Testimony of the American College of Physicians
To the Subcommittee on Health
Ways and Means Committee
On the Medicare Payment Advisory Commission 2006 Report to Congress

March 1, 2006

Introduction

I am C. Anderson Hedberg, MD, FACP, President of the American College of Physicians. The College is the nation's largest medical specialty, with 119,000 internal medicine physician and medical student members. Internists provide primary and subspecialty care to more Medicare patients than any other physician specialty. I appreciate the opportunity to share with the Subcommittee the College's views on the Medicare Payment Advisory Commission (MedPAC) 2006 report to Congress. My comments today will focus on the following:

1. The impending collapse of primary care medicine in the United States and the potential impact of the MedPAC recommendations on slowing or reversing such a collapse.

2. MedPAC's recommendations on the process used by the Centers for Medicare and Medicaid Services to determine and make changes in physician work relative value units that may be overvalued or undervalued.

3. The need to integrate the goal of linking Medicare payments to quality with broader reforms of a dysfunctional Medicare payment system and the College's work to create such reforms.

4. The urgent need to repeal the sustainable growth rate (SGR) and our suggested guidelines for evaluating any alternatives to the SGR that may be recommended by MedPAC or others.

MedPAC's Recommendations and the Impending Collapse of Primary Care

The College is extremely pleased that the Commission's 2006 report to Congress, in the chapter "Valuing services in the physician fee schedule: The five year review" expresses concern about "*the disparities in remuneration between primary care and specialty care, and the implications of these disparities for the future of the physician workforce that will be necessary to meet the chronic care and other needs of Medicare patients*" *[emphasis added].*

The Commission's subsequent recommendations to address the misvaluing of physician services under the Medicare physician fee schedule (MFS) could begin to improve the economic environment for primary care. As the Commission notes, misvaluing of

services can have an impact on physician workforce, because "*over time, if certain types of services become undervalued relative to others, the specialties that perform those services may become less financially attractive, which can affect the supply of physicians.*" We are also pleased that the Commission recognizes that its recommendations on mispricing services are only a first step to the broader reforms that will be needed to assure an adequate supply of primary care physicians, to improve quality, and to reduce the rate of growth in expenditures on physician services.

The Commission's concern about the future of primary care is well supported by evidence on trends in physicians' choice of specialty and demographic changes in the patient population. If anything, the 2006 report *understates* the impact of Medicare payment policies on physician workforce, and particularly, the impact that disparities in remuneration can have on driving physicians away from specialties, like internal medicine and family medicine, that are required to meet the primary care needs of an aging patient population with increased incidences of chronic disease.

Primary care, the backbone of the nation's health care system, is at grave risk of collapse due to a dysfunctional financing and delivery system. Immediate and comprehensive reforms are required to replace systems that undermine and undervalue the relationship between patients and their personal physicians. If these reforms do not take place, within a few years there will not be enough primary care physicians to take care of an aging population with increasing incidences of chronic diseases. The consequences of failing to act will be higher costs, greater inefficiency, lower quality, more uninsured persons, and growing patient and physician dissatisfaction.

Demographic changes will require more primary care physicians:

- General internists and other primary care physicians are at the forefront of managing chronic diseases, providing comprehensive care and coordinated long term care. Yet, 45 percent of the U.S. population has a chronic medical condition and about half of these, 60 million people, have multiple chronic conditions. For the Medicare program, 83 percent of beneficiaries have one or more chronic conditions and 23 percent have five or more chronic conditions. Within 10 years (2015), an estimated 150 million Americans will have at least one chronic condition.

- Within the next decade, the baby boomers will begin to be eligible for Medicare. By the year 2030, one fifth of Americans will be above the age of 65, with an increasing proportion above age 85. The population age 85 and over, who are most likely to require chronic care services for multiple conditions, will increase 50 percent from 2000 to 2010.

- Among adults ages 80 and older, 92 percent have one chronic condition, and 73 percent have two or more. In 2000, physicians spent an estimated 32 percent of patient care hours providing services to adults age 65 and older. If current

utilization patterns continue, it is expected that by 2020, almost 40 percent of a physician's time will be spent treating the aging population.

- It is anticipated that the demand for general internists will increase from 106,000 in 2000 to nearly 147,000 in 2020, an increase of 38 percent.

Unfortunately, there will not be enough primary care physicians to meet this increased demand:

- Over the past several years, numerous studies have found that shortages are occurring in internal medicine and family medicine. Factors affecting the supply of primary care physicians, and general internists in particular include excessive administrative hassles, high patient loads, and declining revenue coupled with the increased cost for providing care. As a result, many primary care physicians are choosing to retire early. These factors, along with increased medical school tuition rates, high levels of indebtedness, and excessive workloads, have dissuaded many medical students from pursuing careers in general internal medicine and family practice.

- A recent study of the career plans of internal medicine residents documents the steep decline in the willingness of physicians to enter training for primary care. In 2005, only 20 percent of third-year internal medicine residents planned to pursue careers in general internal medicine compared to 54 percent in 1998. Among first-year internal medicine residents, only 13 percent planned to practice general internal medicine.

- A 2005 survey of internal medicine physicians who received their board certification in the early 1990s found that 21 percent of those who were practicing general (primary care) internal medicine have left internal medicine practice entirely, compared with only 5 percent of subspecialty internists who reported that they have left their subspecialty.

- More than 80 percent of graduating medical students carry educational debt. The median indebtedness of medical school students graduating this year is expected to be $120,000 for students in public medical schools and $160,000 for students attending private medical schools. About 5 percent of all medical students will graduate with debt of $200,000 or more. Studies show that students with the highest debt are the least likely to choose primary care.

Congress should be concerned about a collapse of primary care because it will result in higher health care expenses and lower health care quality:

- When compared with other developed countries, the United States ranked lowest in its primary care functions and lowest in health care outcomes, yet highest in health care spending.

- Studies have shown that primary care has the potential to reduce costs while still maintaining quality. Not only does early detection and treatment of chronic conditions play a vital role in the health and quality of life of patients, but it can also prevent many costly and often fatal complications when illnesses such as diabetes and cancer are diagnosed at a later stage. As expert diagnosticians, providing patient-focused, long-range, coordinated care, general internists play a significant role in the diagnosis, treatment and management of chronic conditions. It has been reported that states with higher ratios of primary care physicians to population had better health outcomes, including mortality from cancer, heart disease or stroke.

- States with more specialists have higher per capita Medicare spending. An increase in primary care physicians is associated with a significant increase in quality of health services, as well as a reduction in costs.

- Primary care physicians, including general internists, have been shown to deliver care similar in quality to that of specialists for conditions such as diabetes and hypertension while using fewer resources.

- The preventive care that general internists provide can help to reduce hospitalization rates. Studies of certain ambulatory care–sensitive conditions have shown that hospitalization rates and expenditures are higher in areas with fewer primary care physicians and limited access to primary care.

- Strengthening primary care may also result in more appropriate use of specialists. For example, patients receiving care from specialists for conditions outside their area of expertise have been shown to have higher mortality rates for community-acquired pneumonia, congestive heart failure, and upper gastrointestinal hemorrhage.

The College is aware that MedPAC has not found evidence that patients are currently experiencing widespread access problems. We believe that there are areas of the country where Medicare patients' access to primary care services has already declined, even if national surveys do not have enough locality-specific responses to show an overall access problem. Most importantly, a snapshot of current access trends is not a reliable predictor of how access will be affected in the future if Medicare continues to undervalue payments to primary care physicians at the same time that it continues to cut payments to all physicians because of the flawed sustainable growth rate (SGR) formula. The data on changing demographics and workforce trends that point to an impending collapse of primary care are far better indicators of potential future access problems than surveys of current beneficiaries' experiences.

Improving the Process for Valuing Physician Services

The College supports the Commission's recommendations for improving the process for valuing physician services under the MFS. We believe that the Commission's

recommendations could help reduce the economic disincentive for physicians to practice in primary care specialties. Misvalued services contribute to the differentials that are undermining primary care in several ways.

First, there is evidence that services that are overpriced are ordered more frequently and may contribute to an increase in the total volume of services, which in turn, can trigger reductions in payments to all physicians—including primary care physicians—under the SGR formula.

Second, because the SGR limits the extent to which aggregate physician spending can increase, the combination of mispriced relative values and volume means that certain types of services are capturing a larger share of Medicare spending, to the detriment of evaluation and management services provided principally by primary care physicians.

Third, specialties that provide services that are overvalued are more likely to have higher overall earnings, while specialties that provide services, such as evaluation and management services, that are undervalued are likely to have lower overall earnings. This continued earnings disparity is a major reason why young physicians are not going into primary care while many older physicians are leaving primary care medicine.

For these reasons, the College supports the Commission's recommendations for improving the process of valuing physician services, but our support is predicated on maintaining the current requirement that all reductions in work RVUs that result from this process must be put back into the total RVU pool. The College would strongly oppose a process that results in reductions in the work RVUs for some procedures in order to achieve Medicare budget savings, since this would also make it impossible to redistribute the changes resulting from such revisions back into the services that are undervalued under the current MFS.

Specifically, ACP supports the recommendation that the Secretary should establish a standing panel of experts to help CMS identify overvalued services and to review recommendations from the American Medical Association (AMA)-Specialty Society Relative-value scale Update Committee (RUC). The group should include members with expertise in health economics and physician payment, as well as members with clinical expertise. The Congress and the Secretary should ensure that this panel has the resources it needs to collect data and develop evidence.

As the Commission envisions it, the expert panel would play a regular role in the process, particularly at the beginning when CMS is seeking to identify misvalued services. The panel would review the codes that CMS's data analyses identified as potentially misvalued and consider which services warranted further consideration by the RUC. The panel would then develop additional evidence providing support for correction, for example, by conducting its own provider surveys. This supporting evidence would then be forwarded to the RUC for RUC evaluation. To ensure that the panel has sufficient expertise in considering whether services are misvalued it should include representatives from CMS's network of carrier medical directors, experts in medical economics and

technology diffusion, private payer plan representatives, and a mix of physicians, particularly ones that are not directly affected by changes to the Medicare physician fee schedule, such as those employed by managed care organizations or academic medical centers.

The College strongly supports the RUC process and believes that the RUC should maintain its primary role in advising CMS on the relative value units (RVUs) assigned to physician services in the MFS. Medical specialty societies have the best understanding of the work involved in the services provided by physicians in their specialties. The RUC has adopted rules and processes that assure that any recommendations that go forward to CMS are supported by at least two-thirds of the RUC members and are based on survey and other standards to assure that the recommendations are supported by evidence. CMS has consistently shown confidence in the strength and accuracy of the RUC's recommendations by accepting the vast majority of them.

We concur with the Commission's view, however, that the RUC, *by itself*, is not well-positioned to identify work values that may be too high. Because the recommendations that go to the RUC principally come from membership-based specialty societies, it is not surprising that specialty societies rarely suggest that some of the services that their own members provide may be overvalued. It is also difficult for specialty societies to identify services done by other specialties that may be overvalued. CMS itself lacks the internal expertise to identify work RVUs that may be too high. The expert panel recommended by MedPAC could play a valuable role in starting the process of identifying potentially overvalued services, while maintaining the RUC's essential role as the expert body that then evaluates the work RVUs recommended for review.

The College has several suggestions for improving the MedPAC recommendation for an expert panel. In addition to physicians who are employed by managed care organizations or academic medical centers, it is essential that the panel include representatives of physicians in small practices, most of who continue to practice in a fee-for-service environment. The reason is that carrier medical directors and physicians in academic centers or MCOs will have little or no direct experience with the impact of Medicare's valuation of services on running a small primary care practice or the work involved in taking care of patients with multiple chronic diseases.

Consideration should be given to including a member of the RUC on the expert panel in a liaison or observer capacity. It will also be important for the expert panel to operate in the open (public meetings), to solicit comments from specialties and the RUC, and to share the supporting evidence for any recommendations it makes relating to misevaluation of services. Should the expert panel disagree with a recommendation from the RUC, it should provide a clear explanation, with supporting data, on why.

The Commission's report also acknowledges a concern expressed by ACP and others that physicians who furnish primary care services are not represented adequately on the RUC. It calls on the medical community to propose changes in the composition of the RUC, states that it is aware that the AMA and physician specialty societies are having ongoing

conversations about the composition of the RUC, and states that it intends to continue to monitor this issue.

The College agrees with the Commission that the RUC should re-examine its current composition to assure balanced and appropriate representation and expertise from all specialties, and we specifically have suggested to the RUC that it should revise its composition to better reflect measures of each specialty's contributions to care of Medicare patients. For instance, data on the percentage of Medicare Part B evaluation and management (E/M) services allowed and/or percentage of overall Medicare Part B allowed expenditures, could be accepted as proxies for determining how many seats that a particular specialty would have on the RUC. The College anticipates that such a review would lead to an absolute and proportionate increase in primary care representation in the RUC. The RUC should also review its existing criteria (as well as the revised membership criteria that would result from adoption of the above) to assure that it is consistently applied to specialties already on the RUC, as well as to additional specialties asking for membership. This would address concerns from some specialties that the RUC has applied a different standard for specialties that already have permanent seats on the RUC to those applying for seats.

The College believes that the RUC itself should consider the above recommendations, rather than having them imposed by CMS or by Congress. One of the important attributes of the RUC is that it is a private-sector body that has an informal advisory relationship with CMS; as such, the RUC makes its own rules. Therefore, the responsibility for changing its rules lies with the RUC itself. However, MedPAC and CMS should provide appropriate oversight and guidance to the RUC as it examines its composition. We are pleased that the chair of the RUC has expressed a commitment to call on the RUC to re-examine its composition and a willingness to keep MedPAC informed about the results.

The RUC finalized its recommendations on the E/M services in early February 2006. The College and other medical specialty societies originally asked CMS to include evaluation and management services in the Five-Year Review because we believe that there is compelling evidence that many of the services were undervalued as the physician work had increased over the 10-year period since they were last reviewed. CMS agreed to include the E/M codes in the Five-Year Review. The College then worked with the RUC to develop recommendations for the E/M service codes. We are unable to discuss the specific RUC recommendations because of the RUC's confidentiality policy, but we are able to inform the Subcommittee on Health that we support the RUC's recommendations on E/M services. The RUC has now sent all of its Five-Year Review E/M recommendations to CMS. The Subcommittee on Health, if interested, could likely obtain the specific RUC recommendations directly from CMS. The College will be urging CMS to assure that the MFS final rule for 2007 includes increases in the work RVUs for evaluation and management services commensurate with the evidence on increased patient complexity and physician work associated with such services.

The College also supports the following improvements in the process of reviewing relative work values as recommended by MedPAC:

- *The Secretary, in consultation with the expert panel should initiate the five-year review of services that have experienced substantial changes in length of stay, site of service, volume, practice expense, and other factors that may indicate changes in physician work.*
- *CMS should institute automatic reviews of work relative values for selected new services after a specified period of time. The Commission's recommendation reflects the expectation that the work involved in furnishing many new services will change over time. The Secretary would initiate, after a specified period, reviews of the work relative values for selected recently introduced services. Where appropriate, services should be assessed by the RUC as soon as is practicable; reviews should not be postponed until an upcoming five-year review.*
- *CMS should also assess established services for which the newly introduced services are substitutes. As the use of newly introduced services grows, the type of patients using the established services could change.*
- *CMS should work with the RUC to review relative values established more than 15 years ago that have not since been examined by the RUC and that, as a result, may no longer reflect current medical practice.*

One of the original premises behind the resource based relative value scale (RBRVS) is that the physician work associated with a procedure or technology is often greater when it is first introduced, and few physicians have acquired the technical skills required to provide the procedure, than later on when its use has become widely accepted and the "learning curve" associated with providing it has decreased. The current processes have not been effective in identifying services whose work RVUs may decrease over time. The College believes that the Commission's recommendations are a reasonable way to trigger RUC review of services whose work may change over time.

As noted above, it is essential that any reduction in "misvalued" procedures be redistributed into the total budget neutral relative value pool instead of being used to achieve budget savings. Otherwise, there would no way for undervalued evaluation and management services to benefit from the redistribution that would result from reducing the work RVUs for overvalued procedures. Using the RUC and the new expert panel to identify procedures whose payments should be cut by CMS or Congress to achieve overall budget savings would undermine the support, credibility, and validity of the entire process for determining the value of physician work and lead physicians to question the fundamental fairness and accuracy of the RBRVS and the MFS.

Alternatives to the SGR

The College urges Congress to replace the SGR with an alternative that will assure sufficient and predictable updates for all physicians and be aligned with the goals of achieving quality and efficiency improvements and assuring a sufficient supply of primary care physicians. At a minimum, Congress should enact legislation to replace the

2007 SGR cut, estimated to be 4.6 percent, with a positive update. The College supports the Commission's recommendations for a 2007 Medicare fee schedule update based on the Medicare Economic Index, but recommends that further analyses be given to the assumption that the update should be lowered to reflect gains in physician productivity.

We appreciate that leadership shown by Chairman Johnson in seeking repeal of the SGR, and the role that this subcommittee played in getting legislation enacted to reverse the 4.4 percent SGR cut in 2006.

The SGR cuts payments to all physicians, but is especially detrimental to primary care physicians in small practices who already are under-reimbursed and have very low practice margins. The SGR does not control volume and, in fact, cuts payments without regard to the quality or efficiency of care provided by an individual physician. The SGR cuts also deprive physicians in primary care practices of the resources needed to invest in health information technology and quality improvements. It cuts payments for major surgical procedures and primary care services that have experienced lower volume growth by the same amount as procedures that have experienced higher volume growth.

First, Congress must enact additional legislation this year that would avert SGR cuts in 2007 and stabilize payments as a pre-cursor to legislation that would lead to a permanent replacement of the SGR formula no later than calendar year 2007.

Second, CMS, MedPAC and Congress should work with ACP and other medical organizations to develop a long-term alternative to the SGR. Key principles for this longer-term solution include:

- Separate physician fee updates from measures of per capita GDP
- Assure that the update formula is aligned with creating incentives for quality measurement and reporting and allow physicians to share in system-wide savings from quality improvement and coordination of patients with multiple chronic diseases
- Reflect increases in physician practice costs, including resources associated with acquiring health information technology to support quality improvement.
- CMS and Congress should also work with the College and other medical organizations to establish a process to address volume concern issues through a combination of encouraging adherence to evidence-based clinical measures through reporting and pay-for-performance, use of efficiency or cost of care measures, correcting mispricing of physician services under the Medicare fee schedules, addressing geographic variations in quality and cost through increased use of evidence-based guidelines and measures linked to financial incentives, and asking MedPAC to make recommendations regarding suspected inappropriate service/procedure-specific volume increases.

The College supports MedPAC's recommendation for a 2.8% MFS update in 2007 based on the Medicare economic index. We believe though that there should be further analysis of the productivity adjustment being recommended by the Commission. The Commission's view is that physician productivity has increased and that this should be

factored into the update. The College questions the strength of the analysis to support this assumption. Studies and anecdotal reports from physicians indicate that as physicians incorporate electronic health records and quality measurement and reporting in their practices, the impact, at least in the early stages of adoption, is to reduce productivity, not increase it. We also question why the productivity adjustment for physicians is much higher than the productivity gains assumed for hospitals, when there is no evidence or reason to believe that physicians are achieving greater productivity gains than hospitals.

Linking Payments to Quality

The College continues to strongly support reforms to link Medicare payments to quality. We commend Chairman Johnson for her leadership on developing legislation to begin linking payments to quality. In July, the College was pleased to endorse Chairman Johnson's Medicare Physician Value Based Purchasing Act of 2005. We continue to support the bill, but we also recommend that the Subcommittee on Health consider a legislative framework that would go beyond grafting pay-for-performance on the current dysfunctional payment system to one that would create sufficient and sustained incentives for quality improvement, efficiency, and physician-directed coordination and management of care for patients with multiple chronic diseases.

Specifically, we recommend that legislation to link payments to quality be aligned with the larger goals of reforming the payment system based on the following framework:

- The longer-term goal should be to replace the current payment system with new methods of reimbursement that reward physicians who follow evidence-based standards and take on the responsibility of coordinating care for patients with chronic diseases.
- Pay-for-performance (P4P) incentive payments should reflect the level of work and commitment to quality, which will differ among physicians and across specialties.
- P4P systems should rely on valid and reliable clinical measures, data collection and analysis, and reporting mechanisms.
- The value of health information technology should be recognized in the performance-based payments.
- Potential P4P rewards should be significant enough to support continuous quality improvement, directed at positive--not negative—rewards, and be balanced between rewarding high performance and substantial improvement over time.
- Medicare P4P should enable physicians to share in system-wide savings (such as from reduced Part A hospital expenses) resulting from quality improvement.
- Adding an additional portion of reimbursement on top of the current dysfunctional payment system will not achieve the desired results.

ACP believes that Medicare pay-for-performance, if done correctly, can lead to improvements in reimbursement for primary care physicians while improving quality and lowering costs. The College has released a new position paper on "Linking Payments to Quality" (http://www.acponline.org/hpp/link_pay.pdf) that provides a framework for

developing and implementing a Medicare pay-for-performance program that would recognize and support the value of care coordination and quality improvement by a patients' primary care physician. A key conclusion in this paper is that pay-for performance must be done in conjunction with other reforms to fix Medicare's dysfunctional payment system, including those described above, rather than grafting it onto a system that rewards volume and episodic care over quality and physician-directed care coordination.

ACP believes that a Medicare P4P program will have to be supported by redistribution of funds among and across different geographic locations, health care professionals, and even among the College's own members on the basis of quality. It is, therefore, critical that, in providing rewards for physicians who commit to redesigning their practices to support quality improvement, the level of work and commitment involved should be recognized through differential payments. Basing incentives on effort assures that physicians who expend a disproportionately large amount of time and resources trying to improve quality and meet more complex measures, such as those who effectively manage patients with multiple chronic diseases, are recognized and rewarded accordingly. This is especially critical for the internist, whose ability to provide better care at lower costs through effective management of patients has been historically under-valued.

Redistribution of payments is only a small aspect of a larger issue that must be confronted before a system that rewards physicians for quality improvement can be effective: the dysfunctional physician payment system. The current reimbursement system is fragmented and episodic in nature, leading to enormous inefficiencies. Physicians are paid a standard fee regardless of the quality of their care, which discourages innovations, coordination, and practice improvement. The current system must be replaced with new methods of reimbursement that reward those who follow evidence-based standards of care.

The College realizes that designing a fair, credible, and effective P4P program is a challenging and complicated task. P4P is comprised of many aspects, including the development and selection of appropriate performance measures, the integration of acceptable methods of data collection and reporting, and an equitable determination of incentives. Within each of these categories are a set of unintended consequences that must be carefully monitored and reconciled. ACP also realizes that in the short-term, P4P programs may actually increase utilization of more effective but currently under-utilized treatments, thereby raising costs rather than reaping savings. As new systems of payment linked to performance are being explored, it is crucial that the right measures are used, that data collection is accurate and reasonable, that appropriate and adequate financial incentives are provided, and that quality—not just cost reduction—is always the overriding measure of success. The access-to-care problems that disadvantaged and severely ill patients may encounter, if P4P programs lead physicians to avoid sicker or non-compliant patients, must also be carefully monitored.

The College continues to be a leader in developing quality measures that could be incorporated into a program to link Medicare payments to quality. Although we initially

had concerns about number and validity of some of the measures that CMS proposed for the Physicians Voluntary Reporting Program, we have since reached an understanding with CMS that physicians should begin by reporting on a smaller set of measures that are aligned with those approved by the Ambulatory Care Quality Alliance (AQA). The College has since urged our members to strongly consider participating in the PVRP. We continue to be an active participant in the AQA through our leadership in the AQA's steering committee and through the extensive commitment of time that our volunteer physicians and staff have given to the AQA's work groups on performance measurement and data aggregation and reporting. The College also strongly supports and participates in the AMA's Consortium for Performance Improvement. We commend the AMA for its decision to invest more resources in the Consortium and for the AMA's commitment and leadership to work through the consortium to develop a starter-set of evidence-based performance measures for all specialties that could be incorporated into a voluntary reporting program as early as 2007. We believe that the timeline for developing measures for all specialties as recommended by the AMA and the Consortium is reasonable and achievable.

Creating Incentives for Physician-Guided Care Coordination

The College is pleased the Commission's work plan includes consideration of models for improving the care of patients with chronic diseases. We specifically urge the Commission and Congress to work with us to pilot test a new model for organizing and delivering primary and principal care that addresses the fact that the U.S. health care system is poorly prepared to meet the current, let alone the future health care needs of an aging population.

This model, called the advanced medical home model, is based on the premise that the best quality of care is provided not in episodic, illness-oriented, complaint-based care, but through patient centered, physician-guided, cost-efficient, longitudinal care that encompasses and values both the art and science of medicine.

Attributes of the advanced medical home include promotion of continuous healing relationships through delivery of care in a variety of care settings according to the needs of the patient and skills of the medical providers. Physicians in an advanced medical home practice are responsible for working in partnership with patients to help them navigate the complex and often confusing health care system. They provide the patient with expert guidance, insight and advice, in language that is informative and specific to patients' needs. In the advanced medical home model, patients will have a personal physician working with a team of health care professionals in a practice that is organized according to the needs of the patient.

Physician practices would apply for voluntary certification that they have met the standards to be listed as a qualified advanced medical home. Although the standards and certification process still need to be fully developed, ACP envisions that qualified practices will have the following kinds of services in place:

- Primary care physicians who practice in an advanced medical home would be responsible for partnering with the patient to assure that their care is managed and coordinated effectively.
- The practice would use innovative scheduling systems to minimize delays in getting appointments.
- Physicians in the advanced medical home would use evidence based clinical decision support tools at the point of care to assure that assure that patients get appropriate and recommended care.
- They would partner with patients to help patients with chronic diseases, like diabetes, manage their own conditions to prevent avoidable complications. Patients would have access to non-urgent medical advice through email and telephone consultations.
- The practice would have arrangements with a team of health care professionals to provide a full spectrum of patient-centered services.
- Advanced medical home practices will also be accountable for the care they provide, by using health information technology to provide regular reports on quality, efficiency, and patients' experience measures.

The advanced medical home is the way that most primary care doctors want to deliver care to their patients, and what most patients want from their physicians. It can only work, though, if Medicare and other payers develop and implement new ways of paying physicians that recognize the value of care coordinated by a personal physician. A revised reimbursement system would acknowledge the value of both providing and receiving coordinated care in a system that incorporates the elements of the advanced medical home model. Further, such a system would align incentives so physicians and patients would choose medical practices that deliver care according to these concepts. Physicians would elect to redesign their practices because the model is supported by enhanced reimbursement for system-based care in the advanced medical home, rather than the volume-based, episodic, fee-for-service system currently in place. Patients would select an advanced medical home based on service attributes such as the patient centeredness of a practice, improved access, and coordinated care – as well as value attributes as demonstrated by publicly available reports on quality and cost.

Pilot testing is crucial before the Advanced Medical Home model can be implemented nationwide. A pilot test would permit exploration of the model's applicability, reliability, strengths, weakness and identification of potential unintended consequences. The College recommends that the Subcommittee ask the Centers for Medicaid and Medicare Services (CMS) to conduct a national pilot program in 2007 to determine the feasibility, cost effectiveness and impact on patient care of the advanced medical home in a variety of primary care settings. This effort should specifically address the advanced medical home model, but would complement ongoing and planned CMS pilot programs such as the Medicare Physician Group Practice Project, the Medicare Care Management Performance Demonstration (MMA Section 649), and Medicare Health Support Pilot (MMA Section 721) and Medicare Health Quality Demonstration Program (MMA Section 646). The College will also explore testing of this model with commercial payers.

Conclusion

The College applauds the Medicare Payment Advisory Commission for its willingness to recommend improved ways for valuing physician services, for its commitment to address the reimbursement disparities that are contributing to the collapse of primary care, for its work on developing new models for physician-directed care coordination, and for the leadership it has shown on linking Medicare payments to quality. We applaud Chairman Johnson for her outstanding leadership on advocating for a halt to the SGR cuts and for proposing a way to link Medicare payments to quality that would gradually phase-in reporting of quality data and provide safeguards against unintended adverse consequences.

Although we are supportive of the specific recommendations made by the Commission for improving the process for valuing physician services, we also believe that more fundamental reforms of Medicare payment policies will be needed, including replacing the SGR with alternatives that provide positive updates to all physicians and that are aligned with the goals of creating incentives for continuous quality improvements and physician-guided are coordination. We urge the Commission and the Subcommittee on Health to work with us and other physician groups to reach agreement on a framework that would fundamentally change the way that we reimburse physicians to recognize the value of the patient's relationship with a personal physician who is working in systems of care, such as the advanced medical home, that are centered on patients' needs. Such fundamental reforms are essential, we believe, to prevent the impending collapse of primary care medicine and to assure that current and future beneficiaries have access to high quality and affordable care.

I would be pleased to answer any questions.