

September 25, 2006

Institute of Medicine  
500 Fifth Street NW  
Washington DC 20001

Re: Rewarding Provider Performance: Aligning Incentives in Medicare

The American College of Physicians (ACP), representing over 120,000 physicians specializing in internal medicine and medical students, would like to offer the Institute of Medicine (IOM) comments on its report, *Rewarding Provider Performance: Aligning Incentives in Medicare*. ACP appreciates that the IOM's report highlights the deficiencies of the current Medicare physician payment system and lays out a series of thoughtful recommendations for implementing a pay-for-performance (P4P) payment program within the Medicare program.

As the IOM notes, the current Medicare payment system is broken. Its incentives fail to ensure that care meets professionally recommended quality standards, is centered on individual patients' needs, and is delivered efficiently. P4P represents one mechanism that can help transform the payment system into one that rewards both higher value and better outcomes. However, attention must be given to the design of a P4P system, since it could influence far more than just payment rates.

ACP's response to the specific issues raised in the IOM report, *Rewarding Provider Performance: Aligning Incentives in Medicare*, are included below.

#### Selection of Measures

The IOM states that quality measures initially may have to be narrow to encourage provider participation, but should evolve over time to provide more comprehensive and longitudinal assessments of providers and systems. The IOM also suggests that performance measures that relate to Medicare's spending patterns within each care setting should initially be emphasized.

ACP agrees that measures to improve clinical quality should focus on those clinical conditions that have the greatest impact on our health care system. We also believe that robust evidence-based clinical measures of quality will have a greater impact than simple and basic cross-cutting measures that would be broadly applicable to all physicians. Specifically, we recommend that a voluntary Medicare pay-for-reporting program start with the "high impact" measures that address the disease conditions that are most prevalent in Medicare, are among the most expensive to treat, and sensitive to reductions in avoidable hospitalizations by improving management of care in the ambulatory setting.

ACP also recommends that performance measures should be evidence-based, broadly accepted and clinically relevant; should focus on those elements of clinical care over

which physicians have direct and instrumental control; and should be built on statistical methods that provide valid and reliable comparative assessment across populations. It is critical that clinical measures be developed, endorsed, and selected for implementation through a multi-stakeholder process. Validation and selection for implementation by a multi-stakeholder process will assure that the measures meet criteria related to strength of the evidence, transparency in development, and consistency in implementation and reporting across Medicare and other payers.

Most importantly, programs that link payments to quality must be carefully designed to assure that they achieve the desired outcomes. If implemented incorrectly, P4P programs could have unintended but adverse consequences on patients. It is particularly important that the program include safeguards to take into account differences in the “case mix” being seen by a particular physician and in patient populations that may be less compliant because of demographics, culture, or economic factors. Otherwise, physicians who are treating a greater proportion of sicker or less compliant patients could be penalized with lower payments. This in turn could create an unacceptable conflict between a physician’s ethical and professional commitment to take care of all patients and the financial incentives created by participating in a P4P program to avoid seeing sicker or less compliant patients.

### Reporting

IOM also calls for public reporting and transparency of provider quality, stating that providers initially should be given financial incentives for publicly reporting such data. P4P programs should not impose excessive administrative reporting burdens on practices. The IOM also recommends that P4P programs should explore options for getting health care information technology to providers to strengthen the use of performance measures.

ACP agrees that data collection and reporting can offer insight into how a physician practices medicine compared with his or her peers and illustrate trends in care that may not have been realized by a physician during everyday practice. Reporting can also provide valuable information to the consumer. To encourage broad physician participation across all modes of practice, ACP recommends that data collection should be administratively feasible, reliable, practical, and consistent. Physicians should also be given the opportunity to comment on data before it is reported publicly. Particular attention should be paid to the obstacles faced by safety net providers, physicians in small practices, and physicians just entering practice. It is also critical that data collection not violate patient privacy. For instance, patient identifiers should be removed before data is reported publicly.

ACP believes that information technology tools should be used whenever possible to facilitate data acquisition and to minimize any manual data extraction. Medicare payment policies should provide sustained support for physicians’ efforts to acquire information technology and engage in quality improvement and measurement activities. ACP feels that Congress should direct Medicare to provide higher payments to physicians who acquire and use health information technology to support quality measurement and

improvement and authorize separate payments for e-mail and telephonic consultations that can reduce the need for face-to-face visits.

### Implementation

The IOM recommends that Medicare phase in performance-based payment systems for its providers over three to five years. While those health care providers who are able to transition to P4P immediately should be given the opportunity to do so, more time may be needed for other, small providers, such as physician offices. However, P4P could begin for this group immediately if it were voluntary. The initial set of measures and the pace of expanding measures will need to be sensitive to the operational challenges confronted by providers in small practices. The IOM recommends that within three years, the Secretary of the U.S. Department of Health and Human Services (HHS) should determine whether progress toward universal participation by physicians is sufficient under the voluntary approach or whether stronger actions—such as mandating provider participation—are required.

ACP agrees with the IOM that P4P should be phased in gradually to allow physicians to obtain the capabilities and experience in measuring and reporting performance based on accepted measures. As the IOM highlighted, although 100 P4P programs have been implemented in recent years, fewer than 20 studies have assessed their impact, necessitating gradual implementation of P4P in Medicare. Phased implementation would allow for an orderly transition from reporting on structural measures to enhanced payment based on achieving outcomes on evidence-based clinical measures. It would also give providers who have not yet developed quality indicators more time to participate in a P4P program and would create a learning system that has the capacity to monitor and assess early experiences, adjust for unintended consequences, and evaluate impact.

Because of the unique challenges associated with a Medicare P4P program, ACP recommends that initial payments to participating physicians should be based principally on the reporting of limited structural measures, rather than evidence-based clinical measures. Structural measures can be defined as tools and health information technologies that have the capability to support physicians' efforts to improve, measure, and report on the quality of care provided to beneficiaries, improve care coordination of patients with chronic diseases, reduce medical errors, and/or deliver care consistent with evidence-based guidelines of quality and appropriateness. During this initial stage, all physicians who report their structural capabilities should receive the same level of reward.

As the IOM suggested, Medicare should not wait until measures are developed and accepted for all physicians before the initial stages of a Medicare P4P program can begin. As long as all physicians are guaranteed a positive update by statute and the program is voluntary, P4P should begin with those physicians who provide care for conditions where clinical measures have already been developed and validated. At the same time, P4P programs should not punish those who are unable to report on the initial measures. ACP

greatly appreciates that the IOM recognizes the challenges faced by physicians in small practices.

In the second stage, ACP recommends that payments should be based on voluntary participation in a program that uses evidence-based measures. Payment in this stage would not be based on how well a physician performs, but instead on a physician's willingness to report on selective measures.

By the third stage, a program would provide graduated bonus payments to physicians who demonstrate success in meeting evidence-based clinical performance measures.

This "crawl-walk-run" approach to developing a P4P program recognizes the need to improve health system quality as soon as possible, but at the same time, to derive insights from each stage for ongoing improvement.

### Rewards

The IOM recommends that Medicare should design a P4P program that rewards health care that is of high clinical quality, patient-centered, and efficient. Rewards should also recognize improved coordination of care across providers, across health care settings, and during entire episodes of illness. Two performance benchmarks should be used when distributing P4P awards: improvement in meeting quality standards and excellence in meeting or exceeding those standards. However, awards allocated for improvement should be phased out over time, leaving rewards only for high performance.

ACP supports the use of incentives to promote physician quality of care as evaluated through evidence-based performance measures. P4P programs should incentivize *all* physicians to perform better, continually raising the bar on quality. The reward framework should be designed to permit and facilitate broad-scale positive behavior change and achievement of performance goals within targeted time periods. Similar to the IOM's recommendations, ACP recommends that potential rewards should be:

- Significant enough to drive desired behaviors and support continuous quality improvement;
- Reflect the cost and other resources needed to participate in a P4P program;
- Balanced between rewarding high performance and rewarding substantial improvement over time;
- Graduated to create stronger incentives for physicians to participate in performance improvement programs and to ensure that a physician's level of commitment to quality improvement activities is recognized;
- Directed at positive rather than negative rewards; and
- Timely and followed closely upon the achievement of performance.

### Funding

According to the IOM, the current Medicare payment system discourages physicians from organizing care processes to achieve optimal results for patients and places no

emphasis on whether care delivered is of high or low quality. The current system tends to reward excessive use of services, high-cost complex procedures and lower-quality care; reimburses physicians for the treatment of illnesses and injuries; and promotes the use of technology but does not reimburse physicians for patient education or other measures that might reduce costs over time. The current system also does not reimburse for coordination of care for Medicare beneficiaries who receive treatment from several different providers and does not provide financial incentives to encourage providers to invest in improvements in the overall health of beneficiaries.

Taking into consideration these and other constraints, the IOM examined three potential sources of funding for a P4P program in Medicare: 1) existing funds; 2) generated savings; and 3) new money. It looked at each in terms of fairness, stability, adequacy, and impact. The generated savings model would create a reward pool through cost-reducing reforms and efficiencies. However, these efficiencies have not yet been adequately demonstrated. The new funds model would tap the Medicare Trust Funds or call for a separate appropriation of general revenue. However, Congress and private purchasers may not be willing to increase the total amount of money that they are spending on health care beyond what they are currently projected to spend.

The IOM ultimately recommended that over the next three to five years, funding for a P4P program should largely come from existing funds, with provider-specific pools derived from reductions in Medicare's base payments. These pools should be large enough to create adequate motivation for improvement, yet be budget conscious. Once feasible, the separate pools should be consolidated into one pool to be distributed to all qualified providers. Because physicians currently face unique challenges due to the SGR, the IOM noted that new investment dollars may also be necessary to create adequate resources to effect change.

ACP ideally would like to see the appropriation of new funds to support quality improvement efforts. However, ACP acknowledges that under the current fiscal environment, where new funding is unlikely, P4P will have to be supported by a 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. Savings that result from preventing avoidable hospital admissions or readmissions, for example, may be redistributed to physicians. Funds that result from reductions in spending in geographic areas that have higher per capita expenditures but rank near the bottom in quality indicators may be funneled to providers in areas that rank higher on quality indicators but have lower per capita expenditures.

There is growing evidence that improved care in the ambulatory setting can reduce avoidable hospitalizations and other expenses under the Medicare program. However, Medicare's Part A and Part B payment "silos" make it impossible for physicians to share in system-wide cost savings from organizing their practices to reduce preventable complications and avoidable hospitalizations. Congress can begin to break down such silos by mandating that a portion of savings that are attributable to physicians' quality

improvement efforts would be redirected back to the physicians' performance improvement fund, allowing it to grow over time.

Redistribution will require a careful re-examination of existing payment inequities across specialties, particularly those that devalue the critical role played by internists in delivering patient-centered and physician-guided care coordination of patients with multiple chronic diseases. In recognizing the challenges involved, ACP recommends that redistribution should be approached with fairness to all, be driven by quality, provide opportunities for "less efficient" clinicians to improve their own quality and resource use rather than simply cutting their payments, and be sufficient to address existing payment inequities that undermine and devalue certain specialties.

Like the IOM, ACP recognizes that implementation of a P4P program under Medicare likely will improve health care quality but might not reduce costs. However, ACP also believes that a program that begins to link payments to quality would create incentives for physicians to provide care that meets evidence-based standards of practice, identify both over- and under-utilized services, and result in quality improvements and eventual cost efficiencies.

ACP thanks the IOM for recognizing the unique challenges currently faced by physicians due to the SGR. In recent public statements, ACP has called for an overall redesign of payment policies to support models of health care delivery that result in better care of patients. This process must include replacing the sustainable growth rate (SGR) formula, which has been wholly ineffective in restraining inappropriate volume growth and has led to unfair and sustained payment cuts, with a formula that accurately reflects increases in the costs to physicians of providing services. It also must include changes in payment policies to support patient-centered, physician-guided care management based on the advanced medical home (AMH) model. Under the AMH model, primary care physicians would partner with patients to ensure that all of their health care is effectively managed and coordinated by identifying key quality indicators to demonstrate continuous improvement and by using electronic health records and other health information technologies.

Like the IOM, ACP recognizes that P4P is just *one* of many mechanisms that can help transform the payment system into one that rewards both higher value and better outcomes. For P4P to reach its intended goals, the overall payment must undergo much broader reforms. Only after the SGR is replaced *and* the underlying payment methodologies are reformed to support high quality and efficient care will physicians have clear incentives to organize their practices to improve quality and provide care more efficiently.

### Monitoring/Evaluation

The IOM recommends that HHS should implement a monitoring and evaluation system to: assess early experiences with P4P, so any necessary corrective action could be taken; evaluate the impact of P4P on clinical quality, patient-centeredness and efficiency; and

identify the best practices of high-performing delivery settings that could be shared by providers.

ACP agrees that P4P programs should incorporate periodic, objective assessments of measurement, data collection, scoring, and incentive systems to evaluate its effects on achieving improvements in quality, including any unintended consequences. Additional research on the individual strengths and weaknesses of different types of measures and on appropriate ways to aggregate, score, and report data will enhance physician trust in the program and maximize quality improvement.

## **Conclusion**

As the IOM stated in its report brief:

The health of senior citizens in the United States is not as good as it should be, given the billions of dollars spent on health care each year. This raises concerns that Medicare is not getting the best value for the services it purchases. Medicare's current payment system places no emphasis on whether the care delivered is of high or low clinical quality or is appropriate...provides few incentives for overuse of often high cost medical services and does little to encourage coordinated, preventive, and primary care that could save money and produce better health outcomes.

ACP thanks the IOM for drawing attention to the root of the problem—the dysfunctional payment system—and identifying a possible solution. P4P offers a way to speed the process of implementing best practices by rewarding providers for delivering high quality care. However, careful attention must be paid to the design of P4P programs to prevent unintended consequences, such as discouraging physician from treating sicker or less compliant patients. Furthermore, the incentives offered through P4P are not sufficient to achieve the broad institutional and behavioral changes needed to improve quality and lower costs. Medicare payment policies require a bold new framework that promotes appropriate utilization of services based on evidence-based guidelines of care; fosters physician-guided, patient-centered care coordination; and reduces inequities and variations in payments, quality and volume of services. ACP looks forward to working with the IOM to find the most effective ways to improve the quality of care.