



May 23, 2012

The Honorable David Camp, Chairman
U.S. House of Representatives
Committee on Ways and Means
1102 Longworth House Office Building
Washington, DC 20515

Re: April 27, 2012 Request to Dr. David L. Bronson, MD, FACP, President, American College of Physicians

Dear Mr. Camp and Members of the Committee on Ways and Means:

The American College of Physicians (ACP) appreciates the opportunity respond to the April 27, 2012 request by the U.S. House of Representatives' Committee on Ways and Means. ACP represents more than 132,000 internal medicine physicians and medical student members. Internists specialize in primary and comprehensive care of adolescents and adults.

Approaches to Address the Sustainable Growth Rate (SGR)

ACP agrees with the Ways and Means Committee that the SGR is creating uncertainty in the Medicare program for both physicians and beneficiaries. A permanent solution to this problem is needed—and it should include a transformation of the Medicare physician payment system from one that incentivizes volume to one that preserves and promotes the patient-physician relationship and rewards high-quality and efficient care. Therefore, ACP has enthusiastically endorsed the bipartisan bill, titled “Medicare Physician Payment Innovation Act of 2012, H.R. 5707.” The Medicare Physician Payment Innovation Act will achieve five essential policy objectives:

- 1. Repeals the SGR, fully paid for by using money that has been set aside for military operations that the administration says are not needed and will never be spent.** To our knowledge, this is the first and only bipartisan bill to repeal the SGR in a fiscally responsible way.
- 2. Protects access to care for seniors, disabled persons, and military families, by eliminating all scheduled SGR cuts, including a nearly 30 percent cut on January 1, 2013.** Patients need the certainty of knowing that the government will not impose cuts that could force many doctors out of the Medicare and TriCare programs. (TriCare updates are set by the Medicare SGR formula, so military families are at the same risk of losing access to doctors as persons enrolled in Medicare because of the scheduled cuts.)
- 3. Stabilizes payments through 2018, with no cuts for the next six years and positive updates to all physicians during 2014-2017.** The Medicare Physician Payment Innovation Act would continue current Medicare rates through 2013; provide modest positive updates of 0.5 percent to all physicians in calendar years 2014-2017, and then extend the 2017 rates through December 31, 2018. This

sustained period of stability is needed to ensure access to care, while allowing time for Medicare to work with physicians to test, disseminate, and prepare for adoption of new patient-centered payment and delivery models.

4. **Provides a higher update for undervalued primary, preventive and coordinated care services, whether provided by primary care physicians or by other specialists.** The bill provides a 2.5 percent annual update in calendar years 2014-2017 for designated primary care, coordinated care, and preventive service codes when provided by physicians for whom 60 percent of Medicare allowable charges come from these designated codes. Such incentives are critical to improving care coordination and addressing historical payment inequities that contribute to severe shortages in internal medicine, family medicine, internal medicine subspecialties, neurology and other fields.
5. **Accelerates development, evaluation, and transition to new payment and delivery models, developed with input by the medical profession and with external validation.** ACP and other physician organizations have been directly involved in advancing new models of payment and delivery that are centered on patients' needs, including working with CMS, private payers, business, and consumer groups to broadly test the Patient-Centered Medical Home (PCMH) model, which already is showing success in improving outcomes and reducing costs. The six-and-a-half years established by the bill for CMS to develop, evaluate, and then adopt at least five new models, including an alternative fee-for-service option for physicians who participate in designated quality improvement programs, will help ensure sufficient time for CMS and Congress to "get it right" in determining the best models for patients and for physicians to transition to by 2019. Physicians who participate in the new models will likely have opportunities to share in savings and/or be paid more appropriately for work involved in care coordination and achieving good patient outcomes. Although ACP generally believes that penalties for non-adoption are not advisable, given the daunting challenge of getting all physicians to transition to one of the new models, we know that the goal of this bill is for all physicians to have an opportunity to participate in a successful model that best meets their own practice circumstances, thereby avoiding any penalties. It will be important for Congress to hold CMS accountable for ensuring that a viable model is available for all physicians in all specialties, so that physicians are not subject to penalties because the agency was unable to develop an appropriate and workable model for them.

Rewarding Quality and Efficiency through Alternative Delivery and Payment Models

Patient-Centered Medical Home (PCMH)

As noted above, ACP and other physician organizations have been directly involved in advancing new models of payment and delivery that are centered on patients' needs, improving outcomes, and reducing costs. This has included working with CMS, private payers, businesses, and consumer groups to broadly test and rollout the PCMH model.

PCMH in the Public Sector

In its first year the CMS Innovation Center (CMMI), established by the Affordable Care Act (ACA), has introduced 16 initiatives, involving over 50,000 health care clinicians. CMMI's initial efforts have focused on improving patient safety, promoting care coordination, investing in primary care transformation, creating bundled payment models, and addressing the needs of dual eligibles. One critical program of the CMMI is the Comprehensive Primary Care Initiative (CPCi), which is collaboration between private and public payers and primary care practices to support patient centered primary care. The CPCi is modeled on the PCMH and PCMH-Neighborhood concepts, championed by ACP and other national membership organizations representing physicians and other clinicians and supported by thousands of business, consumer, and payer groups represented in the Patient-Centered Primary Care Collaborative (PCPCC). In this initiative, primary

care practices will receive new, public and private funding for primary care functions not included in the fee-for-service payments and will have the opportunity to share net savings generated through the program. Private payers and Medicaid are joining with Medicare to support comprehensive primary care, provided that selected practices demonstrate capabilities aligned with the PCMH model. If successful, CMS has the authority to expand the program throughout Medicare, potentially leading to a sustainable new payment and delivery model for primary care.

Applications for payers were due January 17, 2012 and on April 11 CMS announced the first seven market areas. These include:

- Arkansas: Statewide
- Colorado: Statewide
- New Jersey: Statewide
- New York: Capital District-Hudson Valley Region
- Ohio: Cincinnati-Dayton Region
- Oklahoma: Greater Tulsa Region
- Oregon: Statewide

ACP has reached out to all of our Chapters in these states and regions to help spread the word about the importance of this initiative and encourage our members to apply.

The four-year initial phase of the CPCi would match up with the timeline established by HR. 5707, allowing for CMS, Congress, and the Government Accountability Office (GAO) to assess the results of the models and, if the CPCi is successful in improving outcomes and achieving savings, to more broadly disseminate and implement the PCMH as one of the options that physicians could transition to beginning in 2018. As discussed below, experience in the private sector suggests that the PCMH has a very high potential to improve quality and lower costs.

The College has also assisted in practice recruitment in the Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration—a project that preceded CPCi release, but is similar in concept regarding the facilitating of PCMH implementation. This state-based initiative required participation by multiple payers in order to obtain Medicare participation—including Medicaid and a substantial majority of the private health plans offering coverage in both the group and individual health insurance market in the area. The following states were selected for the MAPCP Demonstration: Maine, Vermont, New York, Rhode Island, Pennsylvania, North Carolina, Michigan, and Minnesota.

PCMH in the Private Sector

There has also been a significant amount of private sector payer activity in area of the PCMH, including test projects or roll-outs of the model in nearly all 50 states. For example:

- In Michigan, Blue Cross Blue Shield of Michigan's (BCBSM) Physician Group Incentive Program (PGIP) was established in 2004 as a collaborative partnership between BCBSM and physician organizations across the state, with the goal of optimizing patient care and transforming the state's health care delivery system. Then, in 2007, in the wake of the growing interest in the PCMH model, and in response to PGIP clinician requests for more direction and structure, BCBSM collaborated with clinicians to develop a set of 12 PCMH Initiatives.¹

¹ Share, David. From Partisanship to Partnership: The Payor-Provider Partnership Path to Practice Transformation. Testimony before the House Ways and Means Committee, Health Subcommittee. February 2012. Available at: http://waysandmeans.house.gov/UploadedFiles/Share_Testimony_FinalHE27.pdf.

- In Genesee County, Michigan, the Genesee Health Plan, in collaboration with local physicians and hospitals, formed Genesys HealthWorks and has implemented a model built on a strong, redesigned primary care infrastructure and has demonstrated significant cost savings.²
- In the Hudson Valley area of New York, the THINC P4P-Medical Home project brings together multiple health plans that service the Hudson Valley region. Using standardized measures agreed upon by clinicians and payers, the project is providing performance incentives from multiple payers to the participating clinicians.³
- Colorado is the site of a multi-payer, multi-state PCMH pilot that includes multiple participants at both the local and national levels. The PCMH model is being tested in 16 family medicine and internal medicine practices selected from across the Colorado Front Range, as well as practices in Cincinnati, Ohio. The pilot is being evaluated by the Harvard School of Public Health to determine the effect on quality, cost trends, and satisfaction for patients and their health care team.⁴ ACP has been actively involved in this pilot, including serving on the steering committee.

In addition to these pilot programs, a number of large insurers have announced their intent to roll the PCMH model out more widely. For instance, in January 2012, Wellpoint, a private insurer covering 34 million Americans with a network of 100,000 primary care doctors, publicly announced its decision to invest in the medical home model across its entire network. Aetna, another large private health plan insuring more than 18 million Americans with a network of 55,000 primary care doctors, also recently announced a PCMH program roll-out in Connecticut and New Jersey, with expectations to expand the program nationally in 2012. And, building on a large medical home pilot project already underway, UnitedHealthcare, insuring 34 million Americans, announced in February 2012 an expansion of its value-based payment model, affecting between 50% and 70% of its customers. Numerous Blue Cross Blue Shield (BCBS) plans across the U.S. have been leaders in their respective marketplace, with over 4 million BCBS members in 39 states currently participating in some version of a PCMH initiative.

These private insurers have made the decision to roll the PCMH model out based on their experience to date with pilot programs, as well as the substantial evidence that health systems with a strong primary care foundation deliver higher-quality, lower-cost care overall and greater equity in health outcomes.⁵ Taking this a step further, research also shows that patient-centered primary care is best delivered in a medical home.⁶ However, it is important to note that peer-reviewed academic studies evaluating the medical home model in its full implementation are still limited.^{7,8,9} But, there is much to be learned from the numerous PCMH evaluations that have considered individual components of the PCMH model in specific settings, including a recent Institute of Medicine report that evaluated methods of care for those who are chronically ill.¹⁰

² Genesys HealthWorks Health Navigator in the Patient-Centered Medical Home. Available at:

<http://www.pcpcc.net/content/genesys-healthworks-health-navigator-patient-centered-medical-home>.

³ Hudson Valley P4P-Medical Home Project. Available at: <http://www.pcpcc.net/content/hudson-valley-p4p-medical-home-project>.

⁴ The Colorado Multi-Payer, Multi-State Patient-Centered Medical Home Project. Available at:

<http://www.pcpcc.net/content/colorado-multi-payer-multi-state-patient-centered-medical-home-pilot>.

⁵ Johns Hopkins Bloomberg School of Public Health. Publications of the bureau of primary health care and primary care policy center. (2012). Available at: <http://www.jhsph.edu/pcpc/publications.html>.

⁶ Commonwealth Fund (2012, March 12). Patient-Centered Coordinated Care. Program Description.

http://www.commonwealthfund.org/~media/Files/Programs/2012/Program%20PDFs/2011_PatientCentered_Coord_Care_with_capti_on.pdf.

⁷ Peikes, D., Genevro, J., Scholle, S. H., Torda, P. (2011, Feb). The patient-centered medical home: Strategies to put patients at the center of primary care. Agency for Healthcare Research and Quality. AHRQ No. 11-0029. Rockville, MD. Retrieved from http://www.pcmh.ahrq.gov/portal/server.pt/community/pcmh_home/1483/pcmh_tools_resources_patient-centered_v2.

⁸ Jaén C. R., Ferrer R. L., Miller W. L., Palmer R. F., Wood R, Davila M, et al. (2010, May 1). Patient outcomes at 26 months in the patient-centered medical home national demonstration project. *Ann Fam Med*, 8(1 Suppl):S57–S67; S92.

⁹ Reid, R. J., Coleman, K., Johnson, E. A., Fishman, P. A., Hsu, C., Soman, M. P., Trescott, C. E., et al. (2010, Mar) The group health medical home at year two: cost savings, higher patient satisfaction, and less burnout for providers. *Health Affairs*, 29(5):835–43.

¹⁰ Institute of Medicine. (2012). *Living well with chronic illness: A public health call to action*. Washington, DC: National Academy Press.

PCMH Roadmaps, Recognition, and Accreditation

The advancement of the PCMH model has also been facilitated through several recognition and accreditation programs. These programs help provide roadmaps for practices that are interested in providing care that is high quality, efficient, and patient-centered—or, in other words, aligned with the PCMH model. Some examples of these programs include:

- The National Committee for Quality Assurance’s (NCQA) Patient-Centered Medical Home Recognition Program (2011)¹¹
- URAC’s Patient-Centered Health Care Home’s Accreditation Program¹²
- The Joint Commission’s Primary Care Medical Home Option¹³

ACP has taken an active role in providing advice in the development of these programs and helping practices to pursue PCMH recognition and accreditation, as well as to engage in general practice improvement, though the development of our Medical Home Builder (MHB).¹⁴ MHB is an online tool that provides a high value/low cost means of providing a self-assessment to primary care practices of all sizes. MHB includes multiple components that can assist practices pursuing workflow improvement, including PCMH recognition. The MHB’s rigorous self-assessment tool is called the Practice Biopsy. Each member of the practice team can complete all or some of the biopsies. Designated staff will be able to see the results of the work and identify areas for possible improvement. In addition, MHB provides a:

- “Virtual bookshelf” of useful resources that can be filtered to help a physician quickly find what they need
- Nationwide community of users that can provide support to each other throughout their practice improvement journey

The MHB is being used by several major payers in their PCMH programs, including the Veterans Health Administration and Carefirst BCBS.

Challenges to the PCMH Model

In addition to the need for further research on the impact of the PCMH model that was noted above, there are a number of other challenges to its successful implementation. Some of these include:

- The need for care coordination across settings and the continuum of patient care. ACP has taken a leadership role in helping to address this challenge through our work on the development of the PCMH-Neighborhood model, which is discussed below.
- Related to the issue of care coordination is the lack of real- or near-time data being provided to practices on their patients, which makes it extremely challenging for them to provide proactive, patient-centered care. This is exacerbated by the lack of effective data and information sharing across sites of care. ACP has been deeply involved in the national policy issues surrounding the use of health information technology to facilitate effective clinical data sharing—including the EHR Incentive Program as initiated with the HITECH act. In our most recent comments on the notice of proposed rulemaking from both CMS¹⁵ and ONC¹⁶ on Stage 2 Meaningful Use, we highlighted our support of the government’s vision to use EHRs and health IT to improve care, but believe that more

¹¹ More information available at: <http://www.ncqa.org/tabid/631/Default.aspx>.

¹² More information available at: https://www.urac.org/healthcare/prog_accred_pchch_toolkit.aspx.

¹³ More information available at: <http://www.jointcommission.org/accreditation/pchi.aspx>.

¹⁴ More information on this tool is available at: http://www.acponline.org/running_practice/pcmh/help.htm.

¹⁵ These comments can be found at:

http://www.acponline.org/advocacy/where_we_stand/health_information_technology/cms_nprm.pdf.

¹⁶ These comments can be found at:

http://www.acponline.org/advocacy/where_we_stand/health_information_technology/onc_nprm.pdf.

needs to be done to align the measures across all of the initiatives currently underway including CMS PQRS and e-prescribing programs. While CMS has made strides in aligning the measures, at a high level the technical requirements in each of the programs are different enough that dual processes must be undertaken. We are also concerned about the approach that CMS has taken when structuring the penalty phases of the EHR Incentive Programs, e-Prescribing Incentive Program, and Physician Quality Reporting System (PQRS) by requiring that the activity to avoid the penalty must be completed in the prior year or even two years in advance of the legislated deadline. As a result, CMS has effectively moved up the legislated deadline beyond what the market can bear. More about ACP's effort to facilitate the adoption of health IT will be addressed below.

- Practices that are trying to transform and that are actively engaging in or pursuing PCMH recognition/accreditation, meaningful use for their electronic health records, e-prescribing, etc. also struggle when they do not receive timely payments from their payers for these activities.
- Finally, in many cases practices are transforming to provide services to their patients in line with the PCMH model, but are only paid to do so for a subset of their patient population (e.g., Wellpoint and Aetna are paying them a per member per month payment for their beneficiaries, but they are not receiving payment from CMS for their Medicare patients). This issue is being addressed in some areas of the country, particularly those that were selected to participate in the CPCi, discussed above, but many other practices across the country are not being “made whole” in terms of payment for the work they are doing.

Patient-Centered Medical Home – Neighborhood

The importance of involvement of the “medical neighborhood” to the ultimate success of the PCMH model to fully achieve its quality and efficiency goals has been highlighted by recent policy papers by ACP¹⁷ and the Agency for Healthcare Quality and Research (AHRQ).¹⁸ Specialty and subspecialty practices, hospitals, and other healthcare professionals and entities that provide treatment to the patient need to be recognized and provided with incentives—both non-financial and financial—for engaging in patient-centered practices that complement and support the efforts of the PCMH to provide high quality, efficient, coordinated care. The above cited College policy paper outlines a model using care coordination agreements to promote a functioning PCMH-Neighborhood.

The NCQA, acknowledging the importance of the involvement of the “medical neighborhood” in support of PCMH (primary) care, is in the process of developing a “medical neighbor” recognition process that identifies those practices that engage in activities supportive of the PCMH model—with particular emphasis on care coordination and integration. This decision was made following the conclusion of a comprehensive feasibility study in which this concept was strongly supported by multiple healthcare stakeholders—including physician groups, employers, health plans, state and federal payers, and patient advocates.

Efforts to promote processes to coordinate care between primary care practices and the other physicians and healthcare professionals providing treatment to the patient have been an integral part of both private and public integrated care systems (e.g. Kaiser, Department of Veterans Affairs) and are an important component of the developing Accountable Care Organization (ACO) models. This new NCQA program, and similar efforts, can serve to encourage specialty/subspecialty practices and other “neighborhood” healthcare entities currently not involved within an integrated system—settings in which most care is currently being delivered—to implement these important processes. This is already happening in several areas of the country. For example:

¹⁷ American College of Physicians. The patient centered medical home neighbor: The interface of the patient centered medical home with specialty/subspecialty practice. 2010. Accessed at http://www.acponline.org/advocacy/where_we_stand/policy/.

¹⁸ Agency for Healthcare Research and Quality (AHRQ). Coordinating care in the medical neighborhood: Critical components and available mechanisms. 2011. Available at http://pcmh.ahrq.gov/portal/server.pt/community/pcmh_home/1483/what_is_pcmh.

- The Vermont Blueprint for Health program is implementing a program in which medical home and related, anchored subspecialty practices engaging in efficient, integrative processes will be sharing a monthly care coordination fee for the treatment of COPD, CHF, diabetes, and asthma.
- The Texas Medical Home Initiative will require participating primary care practices to establish care coordination agreements with their most frequently referred to specialist and hospital settings.

Accountable Care Organizations (ACOs)

Primary care and particularly PCMH recognized practices are acknowledged as the foundation for the rapidly developing implementation of ACOs across the country. These efforts, led by physicians and other healthcare professionals, are directly accountable for the quality and efficiency of care delivered—their payment is substantially aligned with the delivery of such care. As you are aware, CMS has recently approved 32 “Pioneer” ACOs and 27 ACOs to participate within the Medicare Shared Savings Program (MSSP). ACP is particularly supportive of the Advanced Payment Model initiated by the CMMI that provides financial support for small and rural practices to apply for participation within the MSSP. Berenson and Burton¹⁹ in November 2011 reported the growth of the ACO model within in private sector, with at least eight private health plans entering into private contracts with physicians and other healthcare professionals using a shared risk payment model, and over 27 plans offering contracts with only an upside-only feature. A more recent environment scan has estimated over 160 commercial ACO or ACO-like organizations are currently on-going or in some stage of development.²⁰ One example of these private sector programs is the Alternative Quality Contract offered through BCBS of Massachusetts, which has shown both improved quality and a downward bending of the cost growth curve after only one year of implementation.²¹ The growth of the ACO model has led NCQA (released) and URAC (in process) to develop an ACO recognition process that helps ensure that these organizations engage in processes that promote patient centered, high quality, efficient integrative care.

Other Potential Payment Models

While the models discussed above are extremely promising, it is important to note that comprehensive reforms to the payment system must provide flexibility and multiple options with various levels of risk and integration to ensure maximum participation and successful implementation of new payment models in diverse practice settings and geographic regions. Therefore, ACP is also supportive of testing a number of models, including the following.

“Prometheus” Evidence-informed Case Rate (ECR) Model

This payment model, developed by the non-profit PROMETHEUS Payment Inc. establishes case rates for the treatment of specific conditions based on the cost of all services, pharmaceuticals, tests, equipment, etc. needed to treat the condition following agreed upon evidence-based clinical practice guidelines. The case rate is triggered by a diagnosis and, for chronic conditions, takes the form of a yearly rate. The amount of the payment to the practice also depends upon its performance on a quality scorecard and the efficiency of care provided by the other physicians and healthcare professions throughout the system providing care to the patient for the defined condition. Pilot demonstrations are being implemented in Rockford, Illinois and Minneapolis, Minnesota with a third site in Utah.²² PROMETHEUS Payment Inc. has also outlined how this

¹⁹ Berenson R., Burton R. Accountable Care Organizations in Medicare and the Private Sector: A Status Update. Robert Wood Johnson Foundation and Urban Institute, November, 2011. Accessed at <http://www.rwjf.org/pr/product.jsp?id=73470>.

²⁰ Tocknell M. ACO blueprints: Options in accountability. HealthLeaders. May 14, 2012. Accessed at <http://www.healthleadersmedia.com/content/MAG-279707/ACO-Blueprints-Options-in-Accountability>.

²¹ Song B, Safran D, et. al. Health Care Spending and Quality in Year 1 of the Alternative Quality Contract. N Engl J Med 2011; 365:909-918 September 2011. Accessed at <http://www.nejm.org/doi/full/10.1056/NEJMsa1101416#t=articleTop>.

²² Prometheus Newsletter 2. Accessed at <http://www.prometheuspayers.org/news-events/newsletters/2009/PPInewsletter09issue2.pdf>.

model can be used for the payment of primary care services, including the provision of funds to transform primary care practices into medical homes.²³

Comprehensive Global Payment Model²⁴

This model proposes a comprehensive payment structure consisting of a global payment for primary care (coordinated, comprehensive, continuous, personalized care) to replace visit-based compensation paid to the practice. The global fee is linked to the number of patients in the practice and covers the cost of all necessary staff and technology to the practice, as well as a respectable income for the physicians. The global payment would cover:

1. All care and coordination provided by the primary clinician
2. All services rendered by other professional and administrative staff on the treatment team (e.g. follow-up nurses, social workers, nutritionists)
3. Essential practice infrastructure and systems – particularly an interoperable EHR with clinical decision support

This global payment model maintains population risk with the payer, while practices accept technical risk for providing the required ambulatory care in a manner that minimizes waste and inefficiency and facilitates adherence to professional standards of care and referral. The model also includes a meaningful component of payment (15-25 percent) that is outcome-based and linked to validated measures of patient satisfaction clinical performance, and efficiency.

Eligibility for this payment would be limited to those practices that demonstrated having the infrastructure and general capability to deliver the requisite services, as assessed by an organization such as NCQA. The care provided would be documented by an annual random sample of practices. The documentation typically required for each visit would be significantly reduced and payment would be heavily risk- and needs-adjusted to match each patient's burden of care. This payment model is currently being piloted within the Capital District Health Plan in Albany, New York. Initial data reflects decreased costs and improved care quality compared to a cohort control.²⁵

Bundled Payments

The Congressional Budget Office recently released a review of “lessons learned” as a result of Medicare disease management, care coordination and value-based purchasing demonstrations.²⁶ The Medicare Participating Heart Bypass Center Demonstration provided bundled payments to cover all inpatient hospital and physicians' services for coronary artery bypass graft surgeries conducted at seven participating hospitals. It was the only value- based payment demonstration that yielded significant savings for the Medicare program. Bundled payments reduced Medicare's expenditures for heart bypass surgeries by about 10 percent, and there were no apparent adverse effects on patients' outcomes. Medicare has a long history of using bundling of services to stabilize expenditures without decreasing quality—these efforts include the establishment of diagnosis-related groupings (DRGs) for acute inpatient hospital care and the bundling of

²³ Prometheus Payment Incorporated. Sustaining the Medical Home: How Prometheus Payment Can Revitalize Primary Care. 2009. Accessed at <http://www.prometheuspayment.org/publications/pdf/STMH%20Full%20with%20Apps.pdf>.

²⁴ Goroll AH, Berenson RB, Schoenbaum SC, Gardner LA. Fundamental reform of payment for adult primary care: comprehensive payment for comprehensive care. *J Gen Intern Med.* 2007;22:410-415. Summary available at http://www.commonwealthfund.org/~media/Files/Publications/In%20the%20Literature/2007/Mar/Fundamental%20Reform%20of%20Payment%20for%20Adult%20Primary%20Care%20%20Comprehensive%20Payment%20for%20Comprehensive%20Care/Goroll_fundamentalreformpaymentadultprimarycare_1014_id%20pdf.pdf.

²⁵ Feder J. A health plan spurs transformation of primary care practices into better-paid medical homes. *Health Affairs* 2011 30 (3): 397-399.

²⁶ Congressional Budget Office. Lessons from Medicare's Demonstration Projects on Disease Management, Care Coordination, and Value-Based Payment. January 2012. Accessed at <http://www.cbo.gov/sites/default/files/cbofiles/attachments/01-18-12-MedicareDemoBrief.pdf>.

physician fees and services within the Medicare End Stage Renal Disease (ESRD) program. The CMMI in August of 2011 released the Medicare “Bundled Payments for Care Improvement Initiative.” This initiative tests four models of bundling payment for services that patients receive across a single episode of care, such as heart bypass surgery or a hip replacement. All models include an inpatient acute care phase and these CMMI-tested models can be rapidly implemented and expanded throughout the Medicare system if deemed successful through the expanded authority granted to the Secretary through the Affordable Care Act.

Comparison of Alternative Payment Models

The PCPCC, with the assistance of the College and other stakeholders, has developed a document that outlines a number of alternative payment reform models to support high performing practices and discusses their “pros and cons”. The document specifically compares the following models mentioned above—hybrid PCMH payment model, the ACO model, the Prometheus model, and the comprehensive global payment model.²⁷

Shorter-Term Payment Approaches

All of the above payment and delivery models are truly comprehensive in their approach, and while that is where ACP would like to see our health care system evolve, it is important to note some shorter-term approaches that may be helpful to clinicians who are not yet able to transition to the more comprehensive models.

The Medicare Physician Payment Innovation Act, discussed earlier, offers physicians with a demonstrated commitment to quality and efficiency, who are not able to participate in a more comprehensive models, the ability to participate in a new alternative fee-for-service system that would include incentives for care coordination, management of high-risk patients, and other policy objectives to improve the quality and reduce costs. Qualifying physicians must fall into one of the following categories:

- a) Clinicians who adhere to a comprehensive list of cost, quality, and outcome measures, developed in conjunction with medical societies. Such measures include meaningful use standards, participation in the PQRS, and successful participation in an approved Maintenance of Certification (MOC) program, which may include quality registries; or
- b) Exceptional clinicians as demonstrated by achievements in the areas of cost, quality, and outcomes as assessed by the Value-Based Modifier relative to their peers. This group includes those in the top quartile within their geographic fee schedule area. These clinicians would also be required to meet meaningful use standards for electronic medical records.

Option (b) above mentions the Physician Feedback/Value-Based Modifier Program that is still under development within CMS. While it is hoped that this program will “transform Medicare from a passive payer to an active purchaser of higher quality, more efficient healthcare”,²⁸ there are a significant amount of unanswered questions about how this program should best be implemented. These include, but are not limited to:

- Are the Physician Quality and Resource Use Reports (QRURs), which are intended to be the basis of the modifier, able to be reasonably interpreted by physicians?
- Could a physician determine the accuracy of his/her report and act upon the results?
- Are the quality measures appropriate?
- Is the attribution method reasonable?

²⁷ Patient Centered Primary Care Collaborative. Payment Reform to Support High Performing Practices. July, 2010. Accessed at <http://www.pcpcc.net/content/payment-reform>.

²⁸ More information on this program is available at: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/index.html?redirect=/PhysicianFeedbackProgram/>.

Another activity intended to address short-term payment issues is the development of two new CPT codes—(1) for chronic, complex care and (2) for transition care following a facility-based discharge. These new codes have been developed by a CPT Panel workgroup and are being proposed to the CPT Editorial Panel, during the May 2012 CPT Meeting. It is anticipated that if these codes are accepted by CPT, the next phase of development will be for the codes to be assigned recommended values through the Relative Value Update Committee (RUC) process, and then receive a final valuation by CMS. These codes are designed to allow physicians to report their non-face-to-face time and the clinical staff (team) time spent on patient cases—an important element of the overall PCMH model.

ACP Involvement in Quality Improvement Programs and Strategies

In addition to our advocacy around the PCMH and other innovative payment and delivery models discussed above, ACP has a long and multi-faceted history of promoting patient-centered high quality care, through the publication of original scientific research, the provision of critical reviews and advice on performance measure development and use, the development of evidence-based guidelines, clinical decision aids, and quality improvement programs.

Original Scientific Research

The *Annals of Internal Medicine* is ACP's flagship scientific publication and forms one of the most widely cited peer-reviewed medical journals in the world. The journal has been published for 80 years and accepts only 7 percent of the original research studies submitted for publication.

Quality and Outcome Measures

While ACP does not develop performance measures, the College is deeply involved in the critical review and provision of comments on performance measures developed by other organizations. The goal is to ensure that the measures are based on high quality clinical evidence. For example, ACP comments on measures pertinent to Internal Medicine that have been submitted to the National Quality Forum (NQF) for consideration for endorsement. ACP also reviews performance measures that are currently under development or endorsement at national organizations like the NCQA, CMS, and the American Medical Association Physician Consortium on Performance Improvement. Furthermore, ACP reviews performance measures related to ACP's Clinical Guidelines, Guidance Statements, and Best Practice Advice papers.

In addition, ACP educates its membership on performance measurement initiatives through the development of policy papers and performance measurement commentaries in peer reviewed scientific journals. Most recently, ACP produced a policy paper on "The Role of Performance Assessment in a Reformed Health Care System".²⁹ This paper discusses in detail ACP's support for payment and delivery system reforms that promote high-value care, improved patient experiences, better population health, improved patient safety, and reduced per capita spending. It includes the following key points:

- Assessment of the value of the care provided may include reporting on evidence-based measures of outcomes, patient experience, population health, safety and effectiveness, and cost of the care provided.
- Such measures should be evaluated through and collected in a consistent, reliable, feasible, and transparent manner; thoroughly tested prior to full implementation to the extent possible; and applied as part of overall payment and delivery system reform emphasizing collaborative system-based health care.

²⁹ Available at: http://www.acponline.org/advocacy/where_we_stand/policy/performance_assessment.pdf.

- To the extent that such reforms include linking payments to reporting and performance on specific quality measures, such incentives must take into consideration the conflicting evidence on the effectiveness of performance assessment-based payment programs and potential adverse consequences.

Evidence-Based Guidelines

ACP has been producing evidence-based clinical practice guidelines since 1981 and is one of the oldest programs in the country.³⁰ ACP's goal is to provide clinicians with recommendations based on the best available evidence; to inform clinicians of when there is no evidence; and, to help clinicians deliver the best healthcare possible. Published guidelines are publically and freely available on ACP's website and are represented in databases such as the National Guideline Clearinghouse and the Guidelines International Network library. The guidelines are also used to inform ACP's educational products such as ACP's Medical Knowledge Self-Assessment Program (MKSAP) and Smart Medicine.

Registries and Quality Improvement Programs

ACP is helping primary care clinicians apply the distilled scientific and clinical data to their every day practice through registries, practice improvement programs, and technologically advanced tools including tablet- and smart phone-based applications. Patient registries, which involve a systematized method for collecting patient-based data that are often used to help clinicians understand and improve their practice, are being developed and applied by ACP.

- In partnership with the New York-ACP Chapter and Dr. Ethan D. Fried, MD, MS, MACP (the Vice Chair for Education and Residency Training Program Director, in the Department of Internal Medicine at St. Luke's-Roosevelt Hospital and Associate Professor at Columbia University's College of Physicians and Surgeons), ACP's Center for Quality is being certified as a Patient Safety Organization (PSO), as it nationally expands a registry of "near miss" events, by which physicians and their teams can examine instances in which patient safety was put at risk but averted, so as to understand the factors that contribute to and protect from risks.
- In partnership with the American College of Cardiology, ACP is piloting the PINNACLE Registry for primary care. The PINNACLE Registry not only interfaces with various EHR systems, but also has received the designation of EHR data submission vendor (DSV) permitting submission of PQRS data to CMS, linking quality improvement to pay-for-performance.
- ACP is piloting *MedConcert*TM, the first multi-tenant cloud-based platform for QI, including registry, performance measure calculation, and secure communication capabilities. Multiple options for uploading registry data, including data from EHRs and administrative claims databases are permitted with *MedConcert*TM. Educational and quality improvement resources are tagged to specific performance gaps on this platform.

Beyond registries, ACP's newly formed Center for Quality is revitalizing its network of physician-quality improvement champions, known as ACPNet. Including nearly 2,000 internists nationwide, this practice-based research network (PBRN) is being surveyed about the methods by which quality improvement and research in the real-world environment can be more readily integrated into the busy practice environment, including the whole medical team. While PBRNs emerged as a tool for understanding real world practice, a still important goal, they are becoming a resource for identifying, testing, and rapidly spreading powerful quality improvement strategies. Accordingly, ACPNet will become the QI laboratory and trendsetter in internal medicine, guided by a national steering group of experts and grassroots leaders.

³⁰ Qaseem A, Snow V, Owens DK, Shekelle P; Clinical Guidelines Committee of the American College of Physicians. The development of clinical practice guidelines and guidance statements of the American College of Physicians: summary of methods. *Ann Intern Med.* 2010 Aug 3;153(3):194-9.

Emerging technologies, including internet 2.0 network capabilities and applications for smart phones and tablets, are exciting tools for improving the quality of care and are being embraced by the ACP quality improvement leadership. As briefly noted above, the *MedConcert* platform includes virtual private network capabilities to establish and scale virtual clinical communities of practice (VCOPs). The VCOPs established will enable healthcare professionals (practice teams, pharmacists, hospitals, and others) to connect in a meaningful way through real-time communications, private messaging, referral messaging, and notifications that drive coordination of care, so critical in controlling healthcare costs and improving patient outcomes. This year, ACP launched the ACP Immunization Advisor, an immunization mobile application for physicians and other clinicians that “diagnoses” the recommended vaccines for a given patient, in the context of educational information about the latest vaccination recommendations and provides advice on how to talk with patients about vaccines. This is being followed by a patient-app, empowering consumers to track their own and their families’ vaccination records and needs, along with information and questions that can be directed to their healthcare clinicians. Given that most young physicians and certainly trainees are familiar with and utilize these approaches, ACP is embracing the new technologies, as they will usher in the digital revolution in healthcare—promising, in the words of Dr. Eric Topol, “to hyperpersonalize healthcare” in a way that maximizes quality in a patient-centric but also cost conscious way.

The federal government can hasten and strengthen ACP’s efforts through: (1) ongoing dialogue that assures payment reform and professional requirements are aligned with the requisites of quality improvement and a busy clinical practice; (2) adoption of guidelines, measures, and approaches that have enjoyed a robust scientific review; and (3) efforts to support targeting quality improvement initiatives that promise widespread adoption and impact through medical associations and innovative partners.

Efforts to Facilitate Electronic Health Record Implementation

To help our members with the adoption, implementation, and effective use of electronic health records, ACP cofounded AmericanEHR Partners with Cientis Technologies in 2010. AmericanEHR Partners is a free web-based resource that is open to the public. Currently the program is supported by 21 additional professional societies including the American Medical Association (AMA), American College of Surgeons (ACS), American Academy of Family Physicians (AAFP), and American Academy of Physician Assistants (AAPA), collectively representing more than 750,000 clinicians in the United States.

AmericanEHR Partners helps practices find an EHR system that meets the unique demands of their practices. Through a Consumer Reports-like approach, we collect data on EHR systems by surveying physicians, nurse practitioners, and physician assistants in collaboration with their professional associations. We then present this information on the site through the EHR comparison engine and rating system, which allows clinicians to view individual product and benchmark ratings. Users can also filter the ratings based on practice size and specialty. Additionally, AmericanEHR Partners provides an array of interactive tools and educational material to assist practices with the selection, implementation, and effective use of health IT. The educational content on the site is contributed by all of the supporting organizations in an effort to crowd source the collective knowledge of the medical community.³¹

ACP and AmericanEHR Partners are also working on a project commissioned by Doctors Helping Doctors Transform Health Care to look at health information exchanges (HIE). ACP hopes that the results of the project will help inform the policies of the participating organizations as well as the federal advisory committees focusing on meaningful use and various health information exchange efforts by determining what information physicians, nurse practitioners, and physician assistants want and need in order to provide high quality, low-cost, and coordinated care.

³¹ More information concerning AmerEHR partners is available at <http://www.americanehr.com/Home.aspx>.

Advocacy for External Quality Improvement Activities

As discussed earlier, ACP has been actively involved in promoting the efforts of the CMMI, particularly the promising CPCi.

In addition, ACP has on-going efforts to encourage its members to participate in the PQRS and Electronic Prescribing initiatives. The College distills the annual and interim program change information and then distributes it to the membership via policy interpretations and implementation tips in our publications and webinars, and timely notifications to the members about upcoming CMS and contractor teleconferences focused on these program subjects. ACP has also developed a tool called the “PQRIwizard”, which is a web-based registry designed to help collect and report quality measure data for the PQRS incentive payment program. The PQRIwizard guides practices through a few easy steps to collect, validate, report, and submit the results to CMS for payment.³²

Patient and Physician Engagement Efforts

High Value, Cost-Conscious Care Initiative

An important priority for ACP is to help our physicians provide the best possible care to their patients, and simultaneously reduce unnecessary costs to the health care system. Therefore in April 2010, ACP announced its **High Value, Cost-Conscious Care Initiative** (HVCCC), which includes clinical, public policy, and educational components.³³ The overall purpose of the initiative: to help physicians and patients understand the benefits, harms, and costs of an intervention and whether it provides good value, as well as to slow the unsustainable rate of health care cost increases while preserving high-value, high-quality care.

For the clinical component of the HVCCC Initiative, ACP has released materials focused on three areas: low back pain, oral pharmacologic treatment of type 2 diabetes, and colorectal cancer. Furthermore, as part of this initiative, ACP convened a workgroup of physicians that identified, using a consensus-based process, 37 common clinical situations in which screening and diagnostic tests are used in ways that do not reflect high-value care.³⁴

ACP has also joined other leading professional medical organizations in the **Choosing Wisely** campaign,³⁵ which complements our HVCCC Initiative. An initiative of the ABIM Foundation, the goal of the Choosing Wisely campaign is to promote thoughtful discussions among physicians, patients, and other stakeholders about how to use health care resources to improve quality of care. In April 2012, ACP unveiled our list of “Five Things”³⁶ internists and patients should question in internal medicine.

On April 19, ACP and Consumer Reports announced a new collaborative effort to create a series of **High Value Care** resources to help patients understand the benefits, harms, and costs of tests and treatments for common clinical issues. The resources will be derived from ACP’s evidence-based clinical practice recommendations published in *Annals of Internal Medicine*. The initial pieces of the **High Value Care** series will be two patient brochures about diagnostic imaging for low back pain and oral medications for type 2

³² For more information on the PQRIwizard: <https://acp.pqriwizard.com/default.aspx>.

³³ Additional information can be found at: http://www.acponline.org/clinical_information/resources/hvccc.htm.

³⁴ Qaseem A, Alguire P. et al. Appropriate Use of Screening and Diagnostic Tests to Foster High-Value, Cost-Conscious Care. *Ann Intern Med*. 2012;156:147-149. Accessible at <http://www.annals.org/content/156/2/147.full.pdf+html?sid=10a2df33-7fa3-45c1-a01d-dc7ecd1b9f6c>

³⁵ More information on this initiative can be found at: <http://choosingwisely.org/>.

³⁶ This document can be found at: http://choosingwisely.org/wp-content/uploads/2012/04/5things_12_factsheet_Amer_College_Phys.pdf.

diabetes. The *High Value Care* resources will be available on the websites of ACP (ACPOnline.org), Consumer Reports (ConsumerReports.org), and *Annals of Internal Medicine* (Annals.org).³⁷

In terms of public policy, the HVCCC initiative continues the College's position formulated in our 2009 policy paper "Controlling Health Care Costs While Promoting the Best Possible Health Outcomes." In January 2011, ACP released "How Can Our Nation Conserve and Distribute Health Care Resources Effectively and Efficiently?"³⁸ This paper develops the case that there is an urgent need for the country to have a discussion on how to conserve and allocate limited resources in a uniquely American way that puts the principal responsibility on patients and physicians making informed choices based on evidence.

Finally, the educational component of the program involves elements for both physicians and patients. The next edition of ACP's MKSAP will have a focus on optimal diagnostic and treatment strategies, based upon considerations of value, effectiveness, and avoidance of overuse and misuse.

Patient Centered Outcomes Research Institute (PCORI)

The College has for a number of years recognized the need for the establishment of an adequately funded, trusted national entity to prioritize, sponsor, and/or produce comparative effectiveness information—clinical information that physicians and their patients can use to engage in a robust shared-decision process regarding healthcare needs. The College's position is summarized in a policy paper titled "Improved Availability of Comparative Effectiveness Information: An Essential Feature for a High-Quality and Efficient United States Health Care System."³⁹ Many of the elements outlined in that paper have come to fruition with the implementation of PCORI as part of the Affordable Care Act (ACA) of 2010. The College remains actively involved in the PCORI process through the provision of feedback and comments informed by an Expert Panel of ACP members with national recognition and expertise in this area. ACP has provided specific recommendations to PCORI on its draft statement of priorities and research goals.⁴⁰

Administrative and Regulatory Burdens to Health Reform

Administrative Burdens

This letter has already highlighted a number of the challenges facing our members engaged in the transforming of their practices consistent with the requirements of the PCMH. In addition, these practices experience everyday unnecessary administrative burdens that interfere with their ability to more effectively and efficiently address patient needs. For example, there are many administrative hassles associated with care transitions and chronic care management. Prior authorization requirements used both in the public and private sectors are one of the biggest administrative burdens. These procedures could be streamlined by utilizing a uniform process or a common set of requirements. Currently physicians must use various procedures and forms from different payers. ACP recognizes that the rationale behind prior authorization is to help ensure appropriate treatment and medication; however, the administrative hassle it imposes on physicians is a burden to many practices. We have also been advocating for the development of standards and procedures to allow for the electronic processing of these activities, which would lessen the burden. Another example of administrative burden is the new face-to-face requirement for home health care under Medicare. Physicians report that they are inundated with different forms from different home health care agencies to fulfill this requirement. We have advised physicians, after consultation with CMS, that they do not need to adhere to any specific form, as long as the required information specified by CMS is included. ACP recognizes that the face-to-face requirement for home health care is important to ensuring appropriate

³⁷ More information on this effort can be found at: http://www.acponline.org/pressroom/high_value_care_ed_materials.htm.

³⁸ This paper can be found at: http://www.acponline.org/advocacy/where_we_stand/policy/health_care_resources.pdf.

³⁹ This paper is available at: http://www.acponline.org/advocacy/where_we_stand/policy/.

⁴⁰ This statement is available at: http://www.acponline.org/advocacy/where_we_stand/other_issues/#add.

care and improved care coordination among physicians and home health agencies, but we encourage continued efforts to make the process more efficient.

Recently, ACP has also heard from many members having issues with the EHR, PQRS, and eRx initiatives. The lack of true alignment among these programs is problematic, and the inability of these programs to provide timely feedback to members regarding whether they are successfully satisfying program requirements leads to frustration and distrust.

Regulatory Burdens

As payment reform is moving towards models that attempt to integrate/coordinate the efforts of multiple clinicians to deliver high quality, efficient care, it is important that these participating physicians and other healthcare professionals receive adequate guidance and protection from inadvertently triggering one of the complex set of regulations established to control inappropriate manipulation of prices and the delivery of unnecessary or substandard care. These include the anti-trust, anti-kickback, self-referral, gainsharing, and beneficiary inducement regulations. The College believes that the Federal Trade Commission, the Department of Justice, and the HHS Office of the Inspector General did a good job providing these protections, in the form of waivers and safe harbors, for the MSSP and this effort should serve as a model for similar integrative payment reform initiatives.

On a related note, CMS and the Office of the Inspector General (OIG) in 2007 simultaneously established exceptions and safe harbors to the Stark self-referral and anti-trust regulations to allow donations of electronic prescribing and EHR technology. The use of this health information technology is an essential component of care integration throughout the healthcare system and the above exceptions and safe harbors serve as a means for many small practices to receive assistance in implementing electronic health record (EHR) systems from larger healthcare clinician entities. The College is concerned that these exceptions and safe harbors sunset in December 2013. It is recommended that an effort be made to allow for the continuation of this initiative.

Summary and Conclusion

Based upon our above responses, the College specifically recommends that:

1. The Ways and Means Committee report legislation that would repeal the SGR, provide for stability in payments for all physicians, higher updates for undervalued care coordination, preventive, and primary care services, and transition to new payments and delivery models, working from the bipartisan Medicare Physician Payment Innovation Act, H.R. 5707.
2. Congress look to the PCMH as being one of the most promising models for improving outcomes and lowering costs; learning from the extensive and growing experience in the private sector and from the new CPCi and Advanced Primary Care Initiatives in CMS as well as from private sector recognition and accreditation programs. We are confident that the PCMH model, and the related PCMH-Neighborhood, will have enough supporting data and experience to be incorporated into the options available to physicians after a transition period similar to that established by H.R. 5707.
3. Congress and CMS work with the medical profession on reducing barriers to the PCMH model, including facilitating the coordination of care among physicians and across settings; facilitating the use of health IT in meaningful ways; aligning the multiple federal initiatives with the goal of healthcare transformation, including timely payment to those physicians that meet the requirements of these initiatives; and facilitating participation in these initiatives by all payers.
4. Congress support continued evaluation of ACOs, Advanced Payment ACOs, bundled payments, Prometheus, and other promising alternative payment models that could be offered to physicians, following a transition period, along with PCMHs.

5. Congress work with the profession and CMS to encourage shorter-term options to support value-based payments in the current Medicare fee schedule, including coverage and reimbursement for new codes related to care coordination and transition of care.
6. Congress support the efforts by ACP and other physician membership organizations to provide guidance to physicians on high-value cost conscious care, including shared decision-making strategies to communicate such recommendations to Medicare patients in consultation with physicians.
7. Congress work with the medical profession and CMS to reduce administrative and regulatory burdens, including inadequate alignment of federal quality initiatives, unnecessary prior authorization requirements, and the inadvertent triggering of penalties based on complex anti-trust and patient protection regulations. The College also specifically calls for the continuation of the waivers and safe harbors related to the donation of health information technology.

The College appreciates the opportunity to share our observations, experiences and recommendations on how Congress can work with ACP and others in the medical profession to advance comprehensive, patient-centered, and value-based payment and delivery system reforms. Please contact Shari Erickson, ACP's Director of Regulatory and Insurer Affairs, 202-261-4551, serickson@acponline.org or Richard Trachtman, ACP's Director of Legislative Affairs, 202-261-4538, rtrachtman@acponline.org if you have any questions or require additional information.

Sincerely,



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