



March 1, 2007

Letter to Chair and Ranking Member of the Senate Finance Committee, the House Ways and Means Committee and Health Subcommittee, and the House Energy and Commerce Committee and Health Subcommittee.

Dear Chair and Ranking Member:

The American College of Physicians (ACP), representing over 120,000 internal medicine physicians and medical students, wants to share with Congressional healthcare policy leaders through this letter its initial reaction to the Medicare Payment Advisory Committee (MedPAC) mandated Report to Congress that it released earlier today. Overall, ACP commends MedPAC for an excellent, thorough, balanced and well-documented report on a very complex and critical issue. Our current dysfunctional healthcare delivery and payment system directly contributes to less than desired quality and high costs. The analyses and recommendations contained in the MedPAC report provide a solid foundation for further discussion among all stakeholders and for Congress and the Centers for Medicare and Medicaid Services (CMS) to begin taking significant steps to improve the quality and value of care provided to our Medicare beneficiaries and all Americans.

The College's comments on several of the issues addressed in the MedPAC report are below.

**1. Problems with the Medicare Physician Fee Schedule Sustainable-Growth-Rate (SGR) update methodology.**

ACP strongly supports the MedPAC observation that the current SGR methodology is flawed and the College calls on Congress to repeal this methodology. It has been ineffective in controlling volume and expenditure growth in physician services and has resulted in projected payment updates for these services of negative 5 percent throughout much of the next decade—updates that the Medicare Trustees<sup>1</sup> have called “unrealistically low” and MedPAC has characterized as of “particular concern for the Commission.”<sup>2</sup>

**2. The need to improve the value of the Medicare physician payment system.**

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<sup>1</sup> Board of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. 2006. 2006 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.

<sup>2</sup> Medicare Payment Advisory Commission. Physician Services. Report to the Congress: Medicare Payment Policy. March 2006.

The report highlights a number of recommendations that MedPAC has made in previous Reports to Congress that have the goal of improving the efficiency of healthcare delivery while improving or maintaining access and quality. Broadly, the recommended changes include: modifying the current Medicare payment incentives to better align them with improving quality of care; providing incentives to better coordinate care; using resources judiciously; collecting and disseminating information to help physicians improve their performance; and paying increased attention to program integrity and provider standard issues.

ACP agrees with MedPAC that major reforms are needed to improve the value of the Medicare physician payment system. In fact, ACP has released comprehensive Medicare reform recommendations in recent years to improve quality and introduce greater efficiency. In a recent policy paper the College called for aligning Medicare payments “with quality improvement, promoting adoption of HIT [health information technology] in support of quality improvement, promoting physician-guided care management and the Advanced Medical Home, encouraging evidence-based medicine, supporting the value of primary care, and addressing mispricing of services.”<sup>3</sup>

The College is particularly pleased with MedPAC’s recognition of the value of promoting the use of primary care and physician-directed care coordination to increase clinical quality and efficiency, but is surprised that the report makes little mention of the “advanced” or “patient-center medical home” (PC-MH) care model.<sup>4</sup> The PC-MH provides beneficiaries with: a personal physician with a whole-person orientation who accepts overall responsibility for the care of the patient and leads a team that offers enhanced access to care; better coordinated and integrated care, and increased efforts to ensure safety and quality.

Recent ACP policy papers<sup>5 6</sup> and Commonwealth Fund reports<sup>7</sup> provide a large body of evidence that this model of care can be effective in improving quality and reducing costs. The promise of this model of care is also reflected by: the inclusion of a Medicare medical home demonstration in the Tax Relief and Health Care Act of 2006; the College’s current collaboration with private sector entities to implement PC-MH demonstrations across the nation; and the inclusion of various aspects of the PC-MH model in state healthcare redesign efforts (e.g. North Carolina, Louisiana, Missouri).

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<sup>3</sup> American College of Physicians. A System in Need of Change: Restructuring Payment Policies to Support Patient-Centered Care. 2006. Accessible at [http://www.acponline.org/hpp/statehc07\\_4.pdf](http://www.acponline.org/hpp/statehc07_4.pdf).

<sup>4</sup> American College of Physicians. The Advanced Medical Home: A Patient-Centered, Physician-Guided Model of Health Care. 2006. Accessible at [http://www.acponline.org/hpp/adv\\_med.pdf](http://www.acponline.org/hpp/adv_med.pdf).

<sup>5</sup> American College of Physicians. Reform of the Dysfunctional Healthcare Payment and Delivery System. 2006. Accessible at [http://www.acponline.org/college/pressroom/as06/dysfunctional\\_payment.pdf](http://www.acponline.org/college/pressroom/as06/dysfunctional_payment.pdf).

<sup>6</sup> American College of Physicians. A System in Need of Change: Restructuring Payment Policies to Support Patient-Centered Care. 2006. Accessible at [http://www.acponline.org/hpp/statehc07\\_4.pdf](http://www.acponline.org/hpp/statehc07_4.pdf).

<sup>7</sup> Davis, Karen, Schoenbaum, Stephen C. & Audet, Anne-Marie. A 2020 Vision of Patient-Centered Primary Care. *Journal of General Internal Medicine* 2005;20: 953-957.

The College advocates that the PC-MH be supported by a payment system that includes: a prospective bundled payment(s) that covers the infrastructure and work related to providing patient-centered care; a fee-for-service; and a performance-based component. This structure will provide the payment needed to incentive physicians to practice as a medical home and facilitate quality improvement and the potential to realize overall healthcare system savings.

ACP urges Congress to work with the College and others to determine the most appropriate mechanisms for incorporating patient-centered care through a medical home into the Medicare program.

**3. The SGR should not be replaced with a new system of expenditure targets that could have adverse consequences for beneficiaries and introduce new administrative and political complexities.**

The broad reforms recommended by MedPAC and the College to improve the value of Medicare will result in substantial healthcare quality improvements with related cost efficiencies and will effectively contribute to a reduction in and control of inappropriate volume/expenditure growth. We do not believe that a new system of expenditure targets is required or desirable.

Although the Commission makes no recommendation on adoption of regional targets to replace the national SGR target, the report presents regional targets as an option and suggests that they may be more effective than a national one. The College believes that regional targets are likely to suffer from many of the same problems associated with the national SGR target, while creating many new administrative and political complexities:

- Like the current SGR, regional targets would not differentiate between efficient and inefficient providers within a region, and appropriate and inappropriate volume increases;
- This approach may result in an unintended shifting of physicians and services from high volume/cost areas to low, potentially creating access problems in the high volume areas; and
- Providing different physician fee schedule updates based on regional expenditure growth would likely encounter strong political pushback from constituents and their Congressional representatives in areas that are scheduled to receive lower updates, greatly politicizing the process of setting updates. This would especially be true because regional targets would likely result in very deep payment cuts in many areas of the country that serve the largest concentrations of Medicare beneficiaries and are experiencing very high levels of expenditure growth.

An ACP analysis of the volume control alternatives that Congress directed MedPAC to consider, as excerpted from the ACP 2006 policy paper, “A System in Need of a Change: Restructuring Payment Policies to Support Patient-Centered Care,” is included as Attachment A.

As an alternative to MedPAC’s discussion of creating regional targets, ACP proposes that Congress replace the SGR with a new update framework that: provides positive and predictable baseline payments; establishes a transition period leading to repeal of the SGR;

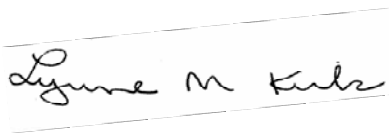
and creates powerful incentives for physicians to design, implement and participate in programs to improve quality and achieve more efficient use of resources. A complete description of the College's alternative update framework, titled, "ACP's Proposed Framework for Repealing the SGR" is listed as Attachment B.

The College's alternative pathway for eliminating the SGR, combined with other measures to introduce greater value into Medicare physician payments that are discussed in the MedPAC report and supported by the College, would create strong incentives for quality improvement and care coordination without the complexities and likely unintended adverse consequences of other forms of spending targets, either at a national or regional level.

In conclusion, ACP urges Congress to give careful consideration to the MedPAC report and specifically enact changes in Medicare payment policies to eliminate the SGR, create incentives for physician-directed care coordination through a PC-MH, support physicians' ability to acquire the systems needed to manage and improve quality, and to address misevaluation of services. We believe these policies should be given a chance to demonstrate their effectiveness before any consideration is given to imposing another form of national or regional spending target(s) that will carry with them many of the same flaws as the SGR while introducing new political and administrative complexities.

Please contact Robert Doherty, Senior Vice President, Government Affairs and Public Policy, by phone at (202) 261-4530 or e-mail at [rdoherty@acponline.org](mailto:rdoherty@acponline.org) if you have questions and/or need additional information.

Sincerely,

A handwritten signature in black ink, reading "Lynne M. Kirk". The signature is written in a cursive style and is positioned above a thin horizontal line.

Lynne M. Kirk, MD, FACP  
President

## Attachment A

### American College of Physicians' Analysis of Volume Control Alternatives

Excerpted from the ACP 2006 policy paper "A System in Need of a Change: Restructuring Payment Policies to Support Patient-Centered Care"

The College provides the following analysis of the five volume control alternatives to the SGR addressed by MedPAC under the Deficit Reduction Act of 2005. This analysis is partially informed by a previous analysis of alternatives to the Volume Performance Standard perform by the Rand Corporation and a recent preliminary discussion on alternatives to the SGR by MedPAC.<sup>8 9</sup>

MedPAC was mandated to evaluate the effects of employing smaller volume target pools within an SGR-type volume control formula. Thus, rather than reducing updates for all procedures and affecting all physicians due to inappropriate overall physician service growth, the conversion factor and related procedure fees would be modified based on inappropriate volume growth by one or more of the following:

**Type of service:** This would reduce updates for those specific medical services displaying inappropriate growth. For example, volume growth for visits (E/M services) and major procedures was 3.3 and 3.4 percent respectively in 2004, while volume growths for imaging and test services were 11 percent and 8.9 percent respectively.<sup>10</sup> Reducing the update for the specific services for which growth exceeds the identified target (e.g. imaging and tests) may provide an increased incentive for related providers and their medical specialty societies to encourage and assist practices to decrease unnecessary growth (i.e. develop practice standards). This approach continues not to differentiate between efficient and inefficient providers, and appropriate and inappropriate volume increases. More importantly, historically this approach has led to stark inequities in the payment for different services of roughly equivalent relative work value. These inequities can affect the volume of service use, and the selection by physicians to enter a given medical specialty.<sup>11 12</sup> This approach must also recognize that there are medical specialty groups (e.g. surgeons, radiologists) who are not totally responsible for the service growth in their area – it is significantly affected by referral

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<sup>8</sup> Marquis M, Kominski G. Alternative Volume Performance Standards for Medicare physician services. *The Milbank Quarterly*. 1994;72(2):329-357.

<sup>9</sup> Medicare Payment Advisory Commission. *Issues in Physician Payment Policy*. Report to Congress: Medicare Payment Policies. March 2005.

<sup>10</sup> Medicare Payment Advisory Commission. *Physician Services*. Report to the Congress: Medicare Payment Policy. March 2006.

<sup>11</sup> Ibid

<sup>12</sup> Ginsberg P, Grossman J. When the price isn't right: How inadvertent payment incentives drive medical care. *Health Affairs*. 2005;Web Exclusive 376-384.

patterns of other providers. Finally, it may provide a perverse incentive for providers to increase volume to make up for income loss.

**Geographic area:** This would focus reduced updates on areas in which medical services display inappropriate growth. Focusing these volume controls on regional pools of physicians may provide a greater incentive for physicians in high-growth states to decrease unnecessary volume growth. Local medical societies and the Quality Improvement Organizations (QIOs) could assist by providing practice guidelines, educational programs, and even local physician profiles of service. This approach continues not to differentiate between efficient and inefficient providers. It will also have to recognize baseline volume and quality of care differences among the regions to be effective. It also has the potential to affect physician location decisions and possibly service access – with providers selecting to practice in those regions that have received higher fee updates.

**Outliers:** This approach would focus volume controls on those physicians that provide a significantly higher volume of services than defined peers based on an analysis of claims data. This highly focused approach would provide a significant incentive for these outlier providers to examine their practices and reduce unnecessary service use. The successfulness of this approach would depend on CMS's ability to include case mix/severity adjustment and quality-of-care factors in defining this outlier group. A high volume of services may be appropriate under certain circumstances. If these factors are not successfully considered, this approach would provide an incentive for providers to avoid the more complex, service-intensive patients or provide poorer quality care. It is questionable whether claims data alone will allow for these necessary differentiations. In addition, the large number of individual providers involved, each possibly having different fee schedules over time, would pose a significant administrative challenge to CMS. Finally, there remains the possibility that this approach will provide an incentive for these providers to increase volume to make up for lost income.

**Hospital medical staff:** This approach would focus spending targets based on services provided by hospital medical staff. These staff have the organizational structure to influence member service provision. Updates would be lower for those staff that do not successfully control spending growth compared some national or regionally-adjusted target. Case mix and quality-of-care factors would need to be included in the analysis to reduce the incentive to avoid complex, service-intense patients or provide inadequate care. This approach doesn't directly differentiate between appropriate/inappropriate volume providers within a staff, it may have difficulty attributing staff membership to a provider, and it appears administratively complex. Finally, it may contribute to major changes in physician referral practices based on hospitals' success in controlling physician service volume growth and the resulting fees paid – this may create financial problems for certain facilities, and potentially lead to referrals based on payment incentive rather than which facility could best meet the patient's needs.

**Group practices:** This approach creates an alternative voluntary spending pool of group practices that have a means of “organization, accountability, and commitment to the use of evidence-based medicine.” Similar to hospital medical staffs, these groups have the

ability to influence the service provision of its members. Group membership would likely require HIT and care coordination processes. Reimbursement would combine fee-for-service payments with performance-payments based on improved care management. Enhanced payments based upon meeting quality and efficiency standards would serve as an incentive to be part of this spending pool. Case mix/severity adjustment and service attribution processes would have to be developed by CMS to implement this idea. Further, the criteria for spending pool membership appears more suited for large group practices – similar to those participating in the Physician Group Practice demonstration – and may discriminate against the smaller practices that see most of the Medicare population.

## Attachment B

### ACP's Proposed Framework for Repealing the SGR

**ACP proposes to repeal and replace the Sustainable Growth Rate Formula with a new methodology that will provide positive and predictable baseline payments and create powerful incentives for physicians to design, implement and participate in programs to improve quality and achieve more efficient use of resources:**

- The College proposes a transitional pathway to eliminate the SGR that will culminate in a stable and predictable methodology for updating physician payments and creates a strong incentive for physicians to participate voluntarily in a Medicare pay-for-reporting program. During the transition period, changes would be made in the transitional program pay-for-reporting program now being instituted by Medicare to provide greater bonus payments to physicians who acquire the systems needed to deliver patient-centered care and who do more to improve quality, rather than a “one size fits all” program that pays all physicians the same amount for reporting a few measures, regardless of the impact of those measures on improving patient care.
- At the end of the transition, the SGR would be replaced with a new update system that would have three components:
  - A baseline physician payment update that takes into account the costs of delivering care, beneficiary access to services, workforce and other data on trends that may affect access and quality.
  - A separate pool of funds that would be set aside to fund qualified physicians' quality improvement programs that have the greatest potential to achieve quality improvements and cost efficiencies for the Medicare population, including programs that are designed to support patient-centered care.
    - Performance payments to physicians would be paid out on a weighted basis to physicians who agree to participate in the quality improvement programs funded by the pool.
    - This physician payment quality improvement pool would be funded in part by system-wide Medicare savings that are attributable to quality improvement programs funded out of the pool. For example, the pool could fund programs that reward physicians for helping to keep patients with multiple chronic diseases out of the hospital. A portion of Medicare Part A savings would then be redistributed back into the physician performance pool.
    - “Weighted” payments mean that physicians who successfully participate in programs that have the greatest impact on quality and cost would receive greater bonus payments than those who do not

participate, or who participate in programs that will have a lesser impact on quality and cost. This is fundamentally different than the current “one size fits all” transitional Medicare pay-for-reporting program, which will pay physicians the same percentage bonus payment for as few as three measures regardless of the impact of the measures on improving quality and reducing costs.

- A process that would direct the Medicare Payment Advisory Commission to consider making formal recommendations to Congress on discretionary bonus payments to achieve specific policy objectives, such as increasing the supply of primary care physicians.