel is also consistent with the often-voiced need for additional resources for CMS to

effectively and accurately maintain the physician fee schedule. However, we do not believe this expert panel should replace or duplicate the role of the RUC, especially if the RUC is willing to make revisions in its membership composition and criteria. Rather, we see the role of this expert panel being one of supplementing the advice received through the RUC, primarily in identifying RVUs that may be overvalued. Thus, the College supports modifications to the process which are consistent with recent recommendations made by MedPAC.[33]

Changes to the Private Body that Advises CMS on Relative Values

The role of the RUC has been described earlier in this paper. ACP supports the RUC process and believes that the RUC should maintain its primary role in advising CMS on the relative value units (RVUs) assigned to physician services in the Physician Fee Schedule. However, ACP believes that the RUC should be reconstituted to better reflect the current practice of medicine.

The RUC is currently composed of 29 members; 23 are appointed by the major national specialty societies, a chair appointed by the AMA Board of Trustees, and five additional members representing the AMA, the American Osteopathic Associations, non-physician health professionals, the Practice Expense Advisory Committee and an Editorial Panel that approves the Current Procedural Terminology (CPT) service codes. The RUC is further informed through an Advisory Committee, which is opened to all 109 specialty societies that compose the AMA House of Delegates. Advisory Committee members are responsible for conducting surveys of physician work and practice data and providing relative value recommendations for the RUC to consider based on the collected data.

The RUC is in the influential position of making recommendations to CMS regarding changes to the RVUs, which directly translate into changes in how much physicians engaging in the affected services are paid. The RUC is currently largely composed of organizations representing procedural-oriented specialties; non-procedural, or cognitive-oriented, organizations are underrepresented, especially those representing primary care physicians who perform the majority of E/M services. This is despite the fact that E/M services account for approximately half of Medicare relative-value weighted service volume and Medicare spending. While the RUC employs procedures to facilitate impartial, unbiased decision making on the part of the RUC representatives, it is only reasonable to assume that the financial effects of their decisions would be at least partially influenced by the specialty group the RUC member represents. The ACP, in a December 2005 letter to MedPAC[34], expressed concern that physicians who provide predominately E/M services (e.g. primary care physicians) were not adequately represented on the RUC. The letter went on further to ask MedPAC to recommend that CMS request the RUC to re-examine its current composition to assure balanced and appropriate representation and expertise from all specialties based on measures of their contributions to the care of Medicare patients**.** It is the contention of the ACP that a RUC composition more directly and proportionately based upon each specialty's contributions to the care of Medicare patients will result in more accurate determinations of recommended RVUs by the RUC.

<u>Position 5</u>: The College recommends that MedPAC examine modifying the RBRVS definition of work to more adequately reflect those processes related to the improving of clinical quality, efficiency and patient experience.

Exploring a Change in the Definition of Physician Work

The RBRVS defines physician work as: "time; technical skill and physical effort; mental effort and judgment; and stress associated with concern about iatrogenic risk to the patient." (p.25)[35] Although this definition captures much of the work associated with physician services, it does not capture a physician's contributions to improving quality, or providing care consistent with evidence-based guidelines or measures, or the complex task of coordinating care for patients, especially those with multiple chronic diseases. These additional contributions involve substantial work on the part of the physician and his or her clinical and administrative staff, but are not explicitly recognized by the RBRVS. Yet these contributions are essential if Medicare is to improve clinical quality, efficiency and patient experience. One strategy to recognize and reward these quality processes would be to revise the RBRVS definition of work to more adequately reflect them. This would allow for higher RVUs for services that have a direct relationship to improving clinical quality, efficiency and patient experience. ACP does not have a specific recommendation at this time on how such contributions might be accounted for in the relative values themselves but the College believes that this approach should be examined. Pay-for-performance pools and direct additional payments for these quality-facilitating activities provide alternative means to recognize the value of such contributions. These approaches are discussed later in the paper.

II. Recommendations to Provide Separate Medicare Payments for Services that Facilitate Accessible and Coordinated Care

The Institute of Medicine (IOM) has defined primary care as:

> the provision of *integrated (comprehensive, coordinated, continuous), accessible health care services* by *clinicians* who are *accountable* for addressing a large *majority of personal health care needs*, developing a *sustained partnership* with *patients*, and practicing in the *context of family and community*. (IOM, 1996)[36]

Similarly, Safran[37] reviewed the literature and found that the essential elements of primary care were: a sustained clinician–patient relationship, ease of accessibility, integrated care, a whole-person orientation, comprehensive care, and clinical management. The importance of these primary care characteristics, particularly for an increasingly aging, chronically ill population, was emphasized in a recent ACP policy paper titled "Patient-Centered, Physician-Guided Care for the Chronically Ill: The American College of Physicians Prescription for Change."[38] Despite the increasing importance of these elements, the current Medicare physician payment system does not recognize or support many of these primary care services.

According to Ginsburg, the President of the Center for Studying Health System Change:

> "The mechanism of payment for primary care services can be a substantial impediment to achieving the vision of the primary care of the future. Fee-for-service payment is not evolving in the same way that the practice of medicine is. Primary care practice now involves more telephone and e-mail communication with patients and time spent on management and coordination of care."[39]

The College calls on policymakers to make immediate reforms so that that Medicare can pay physicians for providing patient-focused, longitudinal, coordinated care.

<u>Position 6</u>: CMS should provide separate payment for services employing e-mail, telephonic, and related technology that could facilitate timely communications between physicians and patients and reduce the need for face-to-face visits for non-urgent care.

Payment for Physician Services Provided by Telephone, E-mail and Related Technology

The current Medicare payment system is based primarily on services provided during a face-to-face interaction between the physician and patient. Thus, physicians are typically only paid if the patient is seen the doctor's office or similar formal clinical setting. The College, in a series of papers on the "The Changing Face of Ambulatory Medicine" has highlighted the positive use of telephone, "Reimbursing Physicians for Telephone Care"[40] and the internet, "Reimbursing Physicians for Computer-based Care"[41] in improving patient accessibility to care, the quality of patient care, and facilitating physician productivity. There has also been a recent rapid growth in the development of remote patient health monitoring devices. Accessibility is improved by making the physician's knowledge and expertise available to the patient outside the structure of an office visit. In addition, it is obviously more convenient for the patient to call or email the physician in appropriate situations. Quality can be improved by facilitating physician-patient contact that will allow for improved symptom recognition, diagnosis and follow-up care. Finally, these tools can also help physicians optimize their productivity in serving patients; allowing them to treat a wide array of non-urgent conditions and needs by phone or internet without the time and expense of an office visit, while reserving face-to-face care for patients most in need of intensive direct care. Appropriate guidelines for the use and billing of these services, including documentation requirements would have to be developed.

It is notable that the private sector has begun recognizing the value of these non face-to-face services. For example, both Microsoft and Cisco Systems have announced that they will begin paying physicians for online consultative services for their employees.[42] CMS and the American Medical Group Association (AMGA) have recently initiated a demonstration project in which physicians receive daily reports from patients, including their vital signs through a secure web-based system.[43]

<u>Position 7</u>: CMS should provide Medicare payment to physicians for the overall provision of defined, care coordination/care management services, and/or provide specific codes for those activities that facilitate care coordination/care management services (e.g., care

coordination across treatment settings, intensive care follow-up, use of patient registries and population-based treatment protocols, patient disease management training).

Payment for Physician Care Coordination Services

Recently, there has been considerable interest in the area of care coordination services. This interest is most clearly reflected by the large number of demonstrations and pilots CMS is currently conducting in this area. These include the Medicare Health Support Program, the Disease Management Demonstration for Severely Chronically Ill People with Medicare, the Disease Management Demonstration for Chronically Ill Dual-Eligible Beneficiaries and the Care Management for High Cost Beneficiaries Demonstration. This interest is also reflected in the rapid growth of disease management and case management entities within the private sector.[44] The literature has correctly indicated that the term "care coordination", which is often used interchangeably with the term "care management," refers to a variety of activities.[45] [46] These include managing the transition of care across settings, the use of patient registries to allow for population-based care protocols, the use of frequent follow-up with patients to promote treatment plan compliance and to obtain healthcare data, the use of clinical practice guidelines, including feedback to the physcian regarding their degree of compliance with the guidelines, and the teaching of disease self-management skills to patients. The literature reflects the effectiveness of various combinations of these activities for a variety of chronic illnesses including diabetes,[47] asthma,[48] congestive heart failure[49] and depression.[50] In addition, there is also promising research support for the cost effectiveness (return on investment) of many of the activities[51].

These care coordination activities are at the core of what defines a primary care physician. They reflect the type of services a physician must provide as a practitioner that values longitudinal, integrated, comprehensive care. Unfortunately, the current Medicare payment system generally does not make payment for these valuable services.

<u>Position 8</u>: CMS should provide an add-on to Medicare payments for office visits that are facilitated by the use of HIT, such as electronic health records, electronic prescribing and clinical decision support tools, and reimburse accordingly. Furthermore, to ensure that the use of this technology is primarily to facilitate improved healthcare quality/safety, payment should be contingent on physicians reporting related data to approved quality improvement and measurement programs.

Payment for the Use of Health Information Technology (HIT)

Technological advances over the past decade, including the development of e-prescribing, electronic medical records, and clinical decision supports, are capable of significantly improving the quality, safety and productivity of healthcare. The importance of the healthcare system adopting this technology is highlighted in the Institute of Medicine's (IOM) 2001 Report, "*Crossing the Quality Chasm – A New Health System for the 21st Century*."[52]

The importance of HIT adoption is particularly true for primary care physicians, who can use this technology to effectively provide the longitudinal coordinated care that is at the core of their generalist practices. The technology can be used to establish patient registries, allow for the effective follow-up of lab tests and treatment delivered by other specialists, provide an

administrative infrastructure to implement intensive patient follow-up and patient self-management protocols, allow for the point-of-care delivery of clinical decision support information and help assess the physician's compliance with quality and treatment guidelines. Again, the current Medicare payment system does not provide any incentive for physicians to implement and use HIT. This current lack of payment for HIT particularly hurts the small practice physician, which manages the treatment for the majority of Medicare beneficiaries. These practices, under the current payment system, do not have the resources to afford the average of $44,000 per full-time equivalent provider to implement an electronic medical record system, nor can they afford the ongoing costs averaging $8,500 per provider per year for maintenance of the system.[53] The College strongly believes that the payment system must recognize the use of HIT in the delivery of care.

III. Adding a Quality Component to the Medicare Payment System

The oft-quoted Institute of Medicine's 2001 "Quality Chasm" report[54] outlined the significant quality gaps within the U.S. healthcare system. More recent data serves to confirm this observation:

- Healthcare outcomes in the United States contrast poorly with those of other industrialized countries, despite evidencing the highest level of spending.[55]
- Patients receive recommended healthcare only about 55 percent of the time.[56]
- Poor-quality care leads to 66.5 million avoidable sick days and $1.8 billion in excess medical costs each year.[57]

The current Medicare payment policy contributes to this quality deficit by not providing any incentives for physicians to engage in quality improvement efforts – all physicians are provided the same standard payment for performing a procedure regardless of the quality. It is the College's position that the present payment model must be changed to recognize and reward physician quality efforts. A payment model that includes a pay-for-performance (P4P) component, if implemented correctly, will not only facilitate improved quality throughout the system, but will provide increased income to those practitioners who expend the financial resources and human capital to provide quality care.

<u>Position 9</u>: Congress and CMS should provide sustained and sufficient financial incentives for physicians to participate in programs to continuously improve, measure and report on the quality and efficiency of care provided to patients. Furthermore:

- The current payment system should be replaced with new methods of reimbursement that rewards those who follow evidence-based standards.
- Rewards should reflect the level of work and commitment to quality, which will differ among physicians and across specialties.
- P4P systems should rely on valid and reliable clinical measures, data collection and analysis, and reporting mechanisms.
- The value of health information technology (e.g. electronic health records, decision-support tools) should be financially recognized for their ability to assist physicians to do well on quality measures and report their progress.

- Potential P4P rewards should be significant enough to support continuous quality improvement (including adequately reimbursing providers for the substantial practice re-design and HIT implementation costs required to participate in these programs), directed at positive rewards, not negative penalties, and be balanced between rewarding high performance and substantial improvement over time.
- Medicare P4P should enable physicians to share in system-wide savings (such as from reduced Part A hospital expenses) resulting from quality improvement

Recognizing and Rewarding Physician Quality Efforts.

There has been significant recent recognition and implementation of P4P in both the private and public healthcare systems. The Commonwealth Fund has counted as many as 105 private payer P4P initiatives in the United States.[58] Med-Vantage, a consulting firm that has surveyed scores of plans, estimates that more than 100 plans, which cumulatively cover 40 million patients, are employing P4P designs.[59] Within the public sector, Medicare has implemented the Hospital Quality Initiative that uses payment incentives to promote public reporting of health care quality. CMS has also recently launched a number of P4P quality initiatives within the ambulatory care setting. These include the Physician Group Practice Demonstration and the Medicare Care Management Performance Demonstration. Furthermore, CMS is initiating a Physician Voluntary Reporting Program for all physicians in 2006 that has the potential to expand into a full P4P program pending required approval of Congress through legislation.

The College has a long history of promoting care quality and has been actively supporting the development and use of performance measures. The College has affirmed its general support of these P4P quality efforts in a recently released position paper "Linking Medicare Payments to Quality."[60] This paper also defines a set of principles that would ensure that any implemented P4P system would be evidence-based, transparent, fair, and equitable for internists and other practitioners.

The establishment of an adequately funded P4P program under Medicare is complicated by the system's financing mechanisms. Medicare finances hospital and physician services through different means. Hospital services (Medicare Part A) are financed through a payroll tax that is maintained in a trust fund, while physician services (Medicare Part B) are financed through a combination of beneficiary premium payments, coinsurance, and federal general revenue funds. Current Medicare financing methodology does not allow expenditures from these different pools to be mixed. Thus, any savings that occur in hospital expenditures (Part A) due to improved care quality in physician services (Part B) – that is, hospitalizations avoided due to improved ambulatory based services – cannot be credited and used to reward those physicians responsible for the savings. The College believes that this "silo" like Medicare financing methodology makes it difficult to adequately fund a Medicare P4P program – particularly given Congress's recent insistence that most changes to the Medicare program must at least be budget-neutral, if not result in overall cost-savings. The Medicare Physician Group Practice Demonstration provides a model for how physicians can share in savings obtained through reductions in Medicare Part A expenditures. Furthermore, the recently enacted Deficit Reduction Act of 2005 requires CMS to implement a gainsharing demonstration project between physicians and

hospitals in which the principals would share in savings incurred directly as a result of collaborative efforts.

IV. Replacing the Sustainable Growth Rate Formula and Introducing Alternative Payment and Delivery Models

Relatively modest modifications of the current physician payment and service delivery system will not be sufficient to permanently maintain and foster a thriving primary care workforce. A system needs to be developed that recognizes the value of longitudinal care delivery, is less likely to induce inappropriate service volume increases, and rewards care that is evidence-based and efficient.

Position 10: Congress must replace the sustainable growth rate (SGR) with an alternative that will assure sufficient and predictable updates for all physicians and be aligned with the goals of achieving quality and efficiency improvements and assuring a sufficient supply of primary care physicians.

Modifying or Replacing the Sustainable Growth Rate (SGR

The current Medicare payment system is based on a payment formula, the sustainable growth rate (SGR). This complex formula decreases Medicare payments to physicians whenever the growth in expenditures on physician-related services exceeds changes in per capita gross domestic product (GDP), after modifications based on enrollment, changes in law and regulation and other factors. Congress implemented this formula as a means to control the substantial growth of physician-related service volume under Medicare. Since its implementation in 2000, this payment formula has been unsuccessful in controlling service volume and has lead to mandated yearly cuts in physician payment since 2002 – with annual cuts of approximately 5 percent projected through 2011.[61] It is notable that Congress has stepped in for all previous years, except 2002, to negate the formula prescribed payment cuts. These increases approved by Congress through legislation have not kept up with physicians' costs to provide these services during this time period – as measured by the Medicare economic index (MEI).

In recent testimony before Congress[62], the Chairman of MedPAC identified three basic problems in the current SGR approach:

- It disconnects payment from the cost of producing services. The formula produces updates that can be unrelated to changes in the cost of producing physician services and other factors that should inform the update. If left alone, negative updates would provide a budget control but in so doing would produce fees that in the long run could threaten beneficiaries' access.
- It is a flawed volume control mechanism. Because it is a national target, there is no incentive for individual physicians to control volume. When fee reductions have occurred they have not consistently slowed volume growth and the volume of services and level of spending are still increasing rapidly.
- It is inequitable because it treats all physicians and regions of the country alike, regardless of their individual volume influencing behavior.

In addition to the problems outlined by the MedPAC Chairman, the SGR also treats all volume increases the same – whether they are desirable or not.

Primary care physicians are hurt the most by SGR mandated cuts and inadequate updates because they already are paid less than other physicians. They also have low practice margins and fixed costs that make it impossible for them to absorb the cuts and have little or no ability to offset cuts by increasing volume. This scenario can only exacerbate the looming crisis in the primary care workforce.

MedPAC[63] has recommended that the SGR-formula based physician payment system be eliminated, that physicians should be provided yearly updates linked to changes in the cost of producing these services as reflected by MEI, and that inappropriate volume increases for specific procedures should be addressed individually. For example, CMS has recently addressed an observed increase in imaging procedures by reducing payment for multiple procedures at the same site or contiguous areas.

The recently enacted Deficit Reduction Act of 2005 has mandated MedPAC to submit a report to Congress by March 2007 on mechanisms that could be used to replace the SGR. It specifically calls for MedPAC to evaluate the effects of employing smaller volume target pools based on geographic region, type of services, physician group practice affiliation, hospital medical staffs and physician outliers.

The College is supportive of attempts to control unnecessary and/or inappropriate growth in the volume of physician services. ACP believes that the implementation of modifications to the Medicare payment and service delivery system to support primary care services and physician-directed care coordination of patients with chronic diseases, and encourage the use of quality and efficient care (P4P programs) will contribute to the reduction of inappropriate volume/expenditure growth. It also recognizes that Congress is interested in exploring alternatives to the SGR methodology. The College believes that any update methodology that replaces the current SGR formula must be aligned with creating incentives for quality measurement and reporting, allow physicians to share in system-wide savings from quality improvement and coordination of patients with multiple chronic diseases, and reflect increases in physician practice costs, including the costs associated with acquiring health information technology to support quality improvement.

The College plans on providing an analysis of potential approaches to control unnecessary or inappropriate volume/expenditure growth in physician services under Medicare in a subsequent Medicare Physician Payment Reform policy paper scheduled for release later this year. The paper will review the anticipated effects of implementing the MedPAC recommended approach of linking yearly updates to changes in the cost of providing physician services and addressing any inappropriate growth through dedicated, specific means. Since the Congressional Budget Office (CBO) estimates that removal of the SGR and implementing yearly updates based on the MEI would be very expensive ($154 billion over 10 years),[64] it is likely that Congress would want to maintain some form of mandated volume/expenditure controls. Thus, the College will also examine the potential effects of implementing the various narrow volume target pools

outlined in the Deficit Reduction Act, , and other alternative approaches to controlling the cost of care provided to beneficiaries.

<u>Position 11</u>: Congress should enact legislation to require a comprehensive study and report on alternative Medicare physician payment and delivery models that would recognize the value of the patient's relationship with a primary care physician, be less likely to induce inappropriate service volume increases, reward care that is evidence-based and efficient, reduce inappropriate geographic variations in cost and quality, and facilitate physician-guided care coordination of patients with chronic diseases. The study should be conducted by nationally recognized experts in health care financing and delivery (including experts on regional variations in cost and quality, quality improvement, and management of chronic diseases) and representatives of physician specialties that serve the most Medicare patients, including national medical specialty societies representing primary care physicians. The Medicare Payment Advisory Committee should review and comment on the study and report.

Alternative Forms of Physician Payment and Service Delivery Under Medicare

The implementation of the many changes recommended in this paper, even the replacement of the ineffective and harmful SGR methodology, will not ensure a thriving primary care workforce. New, alternative Medicare physician payment and delivery models need to be developed that recognize the value of the patient's relationship with a primary care physician, be less likely to induce inappropriate service volume increases, reward care that is evidence-based and efficient, reduce inappropriate geographic variations in cost and quality, and facilitate physician-guided care coordination. Efforts must take place to study and experiment with alternative payment and delivery systems that have the potential to be more effective.

The literature contains discussions of a number of alternative physician payment and delivery models. These include various prospective payment, bundled service, expanded resource-based and salary-based models. In a subsequent policy paper on Medicare Physician Payment Reform, ACP will review the pros and cons of several of the more prominent of these alternative payment systems, including the model outlined in the recently released ACP "Advanced Medical Home" policy paper.[65] These approaches will be analyzed as to their effect on internal medicine and primary care practitioner in general, as well as on the other, more procedure-oriented medical specialists. Most importantly, the College will analyze the potential impact on patients of alternative models for reimbursing physicians.

The Advanced Medical Home

<u>Position 12</u>: Medicare and other payers should work with the ACP to design a new model for financing and delivering primary care called the Advanced Medical Home.

- A pilot or demonstration of the Advanced Medical Home financing and delivery model should be implemented by CMS in 2007.

The College policy paper, "The Advanced Medical Home: A Patient-Centered, Physician-Guided Model of Health Care"[66] defines a new model of primary care with a complementary payment system that appears to meet the goals of rewarding practitioners for taking responsibility for delivering longitudinal, patient-centered care that demonstrates evidence-based quality and efficiency. Physicians providing services under this model would engage in the following key practices:

- Use evidence-based medicine and clinical decision support tools to guide decision-making at the point-of-care based on patient-specific factors;
- Organize the delivery of that care according to the Wagner Chronic Care Model (CCM)[67], but leverage the core functions of the CCM to provide enhanced care for all patients with or without a chronic condition;
- Provide enhanced and convenient access to care not only through face-to-face visits, but via telephone, email and other modes of communication;
- Identify and measure key quality indicators to demonstrate continuous improvement in health status indicators for individuals and populations treated;
- Adopt and implement technology to promote safety, security, information exchange and portals for patient access to their health information; and
- Participate in programs that provide feedback and guidance on the overall performance of the practice and its physicians.

The College envisions a voluntary process to qualify practices for designation as an advanced medical home prior to becoming eligible for the revised reimbursement model. As part of this practice qualification process, physicians in the practice would need to complete a self-paced educational module on the CCM and systems-based care provision, such as the Practice Improvement Modules of the American Board of Internal Medicine or comparable educational programs. Once qualified, a practice would become eligible for reimbursement based on the provision of care according to the advanced medical home concept.

The College is working on developing a payment model to support the advanced medical home. The key elements of a revised reimbursement model should include compensation for the following: a) the coordination of care both within a given practice and between consultants, ancillary providers, and community resources; b) adoption and use of health information technology for quality improvement; c) provision of enhanced communication access such as secure e-mail and telephone consultation; d) remote monitoring of clinical data using technology; and e) pay-for-reporting or pay-for-performance. Examples of other features of a revised reimbursement model to consider include providing enhanced coverage for beneficiaries and reducing co-insurance for patients who select an advanced medical home for their principal care and reducing administrative burdens for physicians and practices, e.g., modification of documentation requirements for coding and elimination of need for advanced beneficiary notices.

The payment structure of this new model of reimbursement may include the following components: (1) a monthly or yearly risk-adjusted fee for each patient who chooses that physician as his/her Advanced Medical Home, to create an incentive for physicians to adopt this practice model and to care for patients with multiple chronic diseases (this payment would also

help support the additional direct costs of this type of practice, such as implementing health information technology and for paying the cost of extra staff to provide patient education and care coordination) (2) a bundled care management fee to recognize the value of physician work associated with care coordination that falls outside of the face-to-face visits and (3) per-visit payments so that physicians continue to have an incentive to see patients face-to-face. The model would also include performance-based payments based on achieving defined quality and efficiency goals. The College will conduct further analysis of the strengths and weaknesses of this proposed reimbursement model and will discuss it further in a forthcoming paper on reforming the dysfunctional payment system.

ACP recommends that CMS conduct a national pilot test of the ACP Advance Medical Home model for implementation in 2007 in order to further study and advance this model. Under this pilot or demonstration, participating practices would have to qualify by displaying the capacity to engage in the key elements of the model as outlined above. The demonstration pilot would be designed to allow participation by small practices, rather than just large groups, and should include a sufficient number of practices from different practice settings (rural, urban, large and small states, etc) to produce generalizable results. Evaluation of the effectiveness of this model would be at the practice level. Design of the program would be determined through a technical and professional advisory group to CMS that would include representatives of those medical specialties (predominantly, but not limited to the primary care medical specialties) that will assume the greatest degree of responsibility for the demonstration program.

Conclusion

The College has profound concerns regarding the looming collapse of primary care and its predictable effects on healthcare throughout the country. Healthcare will become increasingly fragmented, overly-specialized, inefficient and this will lead to lower quality, higher costs, reduced access and increased patient dissatisfaction. The College believes that changes to the current Medicare payment and delivery system that include ensuring the accurate valuation of physician services, providing separate payments that facilitate accessible and coordinated care, and adding a quality component will improve the system and help mitigate the predicted collapse of primary care. The College further believes that these modest changes alone will not be sufficient to permanently maintain and foster a thriving primary care workforce. The SGR formula needs to be replaced with one that adequately reflects the cost for physicians to provide accessible coordinated care that is also of high quality and efficient. Furthermore, entire new payment and delivery models need to be developed and studied, such as the Advanced Medical Home, that more effectively meet the needs of our patients, and the physicians that serve them. The College eagerly looks forward to being an active participant in this process.

Appendix A

The Medicare payment for physician services is based on the Resource-Based Relative Value Scale (RBRVS). Payments are determined by the resource costs required to provide the service. The relative value of each service is divided into 3 components:

1. Physician work – accounts for approximately 52 percent of the total relative value of the service, and consist of factors recognizing the time it takes to perform the service; the technical skill and physical effort; the required mental effort and judgment; and stress due to the potential risk to the patient.

2. Practice expense – accounts for approximately 44 percent of the total relative value of the service, and consists of factors recognizing the direct (e.g. equipment, supplies and cost of administrative and clinical staff) and indirect (e.g. office rent, utilities) costs to the physician to provide the service.

3. Professional liability insurance – accounts for approximately 4 percent of the relative value and reflects the cost of professional liability insurance to the physician.

All relative value components are adjusted for geographic differences in resource costs by a geographic practice cost index (GPCI) and the combined relative value for a service is multiplied by a standard conversion factor expressed in dollars that is established by CMS and that determines the actual fee for the service.

The payment formula is:

> Payment Amount = [(Work RVU * Work GPCI) + (PE RVU * PE GPCI) + (PLI RVU * PLI GPCI)] * Conversion Factor

References

[1] Arora V. Remarks. State of the Nations Healthcare: A Report from the American College of Physicians. January 30, 2006. Accessed at http://www.acponline.org/hpp/statehc06_3.pdf on 3 March 2006.
[2] American College of Physicians. Creating a New National Workforce for Internal Medicine: Recommendations of the American College of Physicians. April 2006.
[3] American College of Physicians. State of the Nation's Healthcare: A Report from the American College of Physicians. January 30, 2006. Accessed at http://www.acponline.org/hpp/statehc06_1.pdf on 3 March 2006.
[4] U.S. Census Bureau, Population Division, Population Projections Branch (2000). U.S. Interim Projections by Age, Sex, Race, and Hispanic Origin. Accessed at http://www.census.gov/ipc/www/usinterimproj/ on 3 March 2006.
[5] Johns Hopkins University Chronic Conditions: Making the Case for Ongoing Care. Baltimore, MD. Johns Hopkins University Partnership for Solutions. Accessed at http://www.parternshipforsolutions.org/dms/files/chronicbook2004.pdf on 3 March, 2006.
[6] US Department of Health and Human Services. Changing Demographics: Implications for Physicians, Nurses, and Other Health Workers. Health Resources and Services Administration, Rockville, MD, U.S. Department of Health and Human Services.
[7] US Department of Health and Human Services. Changing Demographics: Implications for Physicians, Nurses, and Other Health Workers.
[8] Popkave, CG. Research Associate, Office of Reserach, Planning, and Evaluation, American College of Physicians. Personal Communication. February 2006. ITE Exam Survey Data.
[9] Lipner RS, Bylsma WH, Arnold GK, Fortna GS, Tooker J, Cassel CK. Who is maintaining certification in internal medicine—and why? A national survey 10 years after initial certification. Ann Intern Med. 2006;144:29-36.
[10] US. Department of Health and Human Services. Changing Demographics: Implications for Physicians, Nurses, and Other Health Workers.
[11] Shi L. The relationship between primary care and life chances. Journal of Health Care for the Poor and Underserved. 1992;3:321-35.
[12] Shi L. Primary care, specialty care, and life chances. International Journal of Health Services. 1994; 24:431-58.
[13] Fisher E, Wennberg D, et al. The implications of regional variations in Medicare spending. Part 1: The content, quality, and accessibility of care. 2003 Annals of Internal Medicine;138(4) 273-287.
[14] Baiker K, Chandra A. Medicare Spending, the Physician Workforce, and Beneficiaries' Quality of Care. Health Affairs. 7 April 2004.
[15] Bodenheimer T, Fernandez A. High and rising health care costs. Part:4 Can costs be controlled by preserving quality? Ann. Int. Med. 2005;143:26-31.
[16] Starfield B. Primary Care: Concept, Evaluation, and Policy. New York: Oxford Univ Pr; 1992.
[17] Starfield B, Shi L. Policy relevant determinants of health: an international perspective. Health Policy. 2002;60:201-18.
[18] Macinko J, Starfield B, Shi L. The contribution of primary care systems to health outcomes within Organization for Economic Cooperation and Development (OECD) countries, 1970-1998. Health Serv Res. 2003;38:831-65.
[19] Safran, DG. Defining the future of primary care: what can we learn from patients? Ann Intern Med. 2003; 138:248-55.
[20] Medicare Payment Advisory Commission. Reviewing the work relative values of physician fee schedule services. Report to Congress: Medicare Payment Policy. March 2006.
[21] Ginsberg P, Grossman J. When the price isn't right: How inadvertent payment incentives drive medical care. Health Affairs. 2005;Web Exclusive 376-384.
[22] Medical Group Management Association. Physician Compensation and Production Survey. 2005 Interactive Report.
[23] Hauer KE, Alper EJ, Clayton CP, et al. Educational responses to declining student interest in internal medicine careers. Am. J. of Med. 2005; 118:1164-1170.
[24] Medicare Payment Advisory Commission. Reviewing the work relative values of physician fee schedule services. Report to Congress: Medicare Payment Policy. March 2006.
[25] Medicare Payment Advisory Commission. Reviewing the work relative values of physician fee schedule services. Report to Congress: Medicare Payment Policy. March 2006.
[26] American Medical Association. Medicare RBRVS: The Physicians' Guide. 2005 AMA Press.

[27] O'Connor P. Editorial: Adding Value to Evidence-Based Clinical Guidelines, JAMA, August 10, 2005
[28] Centers for Medicare and Medicaid Services, Statistics, 2004. Accessed at http://www.cms.hhs.gov/MedicareMedicaidStatSupp/downloads/2004CMSstat.pdf on 3 March, 2006.
[29] National Ambulatory Medical Care Survey. 2003, 2002, 1997, 1996 data. Centers for Disease Control, National Center for Health Statistics.
[30] Medicare Payment Advisory Commission. Practice expense: Work plan. Transcript of public meeting. November 2005.
[31] Medicare Payment Advisory Commission. Reviewing the work relative values of physician fee schedule services. Report to Congress: Medicare Payment Policy. March 2006.
[32] Medicare Payment Advisory Commission. Reviewing the work relative values of physician fee schedule services. Report to Congress: Medicare Payment Policy. March 2006.
[33] Medicare Payment Advisory Commission. Reviewing the work relative values of physician fee schedule services. Report to Congress: Medicare Payment Policy. March 2006.
[34] American College of Physicians. Letter from Joseph Stubbs, MD, Chair of the Medical Service Committee to Glen Hackbarth, Chair, Medicare Payment Advisory Commission. December 28, 2005.
[35] American Medical Association. Medicare RBRVS: The Physicians' Guide. 2005 AMA Press
[36] Institute of Medicine. Crossing the Quality Chasm: A New Health System for the Twenty-First Century. Institute of Medicine. 2001.
[37] Safran, DG. Defining the future of primary care: what can we learn from patients? Ann Intern Med. 2003; 138:248-55.
[38] American College of Physicians. Patient-Centered, Physician-Guided Care for the Chronically Ill: The American College of Physicians Prescription for Change. October 2004.
[39] Ginsburg PB. Payment and the future of primary care. Annals of Internal Medicine. 2003;138:233-4.
[40] American College of Physicians. The Changing Face of Ambulatory Medicine-Reimbursing Physicians for Telephone Care. July 2003. Accessed at http://www.acponline.org/hpp/tel_care.pdf on 3 March 2006.
[41] American College of Physicians. The Changing Face of Ambulatory Medicine-Reimbursing Physicians for Computer-based Care. March 2003. Accessed at **http://www.acponline.org/hpp/e-consult.pdf** on 3 March 2006.
[42] AM News. Microsoft, Cisco push paying doctors for online work. Accessed at http://www.ama-assn.org/amednews/2006/02/13/bisb0213.htm on 4 March, 2006.
[43] American Medical Group Association. Press release. AMGA Members Begin CMS Demonstration Project to Use Technology for Chronic Care Improvement. February 1, 2006.
[44] Hewitt Associates. (2004). Health care expectations: future strategy and direction 2005. Hewitt Associates LLC (November 17, 2004).
[45] Stille J, Jerant A, Bell D, et al. Coordinating care across diseases, settings, and clinicians: A key role for the generalist in practice. Ann Int Med. 2005;142:700-708.
[46] Medicare Payment Advisory Commission. Care Coordination-Physician Involvement. Transcript of Public Meeting. October 2005.
[47] Norris S, Nichols P, Caspersen C, et al. The effectiveness of disease and case management for people with diabetes: A systematic review. Amer. J. Prev. Med. 2002;22:15-38.
[48] Bodenheimer T, Wagner, Grumbach K. Improving primary care for patients with chronic illness: the chronic care model, Part 2. JAMA. 2002;288:1909-14.
[49] Roglieri B, Futterman R, McDonough K, et. al. Disease management interventions to improve outcomes in congested heart failure. Am. J. of Managed Care. 1997;3:1831-1839.
[50] Unutzer J, Katon W, Callahan, C, et. al. Collaborative care management of late-life depression in the primary setting. JAMA. 2002;288:2836-2845.
[51] Goetzel R, Ozminkowski R, Villagra V and Duffy J. Return on investment in disease management: a review. Health. Care Fin. Rev. 2005;26:1-18
[52] Institute of Medicine. Crossing the Quality Chasm: A New Health System for the Twenty-First Century. Institute of Medicine. 2001.
[53] Miller R, West C, Brown T, et al. The value of electronic health records in solo or small group practices. Health Affairs. 2005;24:1127-1137.
[54] Institute of Medicine. Crossing the Quality Chasm: A New Health System for the Twenty-First Century. Institute of Medicine. 2001.

[55] Starfield B, Shi L. Policy relevant determinants of health: an international perspective. Health Policy 2002;60:201-18.
[56] McGlynn E, Asch S, Adams J, et al. The Quality of Health Care Delivered to Adults in the United States. New England Journal of Medicine. 2003;348(26):2635-45.
[57] The State of Health Care Quality: 2004. National Committee for Quality Assurance. 2004. Accessed at www.ncqa.org/communications/SOMC/SOHC2004.pdf on 25 Aug 2005.
[58] Rosenthal M. Examining Pay-for-Performance Measures and Other Trends in Employer-Sponsored Health Care. The Commonwealth Fund, May 2005. Accessed at http://www.cmwf.org/publications/publications_show.htm?doc_id=277826 on 4 March 2006.
[59] Med Vantage. Provider Pay-for-Performance Incentive Programs: 2004 National Study Results. Accessed at http://www.medvantageinc.com/Pdf/MV_2004_P4P_National_Study_Results-Exec_Summary.pdf on 4 March 2006.
[60] American College of Physicians. Linking Medicare Payments to Quality. 2005.
[61] Medical Payment Advisory Commission. Payment for physician services in the Medicare program. Testimony of Chairman Glen Hackbarth before the Health Subcommittee of the House of Representative's Energy and Commerce Committee. May 2004.
[62] Medical Payment Advisory Commission. Payment for physician services in the Medicare program. Testimony of Chairman Glen Hackbarth before the Health Subcommittee of the House of Representative's Energy and Commerce Committee. May 2004.
[63] Medical Payment Advisory Commission. Payment for physician services in the Medicare program. Testimony of Chairman Glen Hackbarth before the Health Subcommittee of the House of Representative's Energy and Commerce Committee. May 2004
[64] Congressional Budget Office. Preliminary estimates for frequently requested SGR options updated to reflect the March 2005 baseline. March 2005.
[65] American College of Physicians. The Advanced Medical Home: A Patient-Centered, Physician-Guided Model of Health Care. 2006. Accessed at http://www.acponline.org/hpp/adv_med.pdf on 3 March 2006.
[66] American College of Physicians. The Advanced Medical Home: A Patient-Centered, Physician-Guided Model of Health Care. 2006. Accessed at http://www.acponline.org/hpp/adv_med.pdf on 3 March 2006.
[67] Von Korff J, Gruman J, Schaefer SJ, Curry, Wagner E. Collaborative Management of Chronic Illness. Ann Intern Med 1997;127:1097-1102.