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

September 12, 2011

Honorable Patty Murray
U.S. Senate
Washington, DC 20510

Honorable Max Baucus
U.S. Senate
Washington, DC 20510

Honorable John Kerry
U.S. Senate
Washington, DC 20510

Honorable John Kyl
U.S. Senate
Washington, DC 20510

Honorable Rob Portman
U.S. Senate
Washington, DC 20510

Honorable Patrick Toomey
U.S. Senate
Washington, DC 20510

Honorable Jeb Hensarling
U.S. House of Representatives
Washington, DC 20515

Honorable Dave Camp
U.S. House of Representatives
Washington, DC 20515

Honorable Fred Upton
U.S. House of Representatives
Washington, DC 20515

Honorable James Clyburn
U.S. House of Representatives
Washington, DC 20515

Honorable Chris Van Hollen
U.S. House of Representatives
Washington, DC 20515

Honorable Xavier Becerra
U.S. House of Representatives
Washington, DC 20515

Dear Sirs and Madam:

On behalf of the 132,000 internal medicine physicians and medical student members of the American College of Physicians (ACP), I am writing to provide the joint select committee on deficit reduction with our recommendations to reduce federal health care spending in a socially and fiscally responsible manner. Internal medicine physicians specialize in primary and comprehensive care of adults and adolescents. ACP is the largest physician specialty society, and second largest physician membership organization, in the United States.

Our recommendations focus on improving the effectiveness of the care provided, making necessary and appropriate changes in Medicare cost-sharing, reforming payment and delivery systems, supporting the proven value of primary care, and requiring all health care stakeholders to contribute to achieving lower health care spending in a balanced and responsible way. **We have identified a specific menu of options, consistent with ACP policy, to achieve hundreds of billions in federal health care savings. Such savings should be used to reduce the federal deficit, permanently pay for repeal of the failed Medicare sustainable growth rate (SGR) formula *and* allow for continued funding of critical programs to ensure an adequate physician health care workforce, expand coverage, and improve outcomes.**

Specifically, I call your attention to several specific policies we believe must be included in a socially- and fiscally-responsible deficit reduction package:

1. **Improve payment and delivery systems by:**

    A. **Permanently repealing the Medicare SGR and**

    B. **Transitioning to a new payment systems aligned with value**.

In April, ACP provided the House Energy and Commerce Committee (http://www.acponline.org/advocacy/where_we_stand/phys_pay_pro_cl.pdf) with a framework for stabilizing payments, providing higher updates for primary care services, and allowing for broad testing of payment models over the next five years, after which physicians would transition to the models shown to be the most effective in achieving high quality, patient-centered outcomes efficiently and effectively.

ACP's framework potentially could achieve very substantial long-term savings. A landmark new study (www.kc.frb.org/publicat/sympos/2011/2011.BaickerandChandra.paper.pdf) on the *Economics of Smarter Health Care Spending*, released last week 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 to clinicians, hospitals and other providers are put into place. If they are correct, then a substantial part of the savings would accrue to the federal government. Implementing new models to incentivize physicians for achieving greater value requires that a reasonable but not open-ended period be established to stabilize Medicare payments, during which there would be broad pilot-testing and evaluation. This will not happen as long as physicians are faced with a Medicare SGR cut of almost 30 percent on January 1, 2012, with continued uncertainty created by the specter of future cuts if the SGR is not permanently repealed by Congress.

Repeal of the SGR is fiscally responsible**. Each time that Congress postpones enactment of a permanent solution, the budget costs of a permanent solution to the SGR increases—from $40 billion only a few years ago to almost $300 billion today to an estimated $600 billion by 2016.** This is why two bipartisan initiatives, the Senate "Gang of Six" and the Commission on Fiscal Responsibility and Reform, recommended elimination of the SGR. ACP's framework for transition to new payment models is similar to that proposed by the Fiscal Commission.

2. **Establish a national, multi-stakeholder initiative to reduce marginal and ineffective care and promote high value care.** ACP proposes that Congress establish a multi-stakeholder entity, consisting of representatives of leading physician membership and specialty societies (including ACP), health plans, federal health agencies (CMS, AHRQ, PCORI, NIH, and the VA), consumer groups, and health services researchers, and experts in shared decision-making, to develop a national strategy to reduce the use of treatments and diagnostic tests that have no or marginal effectiveness and increase use of treatments and diagnostic tests of higher value. ACP has identified several policies that could be the basis for this multi-stakeholder initiative to improve the value of health care spending, many of which have also been suggested by the same Harvard study referenced earlier, as well as other experts. Specifically, ACP recommends that this multi-stakeholder initiative identify strategies to:

    A. **Provide patients and clinicians with information on the comparative effectiveness of different treatments.** The Harvard researchers report that, *"Perhaps the most important contribution that public policy could make to system-wide efficiency would be to generate*

more information - for both patients and providers - about what care is in fact high value." ACP on its own is doing exactly this, through our "High-Value, Cost-Conscious Care Initiative," www.acponline.org/clinical_information/resources/hvccc.htm. This physician-led initiative provides clinicians and patients with evidence-based and consensus recommendations on providing care of high value while reducing care of no or marginal value. We have already issued guidelines on use of imaging to diagnose low back pain, and will be issuing additional guidelines in the near future. We are working with medical educators to teach medical students and residents on delivery of high-value care and with consumer groups on developing shared decision-making tools.

B. **Establish patient incentives and insurance designed to encourage high-value care and reduce use of low-value treatments and tests.** ACP supports consideration of using "value-based" insurance plans that vary the degree of patient-cost sharing based on the results of research on comparative effectiveness. Public and private health insurers should also take into consideration research on comparative effectiveness, with consideration of cost, in their coverage decisions.

C. **Transition to new payment and delivery models for clinicians, hospitals and other providers aligned with value, as proposed above.** The Harvard study shows that very substantial savings are possible if clinicians are incentivized to provide high-value, cost-conscious and patient-centered care rather than rewarded for increasing the volume of services.

D. **Reduce the costs of defensive medicine.** Excess testing results, at least in part, from physicians' concerns about medical liability lawsuits. The CBO estimates that reform of the medical liability tort system could save $62 billion over the next ten years. ACP recommends that Congress establish caps on non-economic damages as well as authorize and fund a nationwide pilot of no-fault health courts.

3. **Preserve and broaden financing for Graduate Medical Education and allocate GME funding more strategically, based on an assessment of national workforce priorities and goals.** While cutting the deficit is important, across-the-board cuts in GME funding—and especially cuts in programs to train internal medicine specialists and other primary care physicians—would exacerbate the growing shortage of primary care physicians and other specialties facing shortages. Studies show that without enough primary care physicians, patient outcomes will be poorer and health care spending higher—leading to higher spending by Medicare and other government programs. ACP believes, though, that financing for GME needs to be broadened and applied more strategically. Specifically, ACP recommends:

A. **All payers should be required to contribute to financing of GME**. An all-payer system would be an important contribution to deficit reduction by spreading the responsibility for funding of GME to all who benefit from it instead of the federal government bearing a disproportionate share of the cost as it does today. The all-payer system should be linked to the nation's health care workforce needs to ensure an adequate supply of physicians with an appropriate specialty mix and distribution. This could result in a needed increase in aggregate GME funding while allowing the federal government to pay an appropriately smaller share of the costs. GME is a public good—it benefits all of society, not just those who directly purchase or receive it. All payers depend on well-trained medical graduates, medical research, and technical advances from teaching hospitals to meet the nation's demand for a high standard of care. ACP believes that all payers derive value from this system and should share the investment in education and research. All payers should be

concerned about preserving the nation's system of GME, maintaining high standards of quality for patient care services and that opportunities for entry into the medical profession are available to the best-qualified candidates. A mechanism should be established to require all payers to explicitly contribute to GME.

B. In addition, we believe that available GME funds can be spent more effectively and strategically by substantially weighting the payments to primary care training programs, by linking payments to an assessment of workforce needs, and by funding pilot tests of innovative models to train physicians with the skills needed, such as training in team-based comprehensive care in a patient-centered medical home.

ACP's Board of Regents recently approved a major new position paper (http://www.acponline.org/advocacy/where_we_stand/policy/gme_policy.pdf) on GME financing and reform, which provides more details on our recommendations for broadening GME financing and applying it more strategically to support the nation's workforce goals.

ACP also believes that it is important that Congress preserve funding for key programs to ensure access and an adequate physician workforce. In addition to GME funding, we urge the joint committee to continue to support mandatory funding for the Medicare primary care incentive program and Medicaid primary care pay parity, and sufficient discretionary funding for Title VII primary care grants, the National Health Workforce Commission, and other programs to increase the supply of primary care physicians.

ACP also understands that the joint select committee is interested in options to achieve deficit reduction for which specific current budget savings estimates are available. Accordingly, ACP offers for your consideration the attached menu of options, generally consistent with ACP policies, which the Congressional Budget Office (CBO), National Commission on Fiscal Responsibility and Reform, Bipartisan Policy Center, and other trusted sources have said can achieve substantial budget savings. We recognize that many of the options are controversial, and the joint select committee may select some of the options while not including others and come up with other approaches we have not considered. This is why we present the options as a menu of policy changes that ACP would generally support, not as a package that we believe needs to be accepted in its entirety.

In conclusion, ACP believes that by working from the three principal strategies discussed above, and incorporating some of the policies included in the menu of options attached to this letter, the joint committee can establish a framework that would result in hundreds of billions of dollars in deficit reduction, eliminate the SGR, and promote improved outcomes and quality. We stand ready to assist you in developing such a plan.

Sincerely,

Virginia L. Hood, MBBS, MPH, FACP
President