Oral Remarks

State of the Nation's Health Care 2007

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Thank you, Dr. Kirk. I am pleased to be with you today to present the College's proposals to redesign federal health programs around patient-centered primary care.

Our recommendations are presented in detail in the press packets you received today. Your packets include two new College policy statements being released today:

- The College's 2007 report on the State of America's Health Care, which presents our overall vision for reforming federal programs to achieve a patient-centered health care system for all Americans, including the nearly 47 million who currently do not have health insurance coverage.

- A new position paper titled A System in Need of Change: Restructuring Payment Policies to Support Patient-Centered Care, which proposes an entirely new way of paying physicians to deliver patient-centered care. The paper also proposes a pathway for eliminating the flawed Medicare "sustainable growth rate" (SGR) formula.

I will spend the next few minutes summarizing our recommendations.

First, we are calling for Medicare to make fundamental changes in the way they pay physicians for delivering care. If our recommendations are accepted, Medicare would no longer pay physicians based solely on how many procedures or visits are billed.

Instead, physicians would be paid for taking responsibility for coordinating the care of the whole patient and for implementing systems-based approaches to improve outcomes and reduce costs.

Practices would be given the option of going through a voluntary process to demonstrate that they have the systems in place to deliver patient-centered care. Such systems include use of information technologies that enable physicians to:

- Access evidence-based clinical decision support guidelines at the point of care;
- Generate reminders to patients on self-management and treatment recommendations;
- Track patients by disease condition;
- Provide patients with ease of access through secured email and telephone consultations; and

- Measure and report on the quality of care provided.

Qualified practices would then be eligible to be paid under an alternative Medicare payment structure:

- This alternative payment structure would pay physicians on a bundled, prospective basis for the physician work involved in managing and coordinating care that falls outside of the face-to-face encounter, and for the systems needed to deliver better care.

- "Bundled" means that it would include a defined package of services associated with patient-centered care, rather than paying for such services on a piecemeal basis.

- "Prospective" means that physicians would be paid a defined amount per patient on a scheduled basis, such as monthly, for the bundle of patient-centered services.

- Payments would be risk-adjusted so that physicians who manage care of the sickest patients are appropriately reimbursed for the additional work and expenses involved.

- Fee-for-service payment for office visits would be maintained to address the risk that prospective payment alone could create disincentives for physicians to see patients in the office.

- Finally, the alternative payment structure would include a performance-based component for reporting on evidence-based quality, cost, and patient experience measures.

We applaud Congress for including the Medicare Home Demonstration Project in the Tax Relief and Health Care Act of 2006. This demonstration is an essential first step toward implementing the College's vision of patient-centered care in up to eight states. We will work with CMS on implementation of the demonstration project and will seek authority from Congress to expand it into a national project open to any qualified practice.

For physician practices that do not qualify as a medical home, we recommend revisions in Medicare fee-for-service payment policies to allow for separate payments for specific services associated with care coordination. We also support the MedPAC proposal to create a more effective process for identifying overvalued procedures under the resource-based relative value scale (RBRVS).

Today, we are also releasing a proposal for eliminating the SGR and replacing it with a fairer and more accurate system that will result in stable payments to physicians and create stronger incentives for physician engagement in programs to improve quality and lower costs. Continued SGR pay cuts will make it impossible for physicians to invest the resources required to deliver patient-centered care.

First, Congress would legislate a transitional period that would lead to complete repeal of the SGR.

- During this transition, physicians would be guaranteed stable, predictable and positive baseline payments.
- They would also receive additional pay-for-reporting bonuses that would include targeted incentives to acquire the structural capabilities to deliver patient-centered care.

Second, following the transition, a new system would be established for updating physician payments. Each year, the Medicare Payment Advisory Commission would make a recommendation to Congress on an update that would have three components:

- A baseline and positive annual update for all physicians.
- A dedicated source of funding, above the baseline update, which would be set aside to fund a physicians' quality improvement pool.
- Discretionary bonus payments, separate from and in addition to the baseline update, to be recommended on an "as needed" basis to achieve specific policy goals, such as reversing the decline in the number of physicians going into primary care.

The proposed physicians' quality improvement pool would operate very differently from the pay-for-reporting program created by the Tax Relief and Health Care Act of 2007:

- It would be structured to give prioritized funding to physician-initiated quality improvement initiatives that have the greatest potential to improve quality and lower costs.
- Performance-based payments would be on a weighted basis related to the effort involved and the impact of the measures being reported on quality and costs, instead of a "one size fits all" approach that pays the same bonus for reporting on a few quality measures regardless of impact on cost and quality.

We believe that the College's recommendations for reforming payments to support patient-centered care will be shown to be more effective in driving the practice-level changes needed to achieve better quality and lower cost than replacing the SGR with another unproven and complex spending target.

Finally, the College is proposing ways to expand patient-centered care to Medicaid and S-CHIP recipients and the uninsured.

We propose that Congress give states the option of organizing care for Medicaid and S-CHIP recipients around the patient-centered medical home.

We recommend that Congress provide states with a pathway for seeking federal funding to support state initiatives to expand coverage, with preference given to states that include patient-centered care in their proposals.

And we propose that Congress itself take immediate action to reduce the numbers of uninsured Americans by expanding Medicaid and S-CHIP and providing subsidies for low-income persons to buy into the Federal Employee Health Benefits Program. Federal legislation to expand health coverage should also include other reforms to provide recipients with access to patient-centered medical homes.

The legislative road map included in your press packet identifies specific legislative options to implement the proposals released today. Immediately following today's press briefing, we will be meeting with congressional leaders and staff to present our road map.

In those visits, we will emphasize that patient-centered primary care is not a theoretical model with an unknown impact on quality and cost. It is a model that has been implemented successfully in other countries that achieved better quality and more efficient use of resources. But we don't need to look abroad for evidence. As Dr. Kirk noted, states that rely more on primary care physicians consistently have lower Medicare expenditures, lower utilization, fewer ICU deaths, fewer hospital admissions, and better composite overall quality scores. Patient-centered primary care has also been effectively implemented within the United States, by the VA and other health programs that are getting far better results than the national norm.

Patient-centered health care already has broad support from physicians, employers, think tanks, and other stakeholders. IBM, the National Business Group on Health, the ERISA Industry Committee, the Commonwealth Fund, the American Academy of Family Physicians, the American Academy of Pediatrics, and the Society for General Internal Medicine are among those that have come out in favor of reforms to support patient-centered primary care.

Today, we challenge the 110th Congress and President Bush to join with us to use the enormous purchasing power of the federal government to bring the benefits of patient-centered primary and principal care to all Americans.

Dr. Kirk and I will be pleased to answer your questions.