ACP
American College of Physicians
Internal Medicine | Doctors for Adults

September 23, 2011

Glen M. Hackbarth, JD
Chairman
Medicare Payment Advisory Commission (MedPAC)
601 New Jersey Avenue, N.W.
Suite 9000
Washington, DC 20001

Dear Chairman Hackbarth:

On behalf of the 132,000 internal medical physicians and medical student members of the American College of Physicians (ACP), I am writing to provide the Medicare Payment Advisory Commission (MedPAC) with feedback on and recommendations for your proposal to repeal the Sustainable Growth Rate (SGR) system. **While ACP appreciates that MedPAC has put forward a comprehensive proposal to eliminate the SGR with the intent of protecting access to primary care for Medicare beneficiaries, we have very substantial concerns that preclude us from supporting it. We offer the following comments in a constructive effort to develop a framework that would have our full support.**

We are specifically concerned that the proposal will not adequately protect and ensure access to primary care, while also reducing access to other essential physician services. It will also work against MedPAC's goal, which we share, of transitioning to new delivery and payment models aligned with value.

ACP has long been a proponent of eliminating the SGR and transitioning to new payment models, and we recognize that doing so will come at a significant initial cost—of approximately $300 billion over ten years. ACP recently sent a letter to Congress' Joint Select Committee on deficit reduction that proposes hundreds of billions of savings by promoting high value care and by changing payment incentives for physicians and patients. We also outlined other socially and fiscally responsible changes in Medicare cost-sharing, tax policies, Medicare Part D program, and other policies that the Congressional Budget Office, Commission on Fiscal Responsibility and Reform, and other experts agree could reduce spending by enough to fund repeal of the SGR and allow for continued funding of critical health programs to ensure access to care.

While MedPAC developed its proposal in the same spirit as we did for ours—recognizing the importance of identifying potential savings that are sufficient to fund SGR repeal and moving to new payment models aligned with value—we believe that MedPAC's proposal has a fundamental flaw:

> **Although elimination of the SGR is an essential step toward new payment and delivery models, it is only a step—and one that should be designed carefully so as**

not to result in unintended and undesirable consequences. The College is concerned that the payment freezes and cuts outlined in the MedPAC recommendations will have a significant adverse effect on beneficiary access to care, and actually impede timely and effective implementation of new physician payment models.

Specifically, the MedPAC proposal includes a freeze in payments for some services provided by some primary care physicians for the next 10 years, and a nearly 17 percent reduction—followed by a freeze—for all other physician services. We have the following concerns about this approach:

1. **With a freeze, primary care payments would continue to lose value due to inflation**. Given the fact that Medicare fee schedule conversion factor today is essentially the same as ten years ago, this would be a second "lost decade" when payment increases do not keep pace with costs, resulting in a net reduction.
   - With average overhead of more than 60% percent for most primary care practices, a freeze in Medicare payments will result in significant income declines or decreased access for Medicare patients. We anticipate that more primary care physicians will give up their practices and join hospital-based models. Primary care physicians with patients who can afford to pay more will increasingly turn to concierge practices, compounding access problems for other patients. Other patients will enroll in Medicare Advantage plans.

2. Many primary care physicians who would qualify under the MedPAC proposal (i.e., who are designated as primary care specialists and whose primary care E/M charges are 60 percent or more of total billings) also provide ancillary services that would be subject to the nearly 17 percent cut over the next three years. It also is unclear if their hospital visits would be defined as primary care services or subject to the nearly 17 percent cut.
   - Given the historic and continued under-valuation of primary care services, many primary care physicians—especially in smaller practices—depend on such ancillary services to stay in practice. Such ancillary services provide patients with convenient, one-stop-shopping access at the same time as their office visit.
   - It is not clear from the Commission's proposal if hospital visits would be included in the definition of designated primary care services, even though continuing to see patients in the hospital is a hallmark of comprehensive primary care. If they are not, hospital visits too would be subjected to the nearly 17 percent cut over the next three years, even when provided by an otherwise eligible primary care physician.
   - **Applying a nearly 17 percent cut to hospital visits and ancillary services by primary care physicians would be devastating to many internal medicine practices.** For example: if 40 percent of a primary care internist's Medicare revenue comes from ancillary services, and 60 percent from the designated primary care services, then this physician would be subjected to a real cut of approximately 6.8 percent (before inflation) in total Medicare revenue over the next three years under the Commission's proposal.

3. This two tiered system for defining eligible primary care physicians and designated services by specialty and percentage of **billing may leave out many primary care**

internists who truly provide comprehensive primary care, because their ancillary services and/or hospital visits combined make up more than 40 percent of their total Medicare billings.

- This will especially be the case if their hospital visits are not included as "designated primary care services"—as was the case with the original proposed rule on the Primary Care Incentive Payment, which uses a framework similar to the MedPAC proposal for defining primary care physicians and services.
- CMS originally proposed to count both hospital visits and ancillary services against satisfying the 60 percent of designated primary care services threshold to qualify for the bonus, which would have resulted in the exclusion of large numbers of primary care internists.
- CMS later agreed to make significant changes in the final rule so that ancillary services paid outside of the Medicare physician fee schedule and hospital visits no longer would count against a physician qualifying for the bonus.
- Yet we are concerned that MedPAC's current proposal, by maintaining a similarly cumbersome framework for defining which physicians and services would qualify as primary care, would result in many primary care internists not qualifying for a differential primary care update.

4. **The nearly 17 percent cut in payments to non-primary care specialists will adversely affect patient access to care to physicians in every other specialty, including specialties that are facing substantial workforce shortages, and without any evidence to justify that such a cut is merited, appropriate, or serves important policy goals**:
   - "Non-primary care" physicians would be cut without any evidence that their specific services are over-valued by any objective measure.
   - They would be cut no matter how efficient or inefficient the care they provide to patients. (Actually, the nearly 17 percent cut would hurt the most efficient physicians the most, because they tend to generate lower volume of services and therefore have less fee-for-service revenue.)
   - They would be cut even if they voluntarily participate in new payment models, like Accountable Care Organizations (ACOs), bundling payments, Patient-Centered Medical Homes (PCMHs), registries, or other quality improvement programs.
   - They would be cut whether they practice in a high or low cost area of the country.
   - They would be cut regardless of whether their specialty is facing a projected shortage. For instance, general surgery is projected to have severe workforce shortages, yet all general surgeons would be subject to the nearly 17 percent cut. The same is true of many internal medicine subspecialties facing shortages.
   - Internal medicine subspecialists, including those that provide principally "cognitive" services (e.g. endocrinology, rheumatology, infectious disease), would be particularly adversely affected by these cuts. Such subspecialists, like their primary care internal medicine colleagues, also are adversely affected by the historic undervaluation of their cognitive services. They would be cut even though they provide a significant amount of comprehensive principal care to Medicare patients that need their particular expertise. They would be cut even though they often

provide primary care to a substantial number of patients for whom they have taken full responsibility for all of the patient's health care needs.

5. **The MedPAC proposal will unintentionally undermine the goal of transitioning to new payment models aligned with value.**
   - Primary care physicians will not have the resources to invest in practice redesign and transformation because the updates for primary care physicians will not keep pace with costs and many will experience a loss of revenue if the nearly 17 percent cut is applied to their ancillary services and hospital visits.
   - Participation of subspecialists in care coordination through the PCMH—a concept that ACP calls the Patient Centered Medical Home neighborhood—is critical to the success of the PCMH model, and yet those subspecialists would be subject to the nearly 17 percent cut, making it much less likely that they could invest the resources needed to become PCMH neighbors. It also will make it less likely that they will participate in bundled payments or other models that require a significant investment of resources.
   - The nearly 17 percent cut in non-primary care services could potentially lower the baseline for calculating shared savings under the ACO model, making it much less likely that those ACOs will be successful or that physicians and hospitals will take the risk of forming ACOs.

6. **A ten-year freeze for primary care services, and the reduction in payments for other services followed by a freeze, will result in more cost shifting to the private sector**. More cost shifting to the private sector will result in further cost sharing and benefit erosion for workers.

7. The nearly 17 percent cut in payments for non-primary care services will make it much harder to get other changes in payment policies, such as redistributing payments for mis-valued relative value units to the physician payment pool as MedPAC intends, because specialists who already are being cut will likely strongly resist any other changes that will further reduce payments and potentially, reduce access to their services.

Because of these concerns, ACP recommends that MedPAC consider ACP's recommendations to the Energy and Commerce Committee regarding the stabilization of the SGR:

- Repeal the SGR and set the annual update for non-E/M services at no less than zero percent and primary care-related E/M services at no less than 2.0 percent in calendar years 2012 through 2016.
  - **Like MedPAC's proposal, ACP would provide a higher update for primary care services, but it would be set at a level that would keep pace with inflation rather than freezing payments for the rest of the decade.** Unlike MedPAC, ACP also would define primary care simply by service code, rather than specialty and percentage of billings, to prevent the unintended problems experienced with the Medicare Primary Care Incentive Program that we expect would also occur under the MedPAC proposal for defining primary care by

specialty and frequency of service code billings. The designated primary care services eligible for the higher update should include hospital visits as well as office-based, nursing home, domiciliary (and related facilities) and home visit service codes.

- **By setting the update for all other physician services at no less than zero, the severe access problems and unintended adverse consequences – such as discouraging participation in new delivery models – which we believe would occur under the MedPAC proposal, would be reduced.**

- During this time, new payment and delivery models aligned with value would be developed, pilot-tested and evaluated, and the most effective models would be selected for broad implementation. **Physicians would be expected to transition to the new payment models by the end of the decade; if they did not in sufficient numbers, Congress could re-impose spending targets**.

Attached to this letter is a more complete explanation of ACP's proposed framework for eliminating the SGR and transition to new payment models.

ACP also urges MedPAC to consider the proposals we submitted to the Joint Select Committee on Deficit Reduction to finance repeal of the SGR and other critical priorities. For instance, a multi-stakeholder effort to encourage high value care and reduce low value care could yield tens of billions in savings each year out of the estimated $700 billion spent annually on marginal, ineffective and wasteful care, which could be used at least in part to fund SGR repeal.

ACP believes that if there are going to be reductions in payments at some point for some physician services, they should be based on comprehensive payment reforms, not across-the-board percentage cuts that have no grounding in evidence or policy. Instead, new ways to establish the pricing of physician services should be part of new payment models established with clear policy goals in mind, such as basing payment on evidence of value, so that high-value services would be paid more and lower-value services would be paid less; redistributing mis-valued relative value units to the total physician payment pool; and creating incentives to encourage participation in value-based payment models. In the interim, physicians who participate in PCMHs, bundled payments, ACOs, patient registry systems, and other programs to improve the effectiveness of care especially should not be subjected to cuts; instead they should receive higher and positive updates recognizing that they are taking steps to transition to new payment models aligned with value.

In addition, elimination of the SGR is only one step toward a new payment and delivery system that is built on high quality, efficient, and accessible care. Another critical interim step is improving the accuracy of relative value units (RVUs) within the current Medicare system. **Therefore, ACP recommends that, as part of their SGR proposal, MedPAC reinforce its existing positions with regard to RVUs, including:**

- The need for CMS to employ both existing and new processes to identify potentially mis-valued services and correct them. ACP supports MedPAC's recommendation that CMS convene an independent expert panel to undertake this work as a supplement to the Relative Value Scale Update Committee (RUC).

- Providing for automatic reviews of RVUs that may have experienced changes over time in the work involved, based on factors such as changes in length of stay.
- Redistributing any reductions in RVUs resulting from such review to all other RVUs for physician services, E/M as well as non E/M services.

ACP has also recommended to CMS additional short-term steps to move toward a payment and delivery system that incentivizes physicians to provide comprehensive, coordinated care to their patients.

- CMS should work with the primary care community and the various task forces (the Joint CPT/RUC Workgroup, the AAFP Task Force, etc.) to develop short-term, intermediate-term, and long-term changes to better reflect primary care and chronic disease services. ACP feels that the E/M codes could be restructured to more accurately describe those services.
- CMS should also employ tools that already exist in CPT, by establishing Medicare payment for existing CPT codes that describe non-face-to-face E/M services. CMS should investigate the adequacy of payment for physician services that typically take place outside of a face-to-face patient encounter. The College has urged CMS to recognize non-face-to-face services that enable primary care physicians and others who provide chronic disease management and care coordination to provide valuable and timely care to their patients.

These ideas are in line with MedPAC's past statements of concern about the balance between primary care and procedural services and about poor care coordination leading to higher costs and reduced quality. Therefore, ACP encourages MedPAC to reiterate these positions in its recommendations to CMS, as part of a more comprehensive proposal to move away from the SGR and current FFS system toward a payment system that rewards efficient, high quality, coordinated care.

Finally, ACP recognizes that MedPAC believes that physicians should contribute to deficit reduction and funding repeal of the SGR. **For the reasons discussed extensively in this letter, we disagree with MedPAC that cutting and freezing payments, when physicians have already had a decade when Medicare payments have not kept pace with costs, is effective or necessary, and it will create severe access problems and undermine transitions to better payment models.**

But we agree that physicians must contribute to lower health care spending and deficit reduction, by addressing the real cost-drivers. The medical profession must make a firm commitment to reduce marginal and ineffective care and to transition to new payment models aligned with value. Such a policy-driven approach to address the real cost-drivers in medicine will be a far more significant and effective contribution than cuts that are not based on evidence that the physicians whose payments are being reduced are providing ineffective, mis-valued, low-value or inappropriate care.

Again, we do appreciate MedPAC's intent in developing a proposal that has the intent of repealing the SGR, preserving access to primary care services, and transitioning to new payment

models, and we provide the comments in this letter in the spirit of offering constructive ideas for a better way to achieve these shared goals.

Please contact Shari Erickson, Director, Regulatory and Insurer Affairs, by phone at 202-261-4551 or e-mail at serickson@acponline.org if you have questions and/or need additional information.

Sincerely,

Virginia L. Hood, MBBS, MPH, FACP
President, American College of Physicians

Attachment:

ACP's Framework to Eliminate the SGR and Transition to New Payment Models

This framework involves a two-stage process. During the first stage, Medicare would stabilize and improve payments under the current Medicare fee schedule for the next five years by eliminating the sustainable growth rate (SGR) as a factor in establishing annual updates and by ensuring higher payments and protection from budget neutrality cuts for undervalued evaluation and management services. Also, during this stage, physicians who voluntarily participate in specific, designated Physician Payment Innovation Initiatives—including Patient-Centered Medical Homes, Accountable Care Organizations, and other models that meet suggested criteria for value to patients—could qualify for appropriately higher payments. Then, during stage 2, physicians would be given a set timetable to transition their practices to the models that Congress and the Department of Health & Human Services (HHS) has determined to be most effective based on experience with the payment initiatives evaluated during stage 1, leading to permanent replacements to the existing Medicare payment system by the end of the decade.

This framework potentially could achieve very substantial long-term savings through the implementation of incentives for clinicians, hospitals, and other providers to provide high quality, efficient care. A new study on the *Economics of Smarter Health Care Spending*, recently released by Harvard researchers to the Jackson Hole Economic Policy Symposium, suggests that the United States may be able to save between 30 and 50 percent of total health care spending if the right incentives are put into place—and that a substantial part of the savings would accrue to the federal government.