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The Honorable Fred Upton
Chairman
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515-6115

Dear Mr. Chairman:

The American Medical Association (AMA) is pleased to respond to the Committee on Energy and Commerce's bipartisan letter of March 28, 2011, requesting our suggestions on developing a pathway toward reforming the Medicare physician payment system. We want to acknowledge the Committee's continued efforts to address this problem, most recently the Committee's bipartisan effort last December to prevent the 25 percent cut under the current sustainable growth rate (SGR) formula from taking effect for one year, thereby allowing the necessary time to work on this complex issue. We laud the Committee's continued commitment, under both Republican and Democratic leadership, to develop a permanent, sustainable solution and welcome the opportunity to provide you with our ideas.

This letter lays out a three-prong approach to reforming the physician payment system: (1) repeal the SGR; (2) implement a five-year period of stable payments; and (3) transition to an array of new payment models designed to enhance care coordination, quality, appropriateness and costs. Repealing the SGR, implementing a period of stable payments and laying the pathway for a new payment system must be enacted concurrently to ensure an optimal reform approach.

We certainly recognize that reforming the Medicare physician payment system is a daunting task. We are eager to continue to work with members of the House and the Senate on both sides of the aisle to lay the ground work for reform. Over the course of the next weeks and months, we look forward to continuing this dialogue and providing all Members with additional data, information and policy ideas.

Repeal the Sustainable Growth Rate

As part of the Balanced Budget Act of 1997, Congress enacted the SGR formula for the determination of physician payment updates under Medicare Part B. The SGR was intended to function by reducing Medicare payment updates to offset the growth in utilization of physician services exceeding gross domestic product (GDP) growth. Specifically, actual growth in spending on physician services is compared to a cumulative target growth rate linked to GDP, using 1996 as the base year. When actual growth exceeds the cumulative target, payment updates are reduced and will be less than practice cost growth. While well intentioned, the formula is fundamentally flawed. The growth in the cost of caring for Medicare beneficiaries has historically grown faster than the GDP due to technological advances in care, an aging population, expansion of the Medicare program and other factors. It is simply not appropriate for policymakers in 1997 to define what health care spending should be in 2011 or any other

year. Additionally, the concept of a global target affecting the actions of individual physicians is flawed in that there is no individual incentive to reduce spending.

Since 2002, the SGR formula has annually called for reductions in Medicare reimbursements. Payments were cut by 5 percent for 2002. Congress has intervened on 12 separate occasions since then to prevent additional cuts from being imposed. Five separate bills were passed to stop a 22 percent cut in 2010 alone. On all 12 occasions, the funding necessary to reform a formula that is universally judged to be fatally and fundamentally flawed was not provided. Therefore, the current Congress is challenged by the prospect of even steeper cuts than previous Congresses. As a result, the 10-year cost of a long-term solution has grown from about $48 billion in 2005 to nearly $300 billion today, and physician payments are scheduled to be cut by 29.5 percent on January 1, 2012, and those cuts continue for many years to come.

The only way to start on a path to permanently reform the physician payment system is to repeal the SGR. Medical technology, Medicare coverage and benefits, and the cost of running a medical practice have all changed drastically since 1996 yet the SGR has failed to adequately recognize those changes. Repeal of the SGR would also provide stability to patients covered by other payers that tie their rates to Medicare including military members, their families, and retirees in TRICARE, retired Federal employees, and those enrolled in state Medicaid programs.

Period of Stable Payments

Due to the fundamentally flawed nature of the SGR and budget baseline effects from congressional interventions to halt scheduled SGR cuts, physician practices have faced fiscal uncertainty over the last decade. As policymakers, stakeholders and experts work to develop and transition to a new Medicare physician payment system, we recommend that for the period 2012-2016, physicians be provided with positive Medicare physician payment updates that keep pace with the growth in medical practice costs. Providing statutory updates for five years will provide predictability and fiscal stability for physician practices at a time in which they will also be making significant investments in health information technology and quality improvement initiatives.

A replacement for the SGR should not be another one-size-fits-all formula. Rather, replacing the SGR should involve transitioning to a new generation of payment models that reward physicians and hospitals for keeping patients healthy, managing chronic conditions in a way that avoids hospitalizations, and, when acute care episodes occur, delivering high quality care with efficient use of resources. We envision physicians choosing from a menu of payment models, selecting ones that best address their patients' needs, specialty, practice type, capabilities and community. We believe that statutory payment updates for five years will allow time for demonstrations and pilots of new Medicare and private sector payment models to take place. During this time, evidence should be available on how to properly structure and implement those models with the most promise, while addressing issues such as risk adjustment and attribution. We believe this process should be dynamic, enabling physicians to transition into those models as they become available.

Further, we believe this period will provide Congress the opportunity to act on legislation to create a new Medicare physician payment system that incorporates those models by September 30, 2015. The bill establishing five years of statutory updates could include provisions requiring congressional action by such date and provide for congressional "fast-track" procedures to ensure consideration of such legislation. The Centers for Medicare and Medicaid Services (CMS) would begin implementation of the

new payment system, adopted by Congress, through the proposed and final 2016 Medicare Physician Payment Rule, which would become effective on January 1, 2017.

New Payment Model Options

Since Medicare's creation in 1965, previous administrations and congresses have enacted changes to the Medicare physician payment system about every decade or so to address evolving Medicare fiscal constraints. For numerous years since the SGR was implemented, Congress, stakeholders and policy experts such as the Medicare Payment Advisory Commission (MedPAC) have grappled with ideas on how to replace the SGR. In this section we outline several payment models that are being, or will be, demonstrated or piloted in Medicare and the private sector, and possible transition payment models. As the demonstration and pilot process continues to be fluid, so should our discussion about a new system and model ideas.

Demonstration and Pilot Models

An array of approaches to physician payment and delivery reform are being tested in Medicare and the private sector. Approaches include pay-for-performance, bundled payments, medical homes and accountable care organizations, as well as approaches that blend elements of multiple models. This diversity is important because there is no one-size-fits-all payment model that will achieve physicians' and policymakers' objectives for improved care and affordability. These pilot projects are an important means for policymakers and physicians to learn how new models work, how best to structure them, their savings potential, the capabilities practices need to be able to implement these changes, and which models work best for different specialties, communities and practice types before more widespread application. Additionally, it is important to test transitional approaches to reform that will give physicians sufficient time and resources to develop the infrastructure and care management capabilities that will be needed to succeed under a different payment system.

Acute Care Episode (ACE) Demonstration (P.L. 108-173, Sec. 646)

- A tested shared savings model for combined hospital and physician payments.
- Rewards efficiencies while improving quality.

Section 646 of the Medicare Modernization Act of 2003 (MMA) authorized demonstrations to test incentives for delivering improved quality of care and efficient allocation of resources. The ongoing three-year ACE demonstration tests the use of a global payment for an episode of care, covering all Part A and B services associated with a patient's inpatient stay. The episodes of care are for specified cardiovascular and orthopedic procedures only, and participating sites must meet procedure volume thresholds, have established quality improvement mechanisms, and be located in Texas, Oklahoma, New Mexico, or Colorado. The demonstration design allows the hospitals to share savings from the efficiencies they are able to achieve with the treating physicians and with patients. For example, a report indicates that within 18 months of starting the demonstration, 150 orthopaedic surgeons at Baptist Health System in San Antonio, saved $4 million by negotiating discounted prices on supplies and implantable knee and hip joints and shared gains of $558,000. In the absence of the demonstration authority, this so-called "gainsharing" between hospitals and physicians would be prohibited by law. The design also requires each site to have a physician-hospital organization so that there is joint governance and oversight of the project. The first ACE site began its program in May 2009.

National Pilot Program on Payment Bundling (P.L. 111-143, Sec. 3023)

- Next step in the evolution of the ACE demonstration.
- Expands model beyond cardiovascular and orthopaedic services; also to include outpatient care.

By January 1, 2013, the U.S. Department of Health and Human Services (HHS) secretary is required to establish a Medicare pilot program for integrated care. This pilot will include episodes of care involving a hospitalization, broader than the ACE demonstration, to improve the coordination, quality and efficiency of health care services, such as: (1) physician services delivered inside and outside of an acute care hospital setting; (2) other acute care inpatient services; (3) outpatient hospital services, including emergency department services; (4) post-acute care services, including home health, skilled nursing, inpatient rehabilitation, and inpatient services furnished by long-term care hospitals; and (5) other services the secretary determines are appropriate. The secretary will also establish a payment methodology, including bundled payments or bids for episodes of care. Payment will be made to the entity that is participating in the pilot program.

Extension of Gainsharing Demonstration (P.L. 109-171, Sec. 5007; P.L. 111-148, Sec. 3027)

- Expands on the ACE demonstration project for inpatient services.

Section 5007 of the Deficit Reduction Act of 2005 (DRA) authorized a gainsharing demonstration program to test and evaluate arrangements between hospitals and physicians designed to improve the quality and efficiency of care. Similar to the ACE demonstration described above, the project allows hospitals to provide gainsharing payments to physicians that represent a share of the savings incurred through their collaborative efforts. This project began October 1, 2008, and was extended for two years by the ACA. The project consists of two sites: Beth Israel Medical Center, New York City and Charleston Area Medical Center, West Virginia.

Physician Group Practice (PGP) Demonstration (P.L. 106-554, Sec. 412)

- A tested ambulatory care model with increased savings potential over time.

Section 412 of the Benefits Improvement and Protection Act of 2000 (BIPA) mandated the five-year PGP demonstration to test incentives for encouraging better care coordination, improving quality and lowering Medicare expenditures. Ten group practices were competitively selected to participate and many of the lessons learned from the first few years of experience with the PGP demonstration are being applied in developing the new Medicare Shared Savings program. For example, the Regulatory Impact Statement in the recently released proposed rule details the PGP sites' start-up and operating costs as a way of estimating costs to participate in the Shared Savings program (i.e., based on the PGP demonstration, CMS estimates average start-up and first year operating expenses of $1,755,251). After the first year of the PGP demonstration, two of the 10 sites had achieved sufficient savings to receive performance payments from Medicare. By the end of the fourth year, five of the 10 sites were eligible for performance payments. All 10 of the sites have been able to meet quality benchmarks. CMS expects a number of the PGP groups to transition to accountable care organizations within the Shared Savings Program.

Patient-Centered Medical Home (P.L. 109-432, Sec. 204)

- Primary care model for improved care management and coordination.

Section 204 of the Tax Relief and Health Care Act of 2006 (TRHCA) mandated a three-year Medicare demonstration of the patient-centered medical home in up to eight states to provide targeted, accessible, continuous and coordinated care to patients with chronic or prolonged illnesses requiring regular medical monitoring, advising or treatment. Although CMS obtained demonstration design options from Mathematica Policy Research which it shared with the AMA and primary care specialty societies and secured recommended relative value units for the care management payment from the AMA/Specialty Society Relative Value Scale Update Committee, CMS recently announced that they would not pursue this project. It is possible that the shared savings nature of the program has presented an implementation barrier, as the law is structured such that the care management payments to primary care physicians will be offset by the savings that the Medicare medical homes generate. Instead of the Medicare medical home, CMS decided to first put in place a Multi-payer Advanced Primary Care Initiative. This demonstration is also in eight states and involves providing monthly care management payments to physicians who serve as a patient's medical home. The eight states are Maine, Vermont, Rhode Island, New York, Pennsylvania, North Carolina, Michigan, and Minnesota. In addition to Medicare, the program involves private payers and Medicaid. The project is expected to be operational by the middle of 2011 and will last for three years.

Medicare Shared Savings Program (P.L. 111-148, Sec. 3022)

- ACO model built around primary care but potentially encompassing specialty and facility services, scheduled to begin in 2012.

Section 3022 of the Patient Protection and Affordable Care Act (ACA) requires the HHS secretary to establish the Medicare Shared Savings Program by January 1, 2012. The law allows accountable care organizations (ACOs) comprised of groups of physicians, networks of individual practices, joint ventures between hospitals and physicians, hospitals employing physicians, and others to participate in the Medicare Shared Savings Program. To qualify, an ACO must agree to be accountable for the quality, cost and overall care of the Medicare fee-for-service beneficiaries for which it is assigned. An ACO must have physicians who provide primary care to at least 5,000 Medicare patients and have in place: (1) a formal legal structure that would allow the organization to receive and distribute payments for any shared savings; (2) a leadership and management structure that includes clinical and administrative systems; (3) defined processes to promote evidence-based medicine; and (4) processes to report on quality and cost measures. Payments for services provided by physicians and other ACO participants will be made by Medicare according to the usual hospital and physician payment schedules. Additionally, ACOs will be able to share among their participants a portion of Medicare savings achieved in excess of a benchmark. ACOs must agree to participate in the program for at least three years. On April 7, 2011, CMS published in the *Federal Register* a Notice of Proposed Rulemaking on the ACO program with a 60-day comment period. In addition to the proposed rule, the government is also seeking comments on proposed waivers and safe harbors from self-referral, anti-kickback, gainsharing civil monetary penalties, and antitrust laws that would otherwise prohibit the type of coordinated activities and monetary distributions that successful ACOs will require.

Independence-at-Home Demonstration Program (P.L. 111-143, Sec. 3024)

- Designed to avoid costly institutional care.

By January 1, 2012, the HHS secretary is required to establish an independence-at-home demonstration program to bring primary care services to the homes of high-cost Medicare beneficiaries with multiple

chronic conditions. Health teams could be eligible for shared savings if they achieve high-quality outcomes, patient satisfaction and cost savings. The HHS secretary will estimate an annual per capita spending target for the estimated amount that would have been spent under Parts A and B in the absence of the demonstration, with the target adjusted for certain risks. A medical home practice could receive an incentive payment based on actual savings achieved in comparison to the target. This demonstration project is still under development.

Community Health Team Support for Patient-Centered Medical Homes (P.L. 111-148, Sec. 3502)

- Expanded model to support primary care across disciplines.

The HHS secretary is required to provide grants or enter into contracts with eligible entities to establish community-based interdisciplinary, inter-professional "health teams" to support primary care practices (including obstetrics and gynecology practices) within their local hospital service areas, and to provide capitated payments to primary care providers according to criteria established by the secretary. The health teams could, for example, collaborate with patient-centered medical homes in coordinating prevention and chronic disease management services, or develop and implement care plans that integrate preventive and health promotion services.

Proposed Transitional Models

Many of the Medicare demonstration projects outlined above hold great promise for identifying winning payment reform pathways that can simultaneously improve patient care quality and coordination, improve physician operating margins, and reduce the rate of growth in Medicare spending. This is particularly true for the ACE and PGP demonstration programs, which are the only ones that have actually been underway for any length of time. At the same time, the bundling, ACO and medical home demonstrations have a common limitation, which is their sole reliance on shared savings as a means to accomplish their reform objectives. The PGP demonstration has made it clear that there are significant upfront investments required for participation in these new models but demonstration designs limit the incentive payments to distributions of shared savings and do not assist practices with these upfront costs or provide any assurance that they will ever recover them. Shared savings distributions, if they are achieved at all, are not paid until long after these initial investments are required.

In addition to having access to financial reserves, participation in any of the new payment and delivery models requires physician practices to have certain capabilities, including: (1) the ability to obtain and analyze large amounts of data on patient utilization and costs for their own services as well as services provided by others; (2) skills to improve quality and cost performance and report performance measures; (3) ability to identify inappropriate utilization and reduce it; (4) knowledge of evidence-based practices that achieve good outcomes; (5) ability to share information with other physicians and providers at the point of care; and (6) ability to manage patient care in a coordinated way and experience managing risk. In the past, these skills have not been taught in medical school or residency training. Physicians need to acquire these skills through their experience in practice. With the vast majority of medical practices qualifying as small businesses and involving a small number of physicians, it is important to put in place transitional models that will help small and solo practices to develop these capabilities.

To address both of these limitations the AMA recommends that several transitional models be tested by Medicare, in addition to the demonstrations described above. A more detailed discussion of these and other transitional approaches is available in "Transitioning to Accountable Care: Incremental Payment

Reforms to Support Higher Quality, More Affordable Health Care," a paper by Harold D. Miller of the Center for Healthcare Quality & Payment Reform available at www.paymentreform.org.

Partial Capitation

Section 3022 of the ACA authorized but did not require CMS to include partial capitation models in the Medicare Shared Savings Program. In its recent proposed rule, CMS indicates that it is not proposing any partial capitation models at this time, although they may be addressed separately by the Center for Medicare and Medicaid Innovation. Under this payment model, an ACO would agree to accept a pre-defined monthly per-patient payment during a multi-year period that would be used to cover all of the costs of care for a defined group of patients. The payment would be risk-adjusted and would be lower than what CMS would project paying for those patients under the regular Part A and B payment schedules. This model would enable physician practices with experience in successfully managing capitation contracts under Medicare Advantage and commercial insurance, such as North Texas Specialty Physicians, to deliver care to Medicare fee-for-service beneficiaries as well as guaranteed savings to the Medicare program. Additionally, it would provide a means for practices to recoup their upfront investments, reward physicians for achieving savings through the way a particular treatment is delivered even if the treatment would have the same DRG or CPT code in fee-for-service Medicare, and permit them to gain experience managing risk.

Virtual Partial Capitation

A variant of the model above would define a per-patient budget for a defined group of patients instead of making an upfront payment. Individual physicians who volunteered to participate would bill for individual services as they will do in Medicare Shared Savings Program, the total billings would then be compared to the budget, and the payments to the physicians and other providers in the ACO would be adjusted up or down to keep total payments within the budget. This approach gives physicians the flexibility to use alternative treatment approaches, as in capitation, without requiring them to have the capability to pay claims to other providers.

Condition-Specific Capitation

This model would involve making a prospective payment covering all of the services related to a particular condition or combination of conditions for a population of patients, rather than the full range of conditions as in the partial capitation model described earlier. Under condition-specific capitation, a specialty physician practice, multi-specialty group, or IPA would be paid a pre-defined amount to cover the costs of all of the care needed to address a particular condition, whether that care is provided by physicians in the organization receiving the payment or other physicians. For example, a multi-specialty group or IPA could be paid a fixed amount to cover the costs of all services associated with care related to its patients' congestive heart failure, including all physician services, hospital care, rehabilitation, etc. (This payment model could also be structured as a "virtual" payment or budget, as described above for virtual partial capitation.) This would enable primary care and specialty physician practices to work together to take accountability for the subset of patients and patient care they felt they could most effectively manage; over time, they could expand to additional types of patients in order to accept a broader partial capitation payment.

Accountable Medical Home

In contrast with the shared savings approach to medical homes, the accountable medical home model would give a primary care practice, multi-specialty group, or independent practice association (IPA) the upfront resources needed to restructure the way primary care is delivered to its patients in return for a commitment to reduce the rate at which those patients use emergency rooms for non-urgent visits, are admitted and readmitted to the hospital for ambulatory care sensitive conditions, and order diagnostic tests or other ancillary services that may be inappropriate. Accountable medical homes could improve patient care and achieve savings for the Medicare program in several key areas without being penalized for the costs of specialized services they are not in a position to control. In the State of Washington, the Puget Sound Health Alliance and the Washington State Health Care Authority are currently putting this model in place for commercial payers and Medicaid plans. CMS could use the approach they have developed in the Medicare program.

Warranties for Inpatient Care

Adoption of a model like Geisinger Health System's ProvenCare could be a beneficial transitional model for Medicare payment reform. Physicians and hospitals providing treatment for specified conditions would determine a Medicare payment rate that would allow them to offer a warranty for the inpatient treatment and not charge more for addressing infections, complications or other defined adverse events that may occur during the course of the patient's care. Offering such a warranty provides an economic incentive for improving quality and preventing complications from occurring. As quality improves over time and rates of warrantied complications diminish, the physicians and hospitals will be able to reduce the bundled payment rate to save money for Medicare while still obtaining higher margins on their own operating costs. At least initially, the price of the warrantied services is likely to be higher than what Medicare pays for a service with no complications because of the need to cover the costs of treating complications that will arise in a certain number of cases. Since Medicare would no longer be paying separately for the complications covered by the warranty, this method would save money in total. In contrast to the current payment system, this would reward the physicians and hospitals for preventing complications and delivering better quality care rather than paying more when complications arise. Most consumer products that are sold with a warranty do cost more than those without a warranty. Consumers purchase warrantied products not only as a protection against costly repairs but also because they know that the manufacturer must offer a high-quality product in order to manage its own financial risks. The warranty model is also a good transitional model because, as Geisinger did, physicians could begin with one service, like cardiac surgery, and then expand it to other areas as they gain experience with the approach.

Mentoring Programs

Perhaps the simplest way for small and solo practices to develop capabilities like analyzing patient utilization, quality and cost data, sharing information with others to prevent duplicate tests, adopting evidence-based measures and improving quality and cost performance is to learn from those who have done it. Another transitional model, therefore, would be for Medicare to provide financial and technical support to small physician practices that are working with Regional Health Improvement Collaboratives[1]

[1] For more information see "Regional Health Improvement Collaboratives: Essential Elements for Successful Healthcare Reform," Network for Regional Healthcare Improvement, www.nrhi.org.

or partnering with high performing groups in order to learn from them. The Mayo Clinic Affiliated Practice Network, Henry Ford Physician Network, Pittsburgh Regional Health Initiative, and Oregon Health Care Quality Corporation are several examples of this type of mentoring approach.

While replacing the SGR is critical, it must be done correctly. We believe this proposed framework, and timeline, are critical to developing the evidence-base necessary to ensure a reformed Medicare physician payment system meets our mutual goal of improving the Medicare program while ensuring beneficiaries' continued access to care. We look forward to continuing to work with House and Senate members on both sides of the aisle on repealing the SGR and transitioning to a system that incorporates new payment models designed to enhance care coordination, quality, appropriateness and cost.

Again, thank you for affording us this opportunity to work with you on replacing the SGR with a sustainable payment system.

Sincerely,

Michael D. Maves, MD, MBA

cc: House Energy and Commerce Committee Members
Cecil B. Wilson, MD