Statement For the Record
of the
Hearing of the
House Energy and Commerce Committee
Subcommittee on Health
On
"Medicare Physician Payment:
How to Build a Payment System that Provides
Quality, Efficient Care for Medicare Beneficiaries."

Testimony of the American College of Physicians

July 27, 2006

Thank you, Chairman Deal and Ranking Member Brown:

I am Lynne Kirk, MD, FACP. I am President of the American College of Physicians, a general internist, and an Associate Dean for Graduate Medical Education at the UT Southwestern Medical Center in Dallas. For the past twenty six years, I have had the privilege to live and work in the great state of Texas, providing health care to thousands of Texans while training the next generation of American physicians.

The College is the largest specialty society in the United States, representing 120,000 internal medicine physicians and medical students. More Medicare patients count on internists for their medical care than any other physician specialty. Consequently, we have an abiding professional commitment to making sure that our Medicare patients get the best care possible, by advocating for Medicare payment policies that meet the needs of our elderly and disabled patients.

Regrettably, they do not.

Instead of encouraging high quality and efficient care *centered on patients' needs*, existing Medicare payment policies have contributed to a *fragmented, high volume, over-specialized and inefficient model of health care delivery that fails to produce consistently good quality* outcomes for patients.

Medicare Payment Policies are Dysfunctional

The College believes that Medicare payment policies are fundamentally dysfunctional because they do not serve the interests of patients enrolled in the program and the taxpayers that support the program:

1. Medicare payment policies discourage internists and other primary and principal care physicians from organizing care processes to achieve optimal results for patients.

Research shows that health care that is *managed and coordinated by a patient's personal physician*, using systems of care centered on patients' needs, can achieve better outcomes for patients and potentially lower costs by reducing complications and avoidable hospitalizations. Such care usually will be managed and coordinated by a primary care physician, which for the Medicare population typically will be an internist who is trained and practices in general medicine or geriatrics or a family physician. In some cases, a qualified internal medicine subspecialist, such as an endocrinologist, may fill this role as a "principal care" physician by accepting responsibility for managing and coordinating

the total spectrum of a patient's health care needs rather than being limited only to providing care that falls within their specialized training.

The Medicare Payment Advisory Commission (MedPAC) has reported that "*potentially avoidable [hospital] admissions are admissions that high quality ambulatory care has been shown to prevent.*" [MedPAC, A Data Source, Healthcare Spending and the Medicare Program, June 2006, emphasis added]. The Commission identified congestive heart failure and diabetes as two conditions where the evidence shows that high quality ambulatory care can reduce avoidable hospital admissions. [See Appendix A].

The Commonwealth Fund has identified ten clinical conditions where "*effective diagnosis, treatment, and patient education* can help control the exacerbation of an illness and prevent or delay complications of chronic illness, thus reducing hospitalizations" [emphasis added]. [See Appendix B]. The Fund also concluded that "reducing preventable hospitalizations could help to preserve Medicare funds for needed services while concurrently improving patient health" and that "*facilitating access to primary care in underserved areas might reduce the higher rates of preventable hospitalizations* among Medicare beneficiaries" [emphasis added]. [Commonwealth Fund's Quality of Health Care for Medicare Beneficiaries: A Chart Book, May 2005].

Unfortunately, Medicare payment policies discourage primary and principal care physicians from organizing their practices to provide effective diagnosis, treatment and education of patients with chronic diseases:

- Medicare pays little or nothing for the work associated with coordination of care outside of a face-to-face office visit. Such work includes ongoing communications between physicians and patients, family caregivers, and other health professionals on following recommended treatment plans;

- Low fees for office visits and other evaluation and management (E/M) services discourage physicians from spending time with patients;

- Except for the one-time new patient Medicare physical examination and selected screening procedures, prevention is under-reimbursed or not covered at all;

- Low practice margins make it impossible for many physicians to invest in health information technology and other practice innovations needed to coordinate care and engage in continuous quality improvement;

- Medicare's Part A and Part B payment "silos" make it impossible for physicians to share in system-wide cost savings from organizing their practices to reduce preventable complications and avoidable hospitalizations.

2. Medicare payment policies are contributing to an imminent collapse of primary care medicine in the United States.

Last November, my esteemed colleague, Dr. Vineet Arora, appeared on the College's behalf before this Subcommittee. As a young internist who recently completed her training and is now practicing general internal medicine, she shared with the Subcommittee the reasons why so few of her colleagues view primary care as a viable career choice.

In my capacity as an educator at the UT Southwestern Medical Center, I've encountered hundreds of young people who, like Dr. Arora, are excited by the unique challenges and opportunities that come from being a patient's primary care physician. But when it comes to choosing a career path, very few see a future in primary care.

My medical students are acutely aware that Medicare and other payers undervalue primary care and overvalue specialty medicine. With a national average student debt of $150,000 by the time they graduate from medical school, medical students feel that they have no choice but to go into more specialized fields of practice that are better remunerated.

The numbers are startling:

- In 2004, only 20 percent of third year IM residents planned to practice general IM, down from 54 percent in 1998, and only 13 percent of first year IM residents planned to go into primary care;
- The percentage of medical school seniors choosing general internal medicine has dropped from 12.2 percent in 1999 to 4.4 percent in 2004;
- A 2004 survey of board certified internists found that after ten years of practice, 21 percent of general internists were no longer working in primary care compared to 5 percent for medical subspecialties working in their subspecialty.

This precipitous decline is occurring at the same time that an aging population with growing incidences of chronic diseases will need more primary care physicians to take care of them. Within 10 years, 150 million Americans will have one or more chronic diseases and the population aged 85 and over will increase 50 percent from 2000 to 2010.

Medicare payment policies are contributing to the impending collapse of primary care because Medicare:

- *Undervalues the time that primary and principal care physicians spend with patients in providing evaluation and management services.* CMS has published a proposed rule that will begin to make significant improvements in payments for office visits and other evaluation and management (E/M) services. The College strongly supports the proposed rule. Even with the proposed increases, however, E/M and other primary care services will continue to be systematically undervalued compared to many procedural services;

- *Overvalues many procedures* at the expense of services provided by primary care physicians. In a "budget neutral" payment system, overvalued procedures—combined with inappropriate volume increases—divert resources from primary care and other services that are undervalued by Medicare;

  The Medicare Payment Advisory Commission has reported that *overvalued procedures create incentives for inappropriate volume growth that disadvantage evaluation and management services* provided by primary care physicians. According to MedPAC, an Urban Institute analysis of changes in the relative values assigned to services during the first 10 years' experience with the physician fee schedule demonstrated that evaluation and management services initially gained from implementation of a resource-based relative value scale in 1992, but those *gains have since been effectively nullified* because of growth in the volume and intensity of other categories of services. In 2002, evaluation and management services accounted for 49.7 percent of spending under the physician fee schedule. In 2003, the evaluation and management share was 49.2 percent, and in 2004 it dropped to 46.5 percent. [Source: Medicare Payment Advisory Commission, Report to Congress, June 2006];

- And, as noted previously, Medicare fails to reimburse primary and principal care physicians for organizing their practices to manage and coordinate care of patients with chronic diseases.

3. The sustainable growth rate (SGR) formula has been wholly ineffective in restraining inappropriate volume growth, has led to unfair and sustained payment cuts, and has been particularly harmful to primary care.

The SGR:

- Does not control volume or create incentives for physicians to manage care more effectively;

- Cuts payments to the most efficient and highest quality physicians by the same amount as those who provide the least efficient and lowest quality care;

- Penalizes physicians for volume increases that result from following evidence-based guidelines;

- Triggers across-the-board payment cuts that have resulted in Medicare payments falling far behind inflation;

- Forces many physicians to limit the number of new Medicare patients that they can accept into their practices;

- Unfairly holds individual physicians responsible for factors—growth in per capita gross domestic product and overall trends in volume and intensity—that are outside of their control;

- Is particularly detrimental to primary care physicians, because they are already paid less than other specialties and have such low practice margins that they cannot absorb additional payment cuts.

The College recognizes and appreciates that with the support of this Subcommittee, Congress enacted legislation earlier this year to reverse the 4.4 percent SGR cut in Medicare payments that took place on January 1, 2006. But because the legislation did not provide for an inflation update in 2006, this is the fifth consecutive year that Medicare payments have declined relative to increases in the average costs physicians incur in providing services to Medicare patients. The temporary measures enacted by Congress over the past four years to reduce without eliminating the SGR cuts were paid for in large part by creating a $50 billion "payment deficit" that will now need to be closed to prevent an additional cut of 4.6 percent in 2007 and cuts of 30 percent or more over the next five years.

Creating a Framework for a Better Payment and Delivery System

It is essential that Congress act this year to avert more SGR cuts, but we urge Congress not to simply enact another temporary fix without replacing the underlying formula. *The so-called sustainable growth rate is simply not sustainable.* We strongly urge this Subcommittee to report legislation that puts Medicare on a pathway to completely eliminate the SGR.

The College also urges the Subcommittee to go beyond just addressing the SGR in a piece-meal manner. *Instead, we call on the Subcommittee to report legislation that will create an entirely new framework for fundamentally reforming a dysfunctional Medicare payment system:*

1. Congress should set a specified timeframe for eliminating the SGR.

The College recognizes that the cost of eliminating the SGR on January 1, 2007 will be very expensive, but the cost of keeping it—as measured by reduced access and quality—is much higher. Instead of enacting another one year temporary reprieve from the cuts without eliminating the SGR, the College believes that it would be preferable to set a "date certain"—say, no more than five years from now—when the formula will be repealed. Such a timetable will allow for a transition period during which Congress and CMS could implement other payment reforms that can improve access and reduce costs, thereby reducing the perceived need for formula-driven volume controls like the SGR.

2. If there is a transition period before the SGR is repealed, Congress should mandate positive updates for all physicians in each year of the transition. The positive updates should reflect increases in the costs of providing services as measured by the Medicare Economic Index (MEI).

The College specifically recommends that any legislation that creates a pathway and timetable for repeal of the SGR should specify in statute the minimum annual percentage updates (floor) during the transition period. Establishing the minimum updates by statute will provide assurance to physicians and patients that payments will be fair and predicable during the transition. The legislation should also direct the Medicare

Payment Advisory Commission to report annually to Congress, during each year of the transition period, on the adequacy and appropriateness of the floor compared to changes in physician practice costs as measured by the MEI as well as indicators of access to care. Congress would then have the discretion to set a higher update than the floor based on the MedPAC recommendations.

3. During such a transition period, Congress would consider a longer term alternative approach for addressing inappropriate volume increases.

The Deficit Reduction Act of 2005 requires that the Medicare Payment Advisory Commission report to Congress in March, 2007 on alternatives to the SGR, which could be the starting point for a discussion of the pros and cons of alternative policies to address inappropriate volume increases.

We caution the Subcommittee not to conclude at this point that an alternative formula to control volume is needed or to decide on a specific formula to replace the SGR.

Changing the underlying payment methodologies to support high quality and efficient care, as discussed in our following recommendations, may eliminate the need to have a back-up mechanism to control volume, because physicians would have clear incentives to organize their practices to improve quality and provide care more efficiently.

Any consideration of alternative formula-based volume controls at this time should be mindful of the unintended consequences when Congress enacted ill-considered volume controls in prior legislation. The SGR was the result of legislation enacted in 1997 that

has led to the adverse but largely unintended consequences that Congress is now struggling to correct. In 1989, Congress enacted Medicare "volume performance standards" that led to different updates for different categories of services, with the result that some services—including evaluation and management services provided by primary care physicians—received lower updates than surgical procedures, adding to the payment inequities that undervalue primary care. Congress then decided to end the policy of applying different targets and updates in 1997, replacing it with the SGR.

This history suggests that any alternatives that would replace one formula (the SGR) with another formula-based target or multiple targets need to be carefully considered. Otherwise, Congress might end up replacing the SGR with another methodology that will create more unintended consequences requiring legislative correction.

The College believes that it is important to get it right this time by carefully considering a full range of payment reforms that can improve quality and create incentives for efficient care before deciding that the SGR should be replaced by another volume target or targets. We suggest that the relatively short period of time left in this Congressional session does not allow for the kind of careful analysis of the potential unintended consequences of alternative volume controls. Instead, we strongly suggest that such decisions be made during that transition period to full repeal of the SGR.

The College does believe that there are some steps that can be taken now to address inappropriate volume increases. We support MedPAC's recommendation to establish

an independent group of experts to review procedures that may be overvalued under the existing Medicare fee schedule. As noted earlier, services that are overvalued are more likely to be over-utilized by physicians. And, as discussed later in this testimony, we support reforms to create incentives for primary and principal physicians to organize their practices to provide consistently better care, at lower cost, to patients with chronic diseases. Substantial cost savings—mainly from reduced hospitalizations—could potentially be achieved through such reforms. We also believe a program to begin linking payments to quality, as outlined later in our testimony, would create incentives for physicians to provide care that meets evidence-based standards of practice, resulting in quality improvements and potential cost efficiencies.

4. Congress should authorize and direct Medicare to institute changes in payment policies to support patient-centered, physician-guided care management based on the advanced (patient-centered) medical home.

The American Academy of Family Physicians and the American College of Physicians have developed proposals for improving care of patients through a patient-centered practice model called the "personal medical home" (AAFP, 2004) or "advanced medical home" (ACP, 2006). Similarly the American Academy of Pediatrics has proposed a medical home for children and adolescents with special needs. AAFP and ACP recently adopted a joint statement of principles that describes the key attributes of a patient-centered medical home:

Personal physician - each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

Physician- directed medical practice – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

Whole person orientation – the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life: acute care; chronic care; preventive services; end of life care.

Care is coordinated and/or integrated across all domains of the health care system (hospitals, home health agencies, nursing homes, consultants and other components of the complex health care system), facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it.

Quality and safety are hallmarks of the medical home:

- Evidence-based medicine and clinical decision-support tools guide decision making;
- Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement;
- Patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met;
- Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication;

- Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient-centered services consistent with the medical home model.

Enhanced access to care through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and office staff.

Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework:

- It should reflect the value of physician and non-physician staff work that falls outside of the face-to-face visit associated with patient-centered care management;
- It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources;
- It should support adoption and use of health information technology for quality improvement;
- It should support provision of enhanced communication access, such as secure e-mail and telephone consultation;
- It should recognize the value of physician work associated with remote monitoring of clinical data using technology;
- It should allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits);
- It should recognize case mix differences in the patient population being treated within the practice;
- It should allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting;

- It should allow for additional payments for achieving measurable and continuous quality improvements.

Such payments could be organized around a "global fee" for care management services that encompass the key attributes of the patient-centered medical home.

The College urges the Subcommittee to report legislation to direct HHS to design, implement and evaluate a nationwide pilot of the patient-centered medical home. Attached to this testimony is draft legislative language that the College has prepared that could be accepted as a starting point for legislation to mandate a nationwide pilot of the patient-centered medical home.

We also advocate incremental changes in the existing Medicare fee schedule to enable physicians to bill for separately-identifiable services relating to care coordination. In its June 2006 report to Congress on "Increasing the Value of Medicare," the MedPAC suggests that Medicare create mechanisms to directly and indirectly improve care coordination and chronic care management including:

- Medicare could increase payments for evaluation and management services or establish new billing codes to enhance payments for chronic care patients associated with face-to-face visits. These higher payments could be applied generally across all E/M codes, or they could be applied to services provided by patients with multiple chronic conditions;

- Other strategies include pay-for-performance initiatives and strategies to accelerate the adoption of information technology.

5. Congress should direct Medicare to provide higher payments to physicians who acquire and use health information technology (HIT) to support quality measurement and improvement and authorize separate payments for e-mail and telephonic consultations that can reduce the need for face-to-face visits.

MedPAC notes that "data management is a major component of care coordination programs. Initiatives to accelerate physician adoption and use of IT may also improve the coordination of care for Medicare beneficiaries. Indeed, pay-for-performance measures could spur physicians to adopt information technology that improves care." [Source: MedPAC, Increasing the Value of Medicare, June 2006].

The College commends the Energy and Commerce Committee for its leadership in reporting legislation to support health information technology. We believe, however, the goal of accelerating the adoption of health information technology to support quality improvement also will require changes in Medicare reimbursement policy.

The College has endorsed the bipartisan National Health Information Incentive Act of 2005, H.R. 747. With 53 co-sponsors, this legislation is one of the most supported health information technology bills being considered by Congress. We commend the members of the Energy and Commerce Committee—Mr. Gonzalez, Ms. Wilson, Mr. Allen, Mr. Boucher, Mr. Green, Ms. Solis , Mr. Towns, and Mr. Wynn—who have co-sponsored this important bill.

Among other incentives for physician adoption of HIT, the legislation would direct Medicare to include an "add on" to office visit payments when such visits are supported by approved health information technology, conditioned on physician participation in designated programs to measure and report quality. The bill targets the "add on" to

physicians in small and rural practices, because the cost of acquiring HIT are insurmountable barriers for many of those practices.

6. Congress should authorize CMS to begin a voluntary pay-for-performance program as soon as January 1, 2007.

The College believes that linking Medicare payments to quality should be part of an overall redesign of payment policies to support models of health care delivery that result in better care of patients.

ACP has been a lead organization in the development, selection and implementation of evidence-based performance measures for physicians through our participation in the American Medical Association's Physician Consortium for Performance Improvement ("the Consortium"), the National Quality Forum (NQF) and the AQA. The College was among the four principals, along with the American Academy of Family Physicians, America's Health Insurance Plans, and the Agency for Healthcare Quality and Research, who founded the AQA in November 2005. The AQA originally stood for the Ambulatory Care Quality Alliance, but is now known just by the acronym "AQA" because it has expanded its mission to include selection of measures for physician services provided in inpatient setting. The AQA now includes over 100 stakeholders—CMS, health plans, providers, AARP, and employers—that are working collaboratively to select uniform, transparent and evidence-based performance measures for implementation across payers and programs. It has endorsed a starter set of measures for ambulatory care, heart disease (American College of Cardiology measures), and thoracic

and cardiac surgery (Society of Thoracic Surgery measures). It is also developing uniform guidelines on data aggregation and reporting of measures and has begun work on selecting cost of care measures for implementation.

The College believes that programs that link payments to quality need to be carefully designed to assure that they achieve the desired outcomes, however:

- They should be based on the best available evidence-based measures as defined by the medical profession and as reviewed and endorsed by appropriate multi-stakeholder groups including the NQF and AQA;
- They should not be punitive toward physicians who are unable to report on the initial measures;
- They should be applied consistently and uniformly across payers;
- They should not impose excessive administrative reporting burdens on practices;
- They should pay physicians on a "weighted" basis based on their individual contributions to achieving quality improvement; and
- They should include safeguards so that sicker and less compliant patients are not harmed.

Specifically, we recommend that any initial pay-for-reporting program should include the following elements:

A. *Physicians who agree to voluntarily participate in a CMS-approved quality measurement and improvement program should be eligible to share in additional performance-based payments.* Such payments would be in addition to the floor on updates specified in legislation during the transition to complete repeal of the SGR, as described earlier.

B. *The voluntary pay-for-reporting program should initially be funded by dedicating a designated amount of Part B funds into a physicians' quality improvement pool, which would be in addition to the floor on annual updates as described earlier.*

C. *Congress should specify that a portion of savings associated with reductions in spending in other parts of Medicare, which are attributable to quality improvement programs funded out of the physicians' quality improvement pool, should be redirected back to the pool. Such savings would include: reductions in Part A expenses due to reductions in avoidable hospital admissions related to improved care in the ambulatory setting and savings in non-physician Part B expenses (such as reductions in avoidable durable medical equipment expenses or laboratory testing resulting from better management in the ambulatory setting that results in fewer complications). MedPAC should be directed to recommend a methodology for measuring and attributing savings in other parts of Medicare that can be attributed to programs funded out of the physicians' quality improvement pool.*

As discussed earlier in this testimony, there is growing evidence that improved care in the ambulatory setting can reduce avoidable hospitalizations and other expenses under the Medicare program. The current pay "silos" make it impossible for physicians to share in such savings. Congress can begin to break down such silos by mandating that a portion of savings that are attributable to physicians' quality improvement efforts would be re-

directed back to the physicians' performance improvement fund, allowing it to grow over time.

D. *The program should begin with those physicians who provide care for conditions where accepted clinical measures have been developed, endorsed, and selected for implementation through a multi-stakeholder process.* As long as all physicians are guaranteed a positive update (floor) by statute and the program is voluntary, Medicare should not wait until measures are developed and accepted for all physicians before the pay-for-reporting program can begin.

E. *Validation and selection for implementation by a multi-stakeholder process will assure that the measures meet criteria related to strength of the evidence, transparency in development, and consistency in implementation and reporting across Medicare and other payers.* The multi-stakeholder process should include endorsement by the National Quality Forum and review and selection by the AQA for implementation.

F. *The pay-for-reporting program should phase in measures based on a process of prioritization that takes into account the potential impact of the measure on improving quality and reducing costs*. The College believes it is more important to start with voluntary reporting on measures that can have the greatest impact on improving care for patients with multiple chronic diseases and reducing avoidable hospitalizations than developing more measures just to bring more specialties and physicians into the program. We also believe that robust evidence-based clinical measures of quality will have a

greater impact than simple and basic cross-cutting measures that would be broadly applicable to all physicians.

Specifically, we recommend that a voluntary Medicare pay-for-reporting program start with the "high impact" measures selected by the AQA, because the AQA starter measures address the disease conditions that are most prevalent in Medicare, are among the most expensive to treat, and sensitive to reductions in avoidable hospitalizations by improving management of care in the ambulatory setting.

- Two thirds of Medicare funds are spent on the 20 percent of beneficiaries with five or more chronic diseases. [Source: Alliance for Health Reform, Covering Health Issues] The AQA measures address the diseases most prevalent in the Medicare population with the greatest potential for quality improvements.

- Colorectal cancer screening (one AQA measure): In 2000, only one half of community-dwelling adults aged 65 and older received colorectal screening in the past ten years. Colorectal cancer is the second most frequent cause of cancer death. [Source: Commonwealth Fund's Quality of Health Care for Medicare Beneficiaries: A Chart Book, May 2005]

- Coronary artery diseases (three AQA measures): Coronary heart disease is the number one cause of death among elderly Americans. Prevention of disease "offers the greatest opportunity for reducing the burden of CHD in the United States." Most elderly adults have reported that they had a cholesterol test in the past, but little more than half said they knew they had high cholesterol, less than one third were using cholesterol-lowering medications, and few had achieved control over high cholesterol. [Source: Commonwealth Fund chart book]

- Diabetes management (six AQA measures): Diabetes is associated with increased functional disability and premature death. Diabetes incidence increases with age. Complications include blindness, kidney failure, and cardiovascular disease. Fourteen percent of elderly white males and almost one quarter of elderly black and Hispanic adults report that they have diabetes. Most elderly Americans report that they are receiving recommended tests to monitor their blood sugars and lipids but one

quarter did not have an eye exam and three out of ten did not have their feet checked for signs of diabetes complications. [Source: Commonwealth Fund chart book]

- Treatment for depression (two AQA measures): An estimated 2 million elderly Americans, or 6 percent of those over age 65, suffer from depressive illness, and another 5 million, or 15 percent, suffer from depressive symptoms. Late-life depression is associated with increased use of health care and an increased risk of medical illness and suicide. Depressed elderly Americans are less likely than younger Americans to perceive that they need mental health care or receive any specialty mental health care. [Source: Commonwealth Fund chart book]

- Immunization of elderly adults (two AQA measures: influenza and pneumonia): Influenza and pneumonia are the fifth leading causes of death among adults age 65 and older. One third to one half of elderly adults were not immunized in 2003. [Source: Commonwealth Fund chart book]

- The AQA measures target conditions where the evidence suggests there could be substantial decreases in potentially preventable hospitalizations when patients receive timely and appropriate ambulatory care by physicians: congestive heart failure (two AQA measures), bacterial pneumonia (one AQA measure), uncontrolled diabetes and diabetes complications (five AQA measures), lower extremity amputation (one AQA measure) and adult asthma (two AQA measures). [Source: AQA; Commonwealth Fund chart book]

- MedPAC reports that "potentially avoidable admissions are admissions that high-quality ambulatory care has been shown to prevent." MedPAC further states that "rates of potentially avoidable hospitalizations are highest for congestive heart failure" and that "notable, given the amount of emphasis that CMS and others have placed on improving diabetes care, is the decrease in potentially avoidable hospitalizations for beneficiaries with diabetes, both for long- and short- term complications."

- From 2002-2004, MedPAC reported that "potentially avoidable hospitalizations due to high quality ambulatory care" declined by 61 percent for COPD/Asthma, 29 percent for diabetes with long-term complications, and 9 percent for diabetes with short-term complications. [Source: MedPAC, A Data Book, Healthcare Spending and the Medicare program, June 2006]

G. *The program should allocate the performance-based payments to individual physicians on a weighted basis related to performance:*

- *Reporting on high impact measures should receive higher performance payments than lower impact measures;*

- *The weighted performance payments should acknowledge that reporting on a larger number of robust quality measures typically will require a greater commitment of time and resources than reporting on one or two basic measures;*

- *The weighted performance payments should take into account the physician time and practice expenses associated with reporting on such measures;*

- *The weighted performance payments should also provide incentives for physicians who improve on their own performance as well as those who meet defined quality thresholds based on the measures;*

- *The weighted performance payments should allow individual physicians to benefit from reductions in spending in other parts of Medicare attributable to their performance improvement efforts.*

An effective policy of linking payments to performance must provide greater rewards for those physicians who make the greatest commitment to reporting on measures that have the greatest potential to improve quality and achieve savings. Otherwise, the financial incentive will be to report on the fewest measures possible, and those who accept the commitment to report on more than the most basic measures would be penalized because they would be taking on more responsibility and expense without receiving additional performance-based compensation.

Particularly for chronic disease conditions, reporting on measures will require a substantial investment of physician time and resources in implementing the technologies needed to coordinate care effectively, in following up with patients on self-management plans, in organizing care by other health care professionals, and in measuring and reporting quality. Other, more basic, measures will not require a comparable investment of time and resources.

Of the measures approved by the AQA to date, internists might have to report on as many as 24 ambulatory measures as well as several cardiology measures for heart disease, and for a particular patient with multiple chronic conditions, they might have to report on a dozen or more measures for that one encounter. Other physicians will have far fewer measures to report on.

Such differences need to be recognized in how performance-based payments are weighted and allocated by Medicare in order to drive physicians to report on the measures that will have the greatest impact on quality and costs and to avoid creating new inequities in payments that disadvantage internists and other physicians that take care of large numbers of Medicare patients with multiple chronic diseases.

H. *The program should include safeguards to protect patients.*

If implemented incorrectly, pay-for-reporting programs could have unintended but adverse consequences on patients. It is particularly important that the program include safeguards to take into account differences in the "case mix" being seen by a particular physician and in patient populations that may be less compliant because of demographics, culture, or economic factors. Otherwise, physicians who are treating a greater proportion of sicker or less compliant patients could be being penalized with lower payments. This in turn could create an unacceptable conflict between a physician's ethical and professional commitment to take care of the sickest patients and the financial incentives created by participating in a pay-for-reporting program to avoid seeing sicker or less compliant patients.

Any program that would include public reporting of physician performance based on quality measures must be carefully designed to assure that the information being presented is accurate, useful to patients including those with low levels of reading and health literacy, and uses an open and transparent methodology. Physicians must have the right to review the reports on their performance in advance of release, request changes to correct inaccuracies or misleading information, appeal requested changes that are not initially accepted, and to include their own comments and explanations in any report that is made available to the public.

Conclusion

The College commends Chairman Deal, Chairman Barton, Mr. Brown, Mr. Dingell and the members of the Subcommittee on Health of the Energy and Commerce Committee for holding this important hearing.

We believe that Congress should embrace the opportunity to report legislation this year that will transition dysfunctional Medicare payment policies to a bold new framework that will improve quality and lower costs by aligning incentives with the needs of patients. This transition should:

- lead to repeal of the SGR by a specified date;
- guarantee positive updates so that all physicians receive predictable and fair payments during any transition period;
- allow time for Congress to review alternative approaches to addressing inappropriate volume increases during such a transition;

- increase reimbursement for care provided by primary and principal care physicians;
- create a better process to identify potentially overvalued services;
- implement a pilot test of the patient-centered advanced medical home and other reimbursement changes to facilitate physician-guided care coordination;
- implement incentive-based payments for health information technology to support quality measurement and improvement;
- initiate a voluntary pay-for-reporting program that begins with "high impact" measures that have been approved by the NQF and AQA and that reimburses physicians on a weighted basis related to the number, impact, and commitment of resources associated with the measures being reported; and
- Allow physicians to share in system-wide savings in other parts of Medicare that can be attributed to their participation in performance measurement and improvement.

I began my testimony by discussing why Medicare's payment policies are dysfunctional because they are not aligned with patients' needs.

Congress has the choice of maintaining a deeply flawed reimbursement system that results in fragmented, high volume, over-specialized and inefficient care that fails to produce consistently good quality outcomes for patients. Or it can embrace the opportunity to put Medicare on a pathway to a payment system that encourages and rewards high quality and efficient care *centered on patients' needs.*

The framework proposed by the College will benefit patients by assuring that they have access to a primary or principal care physician who will accept responsibility for working with them to manage their medical conditions. Patients with chronic diseases will benefit from improved health and fewer complications that often result in avoidable admissions to the hospital. Patients will benefit from receiving care from physicians who are using

advances in health information technology to improve care, who are fully committed to ongoing quality improvement and measurement, and who have organized their practices to achieve the best possible outcomes.

Medicare patients deserve the best possible medical care. They also deserve a physician payment system that will help physicians deliver the best care possible. The College looks forward to working with the Subcommittee on legislation to reform physician payment that will help us achieve a vision of reform that is centered on patient's needs.

Summary

ACP believes that Congress should embrace the opportunity to report legislation this year that will transition dysfunctional Medicare payment policies to a bold new framework that will improve quality and lower costs by aligning incentives with the needs of patients. This transition should:

1) Lead to repeal of the SGR by a specified date;

2) Guarantee positive updates so that all physicians receive predictable and fair payments during any transition period;

3) Allow time for Congress to review alternative approaches to addressing inappropriate volume increases during such a transition;

4) Increase reimbursement for care provided by primary and principal care physicians;

5) Create a better process to identify potentially overvalued services;

6) Implement a pilot test of the patient-centered advanced medical home and other reimbursement changes to facilitate physician-guided care coordination;

7) Implement incentive-based payments for health information technology to support quality measurement and improvement; and

8) Initiate a voluntary pay-for-reporting program that begins with "high impact" measures that have been approved by the NQF and AQA and that reimburses physicians on a weighted basis related to the number, impact, and commitment of resources associated with the measures being reported.

(1) QUALIFIED PATIENT-CENTERED MEDICAL HOME.- The 'qualified patient-centered medical home' (PC-MH) is a physician-directed practice that has voluntarily participated in a qualification process to demonstrate it has the capabilities to achieve improvements in the management and coordination of care of patients with multiple chronic diseases by incorporating attributes of the Chronic Care Model.

(2) CHRONIC CARE MODEL.- The 'chronic care model' is a model that uses health information and other physician practice innovations to improve the management and coordination of care provided to patients with one or more chronic illnesses. Attributes of the model include:

(A) use of health information technology, such as patient registry systems, clinical decision support tools, remote monitoring, and electronic medical record systems to enable the practice to monitor the care provided to patients with chronic disease who have selected the practice as their medical home (eligible patients), to provide care consistent with evidence-based guidelines, to share information with the patient and other health care professionals involved in the patient's care, to track changes in the patient's health status and compliance with recommended treatments and self-management protocols, and to report on evidence-based measures of quality, cost and patient satisfaction measures;

(B) use of e-mail or telephonic consultations to facilitate communication between the practice and the patient on non-urgent health matters;

(C) designation of a personal physician within the practice who has the required expertise and accepts principal responsibility for managing and coordinating the care of the eligible patient;

(D) arrangements with teams of other health professionals, both internal and external to the practice, to facilitate access to the full spectrum of services that the eligible patient requires;

(E) development of a disease self-management plan in partnership with the eligible patient and other health care professionals, such as nurse-educators;

(F) open access, group visits or other scheduling systems to facilitate patient access to the practice;

(G) other process system and technology innovations that are shown to improve care coordination for eligible patients.

(3) CHRONIC CARE REIMBURSEMENT MODEL.- The chronic care reimbursement model is one or more methodologies to reimburse physicians in qualified PC-MH practices based on the value of the services provided by such practices. Such methodologies will be developed in consultation with national organizations representing physicians in primary care practices, health economists, and other experts. Such methodologies shall include, at a minimum—

(A) recognition of the value of physician and clinical staff work associated with patient care that falls outside the face-to-face visit, such as the time and effort spent on educating family caregivers and arranging appropriate follow-up services with other health care professionals, such as nurse educators;

(B) recognition of expenses that the PC-MH practices will incur to acquire and utilize health information technology, such as clinical decision support tools, patient registries and/or electronic medical records;

(C) additional performance-based reimbursement payments based on reporting on evidence-based quality, cost of care, and patient experience measures;

(D) reimbursement for separately identifiable email and telephonic consultations, either as separately-billable services or as part of a global management fee;

(E) recognition of the specific circumstances and expenses associated with physician practices of fewer that five (5) full-time employees (FTEs) in implementing the attributes of the chronic care model and the qualified AMH;

(F) recognition and sharing of savings under part A and C of the medicare program that may result from the qualified PC-MH;

(4) REIMBURSEMENT.- Reimbursement for services in the qualified PC-MH practice may be made through one or more methodologies that are in addition to or in lieu of traditional fee-for-service payments for the services rendered. In developing the recommended chronic care

management reimbursement model, the Secretary shall consider the following options or a combination of such options:

(A) care management fees to the personal physician that covers the physician work that falls outside the face-to-face visit;

(B) payment for separately identifiable evaluation and management services;

(C) episode of illness payments; and

(D) per patient per month payments that are adjusted for patient health status.

(5) PERSONAL PHYSICIAN.- A "personal physician' is defined as a physician who practices in a qualified PC-MH and whom the practice has determined has the training to provide first contact, continuous and comprehensive care.

(6) ELIGIBLE BENEFICIARIES.- The term `eligible beneficiaries' are beneficiaries enrolled under part B of the Medicare program whom the Secretary has identified as having one or more chronic health conditions. Eligible beneficiaries will be invited to select a primary care or principal care physician in a qualified PC-MH as their personal physician. The Secretary may offer incentives for eligible beneficiaries to select a physician in a qualified PC-MH, such as a reduced co-payment or other appropriate benefit enhancements as determined by the Secretary.

(7) PATIENT-CENTERED MEDICAL HOME QUALIFICATION.- The PC-MH qualification is a process whereby an interested practice will voluntarily submit information to an objective external private-sector entity. Such entity shall be deemed by the Secretary to make the determination as to whether the practice has the attributes of a qualified PC-MH based on standards the Secretary shall establish.

(8) DEMONSTRATION PROJECT.- The term 'demonstration project' means a demonstration project established under subsection (b)(1).

(9) MEDICARE PROGRAM.- The term `medicare program' means the health benefits program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(b) DEMONSTRATION OF QUALIFIED PATIENT-CENTERED MEDICAL HOME MODEL.—

(1) ESTABLISHMENT.- The Secretary shall establish a demonstration project in accordance with the provisions of this section for the purpose of evaluating the feasibility, cost effectiveness, and impact on patient care of covering the advanced medical home model under the medicare program.

(2) CONSULTATION.- In establishing the demonstration project, the Secretary shall consult with primary care physicians and organizations representing primary care physicians.

(3) PARTICIPATION.- Qualified practices shall participate in the demonstration project on a voluntary basis.

(4) NUMBER AND TYPES OF PRACTICES.- The Secretary shall establish a process to invite a variety and sufficient number of practices nationwide to participate in the demonstration project. Participation must be sufficient to assess the impact of the qualified PC-MH in rural and urban communities, under-served areas, large and small states, and be designed to facilitate and include the participation of physician practices of fewer than five (5) FTEs.

(c) CONDUCT OF DEMONSTRATION PROJECT.—

(1) DEMONSTRATION SITES.- The Secretary shall conduct the demonstration with any qualified PC-MH and eligible beneficiary.

(2) IMPLEMENTATION; DURATION.

(A) IMPLEMENTATION.- The Secretary shall implement the demonstration project under this section no later than June 30, 2007.

(B) DURATION.- The Secretary shall complete the demonstration project by the date that is 3 years after the date on which the demonstration project is implemented.

(d) EVALUATION AND REPORT.—

(1) EVALUATION.- The Secretary shall conduct an evaluation of the demonstration project-

(A) to determine the cost of providing reimbursement for the medical home model concept under the medicare program, and to determine cost offsets;

(B) to determine quality improvement measures such as adherence to evidence-based guidelines and rehospitalization rates;

(C) to determine the satisfaction of eligible beneficiaries participating in the demonstration project and the quality of care received by such beneficiaries; and to determine the satisfaction of participating primary care physicians and their staff;

(D) to evaluate such other matters as the Secretary determines is appropriate.

(2) REPORT.- Not later than the date that is 1 year after the date on which the demonstration project concludes, the Secretary shall submit to Congress a report on the evaluation conducted under paragraph (1) together with such recommendations for legislation or administrative action as the Secretary determines is appropriate.

(e) AMOUNT OF REIMBURSEMENT.- The amount of reimbursement to a qualified PC-MH participating in the demonstration project shall be in a manner determined by the Secretary that takes into account the costs of implementation, additional time by participating physicians, and training associated with implementing this section;

(f) EXEMPTION FROM BUDGET NEUTRALITY UNDER THE PHYSICIAN FEE SCHEDULE.- Any increased expenditures pursuant to this section shall be treated as additional allowed expenditures for purposes of computing any update under section 1848(d).

(g) FINANCIAL RISK.- Practices participating in the demonstration project shall not be required to accept financial risk as a condition of participating in the demonstration project established under this section.