



STATEMENT

of the

American Medical Association

before the

Senate Committee on Finance

**Re: Medicare Physician Payment Policy:
Perspectives from Physicians**

Presented by: Ardis D. Hoven, MD

July 11, 2012

**Division of Legislative Counsel
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The American Medical Association appreciates the opportunity to present our views to the Senate Committee on Finance concerning “Medicare Physician Payment Policy: Perspectives from Physicians.” There is strong bipartisan agreement that the sustainable growth rate (SGR) must be repealed and replaced with an alternative, more viable system. The SGR has been plaguing patients and physicians in Medicare and the TRICARE military health program for over a decade, and its repeal is long past overdue. We now have a unique opportunity to improve and restructure care delivery and payment policy. Many ground-breaking innovations are already underway, and it is critical that we continue on this path. As we move forward, we must keep in mind that physician practices widely vary, by size, specialty, practice type, and community. Large, multi-specialty practices may initially be better positioned to quickly implement these innovations than small, rural, solo or two-physician practices. Because of the wide differences in physician practices, both structural and geographic, practices operate at a different pace, reflecting variations in practice capabilities at this point in time. This means we need multiple solutions, including a menu of innovation options available on a rolling basis for varying physician practice types, allowing practices as they are ready to participate in an option most scalable to their practice.

Restructuring our Medicare payment and delivery system is an enormous undertaking that requires initial immediate steps that can advance us further down the road, combined with a long-term strategy that takes us to the finish line. The AMA looks forward to working with the Committee and Congress as we work to develop and implement multiple solutions to the problems of the current Medicare physician payment system.

TRANSITIONING TO A NEW MEDICARE PAYMENT AND DELIVERY SYSTEM

In transitioning to a new Medicare payment and delivery system, several key factors must be taken into account:

- The flawed SGR must be repealed. Physicians face yet another steep payment cut of about 30 percent on January 1, 2013. This vicious cycle must come to an end, and it must be replaced with a new system that moves physicians forward into a coordinated delivery and payment system that is better for patients, physicians, and the Medicare program overall.

- A flexible approach, rather than one-size fits all, is needed during a transition to a new system, including a menu of options to best address patient need of a particular practice, depending on the specialty, practice type, capabilities and community. This menu should go beyond Medicare shared savings and Accountable Care Organizations (ACOs) based on total costs, and should also include innovations such as bundled payments, performance-based payments, global and condition-specific payment systems, warranties for care, and medical homes.
- Alternative payment and delivery models must cut across Medicare silos. When physician delivery of care achieves overall Medicare program savings, physicians (and the Medicare program) should be able to share in those savings. Part B physicians' services often are necessary to prevent patients from needing more costly medical care down the road. While this is good for patients and Medicare spending overall, under the SGR, more physicians' services (even to create overall program savings) drives steeper payment cuts for physicians. This perverse incentive structure has to change as part of a transition to a new system.
- A positive and stable payment structure is needed as we make this transition so that physicians have the financial ability to make up-front capital investments—such as employing additional staff to improve care coordination and adoption of health information technology.

PHYSICIANS HAVE ALREADY BEGUN TRANSITIONING TO ALTERNATIVE PAYMENT AND DELIVERY MODELS

Physicians have already begun transitioning into alternative payment and delivery models, both in Medicare and the private payer market, which can guide the development of a new Medicare physician payment system. This trend should be supported and incorporated into action by Congress and the Centers for Medicare and Medicaid Services (CMS), as discussed below.

Medicare

In April of this year, CMS announced that 27 organizations had been selected to participate in the Medicare Shared Savings Program (MSSP), also referred to as ACOs. These ACOs are geared toward providing coordinated care and chronic disease management while lowering Medicare program costs, with ACOs sharing in a percentage of achieved savings. The first ACO performance period began on April 1, 2012. These ACOs will serve about 375,000 beneficiaries in 18 states. The total number of organizations participating in Medicare shared savings initiatives thus far is 65, including the 32 Pioneer Model ACOs announced last December and six Physician Group Practice Transition Demonstration organizations that started in January 2011. These programs cover more than 1.1 million Medicare beneficiaries.

In addition to Medicare ACOs, the Center for Medicare and Medicaid Innovation (CMMI) is rolling out a number of alternative payment and delivery models, such as the *Comprehensive Primary Care Initiative*, the *Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration*, and the *Bundled Payments for Care Improvement Initiative*, which would include a model to test gainsharing, wherein payments may be made across Medicare silos as a result of collaborative efforts to improve quality and efficiency among physicians, hospitals, and other providers. The CMMI has also selected 16 practices to participate in the *Independence at Home Demonstration* for testing the delivery of comprehensive primary care services at home for Medicare beneficiaries with multiple chronic conditions.

Further, under the CMMI *Advanced Payment Initiative*, physician-based and rural providers can receive upfront and monthly payments for use in making important investments in their ACO care coordination infrastructure. As of April 2012, five organizations (in NC, KY, NH, FL, and TX) are Advanced Payment ACOs, with more organizations expected to begin this month, as well as in January 2013.

Under the *Health Care Innovation Awards* program, CMS is awarding up to \$900 million toward innovative projects that test new payment and service delivery models to deliver high-quality health care services and lower costs. In a recent announcement of initial awardees, CMS stated that, in this one program alone, the agency received about 3,000 applications across all states. **This demonstrates the significant physician level of interest and readiness to engage in innovative, alternative payment and delivery models.**

Also, the ongoing three-year Acute Care Episode (ACE) demonstration tests the use of a global payment for an episode of care, covering all Part A and B services associated with a patient's inpatient stay. The episodes of care are for specified cardiovascular and orthopedic procedures only, and participating sites must meet procedure volume thresholds, have established quality improvement mechanisms, and be located in Texas, Oklahoma, New Mexico, or Colorado. The demonstration design allows the hospitals to share savings from the efficiencies they are able to achieve with the treating physicians and with patients.

The five-year Physician Group Practice (PGP) demonstration tested incentives for encouraging better care coordination, improving quality, and lowering Medicare expenditures. Ten group practices were competitively selected to participate and after the first year of the PGP demonstration, two of the 10 sites had achieved sufficient savings to receive performance payments from Medicare. By the end of the fourth year, five of the 10 sites were eligible for performance payments. All 10 of the sites were able to meet quality benchmarks.

Joint Private Sector and Physician Initiatives

Numerous and similar innovations are simultaneously being conducted in the private sector. As the Committee heard at its June roundtable discussion, Blue Cross Blue Shield (BCBS) of Massachusetts has developed the *Alternative Quality Contract*. Under this model, a single payment amount is established to cover all costs of care for a population of patients, with adjustments for types and severity of conditions, along with annual bonuses based on the quality of care delivered. UnitedHealth Group (UHG) is also developing these types of contracts, and the AMA is working with UHG on this effort.

Further, Regional Health Improvement Collaboratives bring together stakeholders in a community and provide the data and technical assistance these stakeholders need to design and implement better payment and delivery systems customized to the needs of their communities. Regional collaborative projects currently underway include an accountable medical home program in Washington State and the Maine Health Management Coalition.

Blue Cross Blue Shield of Michigan has developed the *Physician Group Incentive Program* (PGIP), which brings together physician organizations to encourage health care information-sharing and collaboration on initiatives to improve the health care system in Michigan. Each initiative offers incentives based on clearly defined metrics to measure performance improvement and program participation. Participating physician organizations can choose from more than 30

PGIP initiatives, based on: (i) practice improvement efforts (ii) opportunities to standardize treatment and improve outcomes for certain diseases or health conditions; (iii) targeting services or procedures that have a wide variation in practice patterns, tracking of needed services, implementing processing for test tracking and follow-up; and (iv) accelerating the adoption of electronic prescribing or implementing patient registries.

The Geisinger Health System's ProvenCare program provides a bundled payment with a warranty that covers all related pre-admission care, inpatient physician and hospital services, related post-acute care, and care for any related complications or readmissions for an entire 90-day period.

As the Committee heard at its June roundtable discussion, CareFirst's Patient-Centered Medical Home (PCMH) is another innovative program to provide primary care providers with incentives and tools to provide higher quality while lowering the cost of care. Panels that produce a savings against their total global cost-of-care target share in the savings. CareFirst recently announced that of the nearly 3,600 participating primary care providers caring for nearly a million patients, almost 60 percent of eligible PCMH Panels earned increased reimbursements for their 2011 performance.

The AMA strongly supports these Medicare and private sector initiatives and urges their continuation in the future. As these models develop, along with distribution of lessons learned and best practices, physicians can then adapt their practices to these new payment and delivery models as their practices, including those in rural areas, become ready to enroll in a structure that makes the most sense for their specialty, practice type, and patient mix. As discussed further below, there are immediate steps Congress can take to help build on this momentum.

AMA INITIATIVES TO ASSIST IN TRANSITION

The AMA has been actively engaged in developing a number of initiatives to assist the physician community transition to alternative physician payment systems. These initiatives focus on the development and use of quality measures, payment for care coordination, data sharing between physicians and payers, promoting adoption of electronic health records, improving patient safety, and identifying innovative delivery and payment models for distribution to the physician community. The following are some key examples of these AMA initiatives.

- To prepare physicians to utilize data for overall system improvement, the AMA has developed Guidelines for Reporting Physician Data (Reporting Guidelines) to increase physician understanding and use of their cost and quality data for practice improvement. These Guidelines outline a course for health plans and other reporting bodies to standardize the format used for physician data reporting and provide physicians with patient-level detail to enhance the utility of data reports. Implementation of the Reporting Guidelines will enhance the effectiveness of the reports and increase physician understanding and use of the data. The AMA released the Reporting Guidelines in June. UHG has endorsed them and we are actively engaging other payers on these guidelines, including CMS and Blue Cross Blue Shield Association and their member plans. We have also convened workshops to help physicians learn how to analyze claims data to identify opportunities to improve care.
- In June 2011, the AMA formed the Innovators Committee, an advisory group of physicians with hands-on experience in the development, management, and operation of innovative delivery and payment models. The initial group of Innovators has already identified several

novel approaches to improving care delivery, and the AMA is working to disseminate this information to physicians.

- Cloud-based data sharing systems offer the potential to achieve significant quality and efficiency gains for a fraction of the cost of integrated EHRs. A group in Massachusetts has applied cloud-based data sharing and other infrastructure support services to smooth its physicians' transition to global payment models. Most significantly, patients covered under these new models have realized further improvements in quality and efficiency compared to their unmanaged counterparts.
- We also highlight the Virginia Cardiac Surgery Quality Initiative. This program, which represents 17 hospitals and 13 cardiac surgical practices providing 99 percent of the open-heart procedures in the Commonwealth, has achieved dramatic reductions in complications and costs of cardiac surgery for cardiac patients.
- The AMA's CPT Editorial Panel and the AMA/Specialty Society RVS Update Committee (RUC) created a Chronic Care Coordination Workgroup (C3W) to recommend new codes and values to better recognize and pay physicians for care coordination. The C3W also recommended that the CPT Editorial Panel create new coding mechanisms for care transition from the hospital to the community and to describe care management for the complex chronically ill patients. Recommended codes and cost information will be available to the Medicare program to begin payment for these services on January 1, 2013. In the proposed physician fee schedule rule for calendar year 2013, CMS has proposed to provide Medicare coverage for these care coordination services, as recommended by the AMA, and we will support adoption of this coverage in the final physician fee schedule rule.

The AMA has also been urging CMS to consider payment for services provided that are not currently paid for, such as anticoagulation management and team conferences. To date, CMS has not adopted these requests. In the proposed physician fee schedule rule for calendar year 2013, CMS discusses its intention to explore other potential refinements for valuing care coordination services (in addition to the care transition from the hospital to the community proposal discussed above). **We recommend that the Committee urge CMS to adopt these types payment policies that incentivize practice patterns, such as care coordination, that can lead to higher quality and lower costs.**

- The AMA-convened Physician Consortium for Performance Improvement™ (PCPI®), which brings together over 170 organizations, including all disciplines of medicine, other health care professions and quality improvement organization, has developed and made publicly available more than 280 clinical performance measures and specifications, covering 46 clinical areas that account for a substantial portion of Medicare services and spending. Many PCPI measures have already been adopted in both the public and private sectors, including the Physician Quality Reporting System (PQRS) and the Electronic Health Record (EHR) Incentive Program, United Healthcare and Highmark BlueCross BlueShield, and the American Board of Internal Medicine. **Further, the PCPI measure portfolio already includes a growing number of intermediate outcome measures, as well as measures focused on the overuse of care. Ongoing PCPI projects are placing a greater emphasis on the need for patient reported and clinical outcome measures, and measures of health care efficiency to align quality measurement with cost of care.**
- The AMA has developed internal teams to re-focus our work toward improving health outcomes. We seek to ensure health equity, reduce unwarranted variation in care, advance

the quality and safety of the health care delivery system, partner with families and communities to enable healthy choices, and contribute to the appropriate use of finite health care resources.

- The AMA is involved in a project, led by Brandeis University, to define and measure episodes of care that capture the vast majority of Medicare payments and include quality as well as cost data. The results of this project are in part aimed at informing Medicare regarding transitions toward innovative approaches, such as bundled payments and ACOs, that require the aggregation of services into larger units of care.

CONGRESS AND CMS CAN HELP: IMMEDIATE STEPS TO ASSIST IN TRANSITIONING TO NEW MEDICARE PHYSICIAN PAYMENT AND DELIVERY SYSTEM

Congress and CMS can take immediate steps to help transition to a new Medicare physician payment and delivery system. Additionally, existing laws and regulations can be adapted to better facilitate fundamental delivery reform, instead of acting as barriers to reform. Examples are as follows:

- The CMMI should expand the initiatives discussed above, including the payment advances under the *CMMI Advanced Payment Initiative*.
- **Congress should require that CMS and CMMI make opportunities to engage in new models available on a rolling basis so physician practices can plan for the needed changes and join as they become ready.** To date, those wishing to participate in new Medicare payment and delivery reform pilots have had to respond to requests for applications made available on a one-time basis with a short turnaround time. It is difficult to plan ahead for these announcements and organize the projects and resources necessary for a successful proposal. **This will increase overall physician participation in new models, and will significantly aid the transition for small, solo and rural practices.**
- **CMS feedback to physicians must be improved. To help achieve this goal, Congress should require CMS to modernize its Medicare data systems so the agency can bridge significant gaps in efforts to transition to alternative models.** Currently, because of its antiquated data systems, CMS has had great difficulty providing timely incentive payments and feedback reports, as well as actionable, real-time data to physicians that is correctly attributed, appropriately risk-adjusted, and relevant. These are key elements in effectively implementing quality improvement programs. Providing timely data to physicians is critical so they can verify the accuracy of performance reports and more accurately engage in data-driven decision-making.
- **Congress should require CMS to establish models that coordinate Medicare and private payers efforts.** Multi-payer initiatives hold much promise when Medicare and private payers align their programs so physicians can implement reforms in the way they deliver care to all their patients, with a consistent set of financial incentives and quality metrics. **For example, CMMI is doing this now with the Comprehensive Primary Care Initiative to improve care coordination among advanced primary care practices. Congress should require CMS to establish other initiatives, modeled on existing initiatives such as the BCBS Alternative Quality Contract discussed above, that engage physician specialties beyond**

primary care and include a range of settings—in cities and rural areas, and for large and small group practices and solo practitioners.

- **Congress should require CMS to implement certain PQRS improvements.** In 2010, 24 percent of Medicare eligible professionals participated in the program, and 69 percent of those professionals successfully received an incentive payment. Certain steps can be taken to improve these percentages:
 - **Congress could require CMS to reduce the number of measures required for inclusion in a PQRS measures group to a minimum of three measures, rather than four.** This would expand the number of measures groups and allow physicians to further focus quality performance activities on clinical conditions relevant to their practice.
 - **Congress could also provide CMS with authority to establish a process that allows physicians and other eligible professionals to be deemed successful PQRS participants if they successfully participate in other meaningful quality improvement activities.** Some physician practices reporting on specific quality measures to facilitate improved patient outcomes at the local level, through a regional health improvement collaborative or state-initiated health care improvement programs. Many of these efforts have been successful, allowing these practices to appropriately measure and improve upon those health care services and treatments most relevant to their communities, *e.g.*, diabetes, maternity care, HIV. CMS should have the authority to identify a deeming entity, such as Quality Improvement Organizations, that would determine if a physician practice successfully participated in a regional or local quality improvement program. If so, CMS could deem these practices as having met the requirements for the PQRS and meaningful use programs. A deeming process would allow meaningful quality improvement efforts at the regional and local level to move forward unencumbered by conflicting federal requirements.
- **Congress should provide Medicare funding to CMS for quality measure development, testing, and maintenance, along with review and endorsement of measures.** In recent years, Congress has directed CMS to implement various quality reporting and value-based purchasing programs, including for example the PQRS, Physician Resource Use Feedback Program, and Physician Value-Based Payment Modifier. These programs are intended to improve quality of care while helping to transition to a new Medicare delivery and payment structure. The development, testing, and maintenance of evidence-based quality measures, along with measure endorsement and review, are critical aspects of these programs. Development and testing of measures creates a continuous pipeline of measures, including advancement to subsequent generations of measures, such as outcomes or efficiency measures. Measure maintenance is also just as critical to ensure measures remain accurate, evidence-based, and meaningful. Endorsement and review of measures is meaningless without continuous measure development, testing and maintenance, and vice-versa. And, both aspects are critical as we move into a new Medicare payment and delivery structures, rooted in quality and value-based purchasing approaches.
- **Congress should require CMS to establish models that focus on limited bundles for physicians' services or episodes of care (with warranties) and care coordination/case management activities, with limited up-front risk for physicians.** For example, physicians should be able to propose bundled payments for chronic conditions like diabetes,

hypertension, or inflammatory bowel disease even when there is no hospitalization involved. This approach was recommended to the Committee by former CMS Administrators.

- **Certain existing laws and regulations are not compatible with many new payment models.** These laws include the physician self-referral law (or “Stark law”), the federal anti-kickback statute, the civil monetary penalties law prohibiting hospital payments to physicians to reduce or limit services (gain-sharing CMP), and the CMP prohibiting beneficiary inducements. **Congress should waive these laws and regulations when they pose barriers for physicians who seek to engage in and lead innovative delivery models that promote quality, increase coordination, and reduce costs, based on the flexible approach taken by CMS/Office of Inspector General (OIG) for the MSSP. Congress should also require the current waivers for EHRs be made permanent, instead of allowing them to expire in 2013.** Currently, when a hospital provides physician practices with EHR systems, this permissible donation does not run afoul of the Stark law and the Medicare anti-kickback statute under a temporary safe harbor that is in effect through 2013. Congress should make this waiver permanent since this would foster EHR adoption.
- CMS has established 2013 as the performance year for applying 2015 PQRS penalties, citing its own data processing system as an obstacle to calculating performance closer to or during the penalty year stipulated in statute. CMS has also extended this “back dating” policy to the electronic prescribing, meaningful use, and value-based modifier programs, thereby pushing up participation deadlines by up to two years due to CMS’ own administrative data processing issues. This will unfairly subject a significant number of physicians to financial penalties and slow down EHR adoption and implementation rates. **Congress should require CMS to use a performance year that is the same as the actual penalty year. An updated CMS data processing system could enable the agency to use the actual penalty year as the performance period.**
- **In addition, Congress should pass the *Medicare Patient Empowerment Act* (S. 1042 and H.R. 1700), which would establish an additional Medicare payment option to allow patients and physicians to freely contract, without penalty, while allowing patients to use their Medicare benefits.** This would allow patients and physicians to develop their own innovative arrangements that enhance patient care.

The AMA appreciates the opportunity to provide our comments on these critical matters, and we look forward to working with the Committee to repeal the flawed SGR formula and assist in the transition to a new health care payment and delivery system that provides more coordinated care that improves health outcomes and slows the growth of costs in the Medicare program.