ACP
AMERICAN COLLEGE OF PHYSICIANS
INTERNAL MEDICINE | *Doctors for Adults*®

April 17, 2013

The Honorable Dave Camp
Chairman, Committee on Ways and Means
U.S. House of Representatives
Washington, DC 20515

The Honorable Fred Upton
Chairman, Energy and Commerce Committee
U.S. House of Representatives
Washington, DC 20515

Dear Chairmen Camp and Upton:

On behalf of the American College of Physicians (ACP), I appreciate this opportunity to respond to your request for comments on the second iteration discussion outline, as released on April 3rd to repeal the sustainable growth rate (SGR) and reform the Medicare physician payment system. We applaud you for your leadership in addressing the flawed SGR and for your initiative in working to advance a solution with input from physicians, physician organizations, and other stakeholders. Overall, the College supports the intent of your proposal to move toward a more stable, effective and efficient physician payment system, something we agree is absolutely necessary. However, ACP would like to provide some recommendations for the Committees to consider as they further develop this proposal.

ACP is the largest medical specialty organization and second-largest physician group in the United States, representing 133,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum, from health to complex illness.

Proposal - Phase I: Stable Predicable Updates

SGR will be repealed so that it will not determine the payment update in any future year. Providers will receive stable, predictable fee schedule updates that are set in statute for a period of time sufficient to support the policy objectives contained within the proposal. These updates will apply to all providers. This will allow providers the time to develop quality and efficiency measures as well as clinical improvement activities that are key to Phase II and Phase III. This stable period will also afford providers time to assess the applicability of private sector and Medicare alternative payment models.

ACP Comments

ACP supports a phased approach, along the lines of what is outlined in the Energy and Commerce and Ways and Means Committees' proposal. ACP similarly has proposed a legislative framework that consists of two phases that were outlined in our response to your first iteration proposal.[1]

[1] ACP's full response to the first iteration of this proposal (dated February 25, 2013) can be found at: http://www.acponline.org/acp_policy/letters/gop_sgr_framework_proposal_as_released_by_the_ways_means_energy_commerce_committees_2013.pdf.

We note that the committees' second iteration proposal does not specify what the payment rates will be during the first phase, nor its duration. ACP recommends that during the first phase of your proposal (1) all physician services should receive a positive update and (2) undervalued evaluation and management services, whether delivered by primary care physicians or by other specialists, should receive an additional annual update above the baseline for all other services. We believe such incentives are critical to improving care coordination and addressing historical payment inequities that contribute to severe shortages in internal medicine, family medicine, internal medicine subspecialties, neurology, and other fields that principally provide evaluation and management services. We also recommend that this initial phase be no less than five years in duration. This overall sustained period of stability is needed to ensure access to care, while allowing time for Medicare to work with physicians to test, disseminate, and prepare for adoption of new patient-centered payment and delivery models.

The necessity of providing higher updates for undervalued evaluation and management services has broad support within the medical community and from independent experts. The National Commission on Physician Payment Reform, co-chaired by former Senate Majority Leader Bill Frist and Steven Schroeder, MD, MACP, recommended that "For both Medicare and private insurers, annual updates should be increased for evaluation and management codes, which are currently undervalued." It notes that,

> "Time spent on services performed under evaluation and management (E&M) codes is reimbursed at lower rates than time spent providing services under procedure codes. The undervalued E&M services at issue are often those that provide preventive health and wellness care, address new or undiagnosed problems, and manage chronic illnesses. The current skewed physician payment system causes a number of problems, such as creating a disincentive to spend time with patients with complex chronic conditions; leading physicians to offer care for highly reimbursed procedures rather than lower-reimbursed cognitive care; neglecting illness prevention and disease management, which tend to be cognitive in nature; and inducing medical students to choose procedural specialties over evaluative ones. While the discussion about reimbursement has generally focused on services performed by primary care physicians, *the commission believes that the real issue is not one of relative payment of specialists versus primary care physicians but, rather, of payment for E&M services as contrasted with procedural services.* These include E&M services provided by, among others, cardiologists, endocrinologists, hematologists, infectious disease specialists, neurologists, psychiatrists, and rheumatologists." (Emphasis added in italics).[2]

Similarly, the National Commission on Health Care, a multi-stakeholder organization representing business, consumers, purchasers, payers, and providers, recommended that "the overall proposal [to replace the SGR, stabilize payments and transition to value-based models] must encourage and reward primary care while enabling primary care providers to work effectively with specialists."[3]

The Commonwealth Fund, in its recent proposal to replace the Medicare SGR formula with a new system focused on value, also recommended that "As part of a new method of setting and updating physician

[2] The full report can be accessed at: http://physicianpaymentcommission.org/wp-content/uploads/2013/03/physician_payment_report.pdf.
[3] The full NCHC report can be accessed at: http://nchc.org/sites/default/files/NCHC%20Plan%20for%20Health%20and%20Fiscal%20Policy.pdf.

payment rates, Medicare would raise payments for primary care services, which are currently undervalued relative to more specialized services."[4]

Ensuring higher updates for undervalued evaluation and management services is also a key feature of the bipartisan *Medicare Physician Payment Innovation Act*, H.R. 574, introduced by Representatives Allyson Schwartz (D-PA) and Joe Heck (R-NV). The legislation, similar to your proposal, provides a viable and reasonable pathway to full SGR repeal and implementation of new value-based models of care that focus on quality of care, as opposed to volume of care -as occurs under the current payment system. H.R. 574 is supported by ACP and dozens of other medical specialty societies, representing both primary care and non-primary care medical specialties. Your second iteration proposal achieves most of the same policy goals of H.R 574, including eliminating the SGR, stabilizing payments, and establishing a clear pathway to patient-centered, value-based models, but lacks a policy of improving payments for undervalued primary, preventive and coordinated care services

We strongly urge the committees to similarly incorporate a policy of providing higher updates for undervalued evaluation and management services.

ACP appreciates that this second iteration proposal notes that the stable, predictable fee schedule updates will allow providers the time to assess the applicability of private sector and Medicare alternative payment models. **However, ACP further recommends that physicians be able to qualify for higher updates during this initial phase if they successfully participate in a transitional value-based payment or approved quality improvement initiative—rather than waiting until Phase II as the draft currently proposes.** In our previous testimony before the Energy and Commerce Health Subcommittee on July 18, 2012[5]—and reiterated in our statement for the record on February 14, 2013,[6] as well as in our response to the earlier draft of this proposal on February 25, 2013—we outlined a set principles for developing a transitional quality improvement (QI)/value-based payment (VBP) program. Therefore, we ask that the committees take those principles into consideration as they continue to develop this proposal.

Proposal – Phase II: Portion of Payment Based on Quality through Update Incentive Program (UIP)

Questions for Phase II:

- How should the Secretary address specialties that have not established sufficient quality measures?
- Is it appropriate to reward improvement in quality over time in addition to quality compared to peers?
- Are there sufficient clinical practice improvement activities relevant to your specialty? If not, does your organization have the capability to identify such activities and how long would it take?
- Should small practices have the ability to aggregate measurement data to ensure that there are adequate numbers of patient events to reliably measure performance? If so, how?

[4] The Commonwealth Report can be accessed at: http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2013/Mar/1678_Guterman_paying_for_value_ib.pdf.

[5] ACP's complete testimony can be found at: http://www.acponline.org/acp_policy/letters/innovation_reform_medicare_2012.pdf.

[6] ACP's full statement for the record can be found at: http://www.acponline.org/advocacy/where_we_stand/assets/statement_for_the_record_ec_health_hearing_sgr_2013.pdf

ACP Comments:

- How should the Secretary address specialties that have not established sufficient quality measures?

ACP believes that all specialties need to be engaged in programs that will result in measurable improvements in quality. To ensure a level playing field, no specialty should be exempted from having its performance measured or held to a higher or lower standard than any other. Dozens of externally validated measures already are applicable to and are widely in use for internal medicine specialists. Specialties that have not developed or incorporated such clinical measures and/or obtained external validation for them should be given reasonable but not open-ended time to incorporate or create such measures; in the interim, the Secretary should ensure that in order to qualify for higher updates, such specialties be able to participate in robust programs to achieve measurable gains in patient safety, quality, and effectiveness, such as by participating in patient registry programs that meet certain standards to ensure that they meaningfully "raise the bar" on quality, programs to reduce medical errors, programs to encourage high value care and cost-conscious care, or programs aligned with their own specialty board's Maintenance of Certification performance and practice improvement efforts.

- Is it appropriate to reward improvement in quality over time in addition to quality compared to peers?

Yes, we believe that it is appropriate to reward improvement in quality over time in addition to quality compared to peers, although we also believe that those physician who have shown that they are able and willing to achieve an even higher level of performance, earlier than some of their peers, should be able to qualify for appropriately higher updates. Any comparison of performance compared to peers must be carefully adjusted to reflect differences in the complexity of the patient population being treated and especially, ensure that it does not disadvantage physicians who are taking care of underserved patient populations who may be at greater risk of poor health and outcomes.

- Are there sufficient clinical practice improvement activities relevant to your specialty? If not, does your organization have the capability to identify such activities and how long would it take?

As noted above, there are many dozens of externally validated measures that apply to internal medicine and its subspecialties.

While ACP does not independently develop performance measures, the College is deeply involved in the critical review and provision of comments on performance measures developed by other organizations. The goal is to ensure that the measures are based on high quality clinical evidence. For example, ACP comments on measures pertinent to Internal Medicine that have been submitted to the National Quality Forum (NQF) for consideration for endorsement. ACP also reviews performance measures that are currently under development or endorsement at national organizations like the NCQA, CMS, and the American Medical Association Physician Consortium on Performance Improvement. Furthermore, ACP reviews performance measures related to ACP's Clinical Guidelines, Guidance Statements, and Best Practice Advice papers.

More specifically, the College is strongly encouraging CMS and others to facilitate the development of care coordination measures. In particular the new transitional care management service (TCM) codes established in the 2013 Medicare Physician Fee Schedule, as well as the complex chronic care coordination (CCCC) service codes being considered by CMS, provide an important opportunity to test care coordination measures through registries and encourage overall innovation in the measure

development process. These types of measures will serve internal medicine, its related subspecialties, and many other specialties well as we move toward more robust value-based payment programs.

In terms of specific quality improvement efforts focused on clinical practice improvement, including for small practice settings, ACP is helping primary care clinicians apply the distilled scientific and clinical data to their everyday practice through registries, practice improvement programs, and technologically advanced tools including tablet- and smart phone-based applications. Patient registries, which involve a systematized method for collecting patient-based data that are often used to help clinicians understand and improve their practice, are being developed and applied by ACP.

- In partnership with the New York-ACP Chapter and Dr. Ethan D. Fried, MD, MS, MACP (the Vice Chair for Education and Residency Training Program Director, in the Department of Internal Medicine at St. Luke's-Roosevelt Hospital and Associate Professor at Columbia University's College of Physicians and Surgeons), ACP's Center for Quality is being certified as a Patient Safety Organization (PSO), as it nationally expands a registry of "near miss" events, by which physicians and their teams can examine instances in which patient safety was put at risk but averted, so as to understand the factors that contribute to and protect from risks.
- In partnership with the American College of Cardiology, ACP is piloting the PINNACLE Registry for primary care. The PINNACLE Registry not only interfaces with various EHR systems, but also has received the designation of EHR data submission vendor (DSV) permitting submission of PQRS data to CMS, linking quality improvement to pay-for-performance.
- ACP is piloting *MedConcert™,* the first multi-tenant cloud-based platform for QI, including registry, performance measure calculation, and secure communication capabilities. Multiple options for uploading registry data, including data from EHRs and administrative claims databases are permitted with *MedConcert™*. Educational and quality improvement resources are tagged to specific performance gaps on this platform.

Beyond registries, ACP's newly formed Center for Quality is revitalizing its network of physician-quality improvement champions, known as ACPNet. Including nearly 2,000 internists nationwide, this practice-based research network (PBRN) is being surveyed about the methods by which quality improvement and research in the real-world environment can be more readily integrated into the busy practice environment, including the whole medical team. While PBRNs emerged as a tool for understanding real world practice, a still important goal, they are becoming a resource for identifying, testing, and rapidly spreading powerful quality improvement strategies.

The College would again like to reiterate our support for measures and measure strategies to be thoughtfully aligned with – and where possible leverage – the regular practice assessment, reporting and quality improvement activities that individual physicians already are required to undertake as part of their specialty board Maintenance of Certification (MOC). For example, the American Board of Internal Medicine (ABIM), which is the largest of the certifying boards, includes in its MOC program a suite of quality measurements, reporting and improvement tools specifically focused on patient-centered primary care/specialist communication, and will soon introduce a care coordination module developed by several of the experts who also helped shape the Medical Neighbor concept, discussed below. Aligning PCMH/N practice accreditation standards with professional MOC assessment and improvement activities will send a powerful signal to physicians about the significance of the PCMH model, reduce redundant reporting requirements and facilitate participation by smaller practices. This alignment would also provide a means of accounting for changes or advancements in quality and improvement activities and of educating physicians on the benefits of such quality measures and clinical improvement activities. In 2012, ACP released a paper titled, *The Role of Performance Assessment in a Reformed Health Care System*, in which we laid out a series of policy statements focused on the evolving

roles of performance assessment efforts within the realm of medical care, including programs linking payments to reporting and performance on specific quality measures. We discussed several of those statements in our response to the committees' first iteration of this proposal.

Although ACP agrees with the goal of encouraging the development of performance measures applicable to all specialties, it is essential that this not result in specialty specific "siloed" efforts, but one that is part of a national strategy for quality improvement. **The development, validation, selection, refinement, and integration of performance measures should be a multilevel process that takes advantage of the most recent scientific evidence on quality measurement and have broad inclusiveness and consensus among stakeholders and in the medical and professional communities.** This entire process should be transparent to the medical community. Measures should be field-tested to the extent possible prior to adoption to ensure their viability in the medical setting and applied as part of overall payment and delivery system reform emphasizing collaborative system-based health care. In addition, ACP recommends the measurement targets remain patient centered and reflect potential differences in risk/benefit for specific populations. For example, targets for the frail elderly frequently differ from younger patients. **All measures, whether developed by a specialty society or other experts, should go through the National Quality Forum's (NQF) multi-stakeholder evaluation process. ACP would not support creation of a pathway to allow measures to be accepted by Medicare without such validation.** ACP encourages the committees to ensure that there is stable and sustainable financing for the NQF as the trusted validator for quality measures, as recommended by the Stand for Quality proposal.[7]

- Should small practices have the ability to aggregate measurement data to ensure that there are adequate numbers of patient events to reliably measure performance? If so, how?

Yes, ACP is supportive of small practices having the ability to aggregate their data in order to ensure the validity of their data. The committees should take advantage of the experience being gained in how to reliably measure performance in small practices through both public and private patient-centered medical home programs. The CMS Innovation Center is heading up the Comprehensive Primary Care Initiative (CPCi)[8], which is a collaboration between private and public payers and primary care practices to support patient centered primary care. The CPCi currently involves nearly 500 practices in 7 regions across the country. The application for payer participation in the CPCi[9] suggests an approach to data sharing between practices and CMS and other participating payers that could be more broadly applicable to other efforts by smaller practices to reliably measure and report on performance:

> "The Innovation Center will monitor the program on a continuous basis with performance and outcome "gates" for practices at six month intervals:
>
> - At six months – practices provide documentation that key implementation infrastructure (e.g., staff, equipment, etc.) is in place. This might be accomplished through a practice readiness assessment survey.
> - At 12 and 18 months – payers sharing data with the practices, practices reporting measures and on improvement path. This might be accomplished through tracking practice participation in learning Sessions.

[7] The full Stand for Quality Proposal can be accessed at: http://www.standforquality.org/draftlegnarrative_91212.pdf

[8] More information can be found on the CPCi at: http://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/

[9] The full solicitation for payer participation in the CPCi can be found at: http://innovation.cms.gov/Files/x/Comprehensive-Primary-Care-Initiative-Solicitation.pdf

- At 24 months, and every 6 months thereafter – practice Medicare patients' cost and utilization trends compared to market target and an evaluation of process and quality measures."

The application also notes that:

> "In addition to recruiting practices for the intervention, we may also recruit practices for a comparison group for evaluation purposes. In constructing a comparison group, providers will be selected in a deliberate way so that they match the awardees along a variety of measurable dimensions, including but not limited to provider and market specific characteristics."

The CMS Innovation Center is also engaged in the Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration[10]—a project that preceded CPCi release, but is similar in concept regarding the facilitating of PCMH implementation in small to medium sized practices. This state-based initiative required participation by multiple payers in order to obtain Medicare participation—including Medicaid and a substantial majority of the private health plans offering coverage in both the group and individual health insurance market in the area. Additionally, the Adirondack Region Medical Home Pilot,[11] which is a partnership between private and public payers in upstate New York, includes more than 40 small practices and has a significant focus on the collection and aggregation of data to improve care and contain costs for several high-risk, high-frequency chronic conditions (diabetes, hypertension, coronary artery disease and asthma).

It is also important to note here that participation in quality reporting programs as part of a reformed fee-for-service system or in alternative models, particularly for small practices, should be facilitated by reducing administrative barriers, improving bonuses to incentivize ongoing quality improvements for all physicians, and broadening hardship exemptions. Additionally, it will be important for Congress to hold CMS accountable for ensuring that viable options for participation in these programs are available for all physicians in all specialties, so that physicians are not subject to penalties because the agency was unable to develop an appropriate and workable model for them. The committees should further create a limited exemption from participation in a reformed fee-for-service or alternative models for providers who are incapable of transitioning, perhaps because they are late in their careers.

Proposal – Phase III: Reward for Efficient Resource Use

Questions for Phase III:

- How much time is needed to refine the methodology for determining and attributing efficient use of health care resources?
- Is it preferable to only have a payment implication based on efficiency for providers that meet a minimum quality threshold?

[10] More information can be found on the MAPCP at: http://innovation.cms.gov/initiatives/Multi-Payer-Advanced-Primary-Care-Practice/

[11] More information on the Adirondack Region Medical Home Pilot can be found at: http://www.adkmedicalhome.org/home/

ACP Comments:

In 2011, ACP released a policy paper titled, *How Can Our Nation Conserve and Distribute Health Care Resources Effectively and Efficiently?*,[12] which included a number of recommendations that the committees' should consider when determining how best to reward for efficient resource use. One of the main recommendations in this report was that sufficient resources should be devoted to developing needed data on clinical and cost-effectiveness of medical interventions for comparative, evidence-based evaluations that should serve as the basis for allocation decisions about the utilization of health care resources.

Along these lines, the College has for a number of years recognized the need for the establishment of an adequately funded, trusted national entity to prioritize, sponsor, and/or produce comparative effectiveness information—clinical information that physicians and their patients can use to engage in a robust shared-decision process regarding healthcare needs. The College's position is summarized in a policy paper titled, *Improved Availability of Comparative Effectiveness Information: An Essential Feature for a High-Quality and Efficient United States Health Care System*.[13] Many of the elements outlined in that paper have come to fruition with the implementation of the Patient Centered Outcomes Research Institute (PCORI) as part of the Affordable Care Act (ACA) of 2010. The College remains actively involved in the PCORI process through the provision of feedback and comments informed by an Expert Panel of ACP members with national recognition and expertise in this area.

Additionally, in April 2010, ACP announced its High Value Care Initiative[14], which includes clinical, public policy, and educational components. The overall purpose of the initiative: to help physicians and patients understand the benefits, harms, and costs of an intervention and whether it provides good value, as well as to slow the unsustainable rate of health care cost increases while preserving high-value, high-quality care.

ACP has also joined other leading professional medical organizations in the Choosing Wisely campaign,[15] which complements our High Value Care Initiative. An initiative of the ABIM Foundation, the goal of the Choosing Wisely campaign is to promote thoughtful discussions among physicians, patients, and other stakeholders about how to use health care resources to improve quality of care.

With regard to the specific measurement of efficiency by clinicians, the College recommends that measure sets must primarily focus on improving patient outcomes, gauging the patient-centeredness of a practice, and improving the coordination of care across all providers. The College maintains that efficiency—or "value-of-care" measures—must be based on an objective assessment of evidence on the effectiveness of particular treatments, with both cost and quality taken into consideration. Value-of-care measures must appreciate the nuances of physician care and must not compromise the patient–physician relationship. Stakeholders must also work to develop population health measures designed for specific populations.

[12] This paper can be accessed at: http://www.acponline.org/acp_policy/policies/conserve_distribute_health_care_resources_2011.pdf
[13] This paper can be accessed at: http://www.acponline.org/acp_policy/policies/improved_availability_healthcare_system_2008.pdf
[14] More information on the ACP High Value Care initiative can be found at: http://hvc.acponline.org/
[15] More information on the Choosing Wisely campaign can be found at: http://www.choosingwisely.org/

Proposal – Provider Opt-Out for Alternate Payment Model (APM) Adoption

Questions for APM Adoption:

- What do you believe will be necessary to support provider participation in new payment models?
- What is a reasonable time frame for CMS to approve and adopt APMs?
- Should providers be able to participate in more than one payment model?

ACP Comments:

As was outlined in our testimony before the Energy and Commerce Health Subcommittee on July 18, 2012—and in our statement for the record on February 14, 2013, as well as in our response to the first iteration of the committees' proposal—**ACP strongly believes that the Patient-Centered Medical Home (PCMH) and Patient-Centered Medical Home Neighborhood models are ready to be a part of a new, value-based health care payment and delivery system, given all of the federal, state, and private sector activity to design, implement and evaluate these models.**

The NCQA, acknowledging the importance of the involvement of the "medical neighborhood" in support of PCMH (primary) care, initiated in March 2013 a "medical neighbor" recognition process that identifies specialty and subspecialty practices that engage in activities supportive of the PCMH model—with particular emphasis on care coordination and integration. Several areas of the country are also involved in testing and implementing the PCMH neighborhood concept, including: the Vermont Blueprint for Health program, the Texas Medical Home Initiative, and programs in both the Denver and Grand Junction areas of Colorado.

Also, as noted in our earlier feedback, ACO development is also rapidly occurring throughout the country in both the public and private sector. Therefore, it should also be considered part of a new value-based payment and delivery system.

ACP recognizes that a one-size fits all approach is not ideal and therefore believes that moving toward alternative delivery system and payment models can be done in parallel with reforming a post-SGR fee-for-service system to incentivize improved care coordination and better reflect the quality of care provided, particularly for those physicians and specialties for which FFS is better suited. Physicians should not be limited to only one payment model—the focus should be on the right mix of incentives that support the ability of physicians and patients to spend more appropriate clinical time together.

In fact, allowing physicians to spend appropriate clinical time with their patients—time spent learning about them and their families and home life, listening to them, uncovering the reasons for their symptoms, explaining the clinical issues, developing an appropriate treatment plan, and engaging their patients in shared decision-making—is at the very essence of the patient-physician relationship and should therefore be an explicit goal of payment reform.

Proposal – Improvements upon Current Law

Questions for Current Law Improvements:

- What improvements upon current law do you believe will be required to support alternate payment model adoption?
- What improvements upon current law will help ease the administrative burden upon medical providers and allow more time caring for Medicare beneficiaries?
- What improvements upon current law would support the provision of quality health care delivery for Medicare beneficiaries?

ACP Comments:

ACP strongly believes that a specific goal of payment reform should be to reduce the time that physicians must spend in administrative tasks that do not improve patient care or outcomes; at a minimum, they should not add to the administrative burden.

As policymakers develop new payment and delivery models aligned with "value" to the patient, they must recognize that among the values that patients hold dearest is having enough clinical time with their physicians and among the values physicians hold dearest is being able to spend appropriate clinical time with their patients. Indeed, as noted earlier and discussed in more detail in our feedback on the first iteration of this proposal, allowing physicians to spend appropriate clinical time with their patients is at the very essence of the patient-physician relationship. Yet discussion of new and improved payment models often appears at best to be indifferent to how their incentives might support or devalue physicians' and patients' clinical time together.

ACP does support the use of existing QI programs such as Medicare PQRS, e-RX, and meaningful use programs. However, we do share the significant concerns expressed by many organizations that these programs are burdensome and currently not well-aligned with one another, with private payer initiatives, or with specialty boards' maintenance of certification programs. In our recent State of the Nation's Health Care report, the College recommended that Congress and CMS work with physicians to encourage participation in quality reporting programs by reducing administrative barriers, improving bonuses to incentivize ongoing quality improvements for all physicians, and broadening hardship exemptions. If necessary, Congress and CMS should consider delaying the penalties for not successfully participating in quality reporting programs, *if* it appears that the vast majority of physicians will be subject to penalties due to limitations in the programs themselves. This report also called for CMS to harmonize (and reduce to the extent possible) the measures used in the different reporting programs, working toward overall composite outcomes measures rather than a laundry-list of process measures.

Further, the College encourages the Committees to consider the initiatives of the CMS Innovation Center—discussed in greater detail in our previous feedback—which is working to align federal, state, and private payer payment and deliver system reform efforts.

Finally, as the United States transitions to models where physicians will be held more accountable for the outcomes of care, not the processes they follow to get there, the quid pro quo should be a dramatic reduction in clinical "micro-management" by third-party payers and government. If physicians can show that they can achieve high-quality and cost-effective outcomes and positive patient experiences with the care provided, based on good and readily reportable composite measures, there is little or no justification for pre-authorization requirements, detailed documentation of each code and encounter, and post-payment second-guessing of clinical decision-making.

The College appreciates this opportunity to share its recommendations on the discussion outline, as released on April 3rd, to repeal the sustainable growth rate (SGR) and reform the Medicare physician payment system and looks forward to working with you to address these critical issues. We provide this

feedback to you in the interest of being constructive and appreciate your willingness to consider our recommendations. Please contact Richard Trachtman at rtrachtman@acponline.org or 202-261-4538 if you have any questions or would like additional information.

Sincerely,

Molly Cooke, MD, FACP
President, American College of Physicians