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MEDICARE PHYSICIAN PAYMENT: HOW TO BUILD A PAYMENT SYSTEM THAT PROVIDES QUALITY, EFFICIENT CARE FOR MEDICARE BENEFICIARIES

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE
HOUSE OF REPRESENTATIVES

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CONTENTS

	Page
Hearings held:	
July 25, 2006	1
July 27, 2006	144
Testimony of:	
Marron, Donald B., Acting Director, Congressional Budget Office	33
Steinwald, A. Bruce, Director, Health Care, Government Accountability Office	50
Miller, Mark, Executive Director, Medicare Payment Advisory Commission	74
Guterman, Stuart, Senior Program Director, Program on Medicare's Future, The Commonwealth Fund	86
McClellan, Hon. Mark, Administrator, Centers for Medicare & Medicaid Services	148
Wilson, Dr. Cecil B., Chair, Board of Trustees, American Medical Association	192
Heine, Dr. Marilyn, on behalf of Alliance of Specialty Medicine	203
Rich, Dr. Jeffrey B., Mid-Atlantic Cardiothoracic Surgeons, on behalf of Society of Thoracic Surgeons	210
Opelka, Dr. Frank, Associate Dean of Healthcare Quality and Management, LSU Health Sciences Center Dean's Office, on behalf of American College of Surgeons	221
Kirk, Dr. Lynne M., Associate Dean for Graduate Medical Education, University of Texas Southwestern Medical School, on behalf of American College of Physicians	248
Schrag, Dr. Deborah, Past Chair, Health Services Committee, American Society of Clinical Oncology	267
Brush, Dr. John, on behalf of American College of Cardiology	272
Martin, Dr. Paul A, Chief Executive Officer and President, Providence Medical Group, Inc. and Providence Health Partners, LLC, on behalf of American Osteopathic Association	282
Additional material submitted for the record:	
Miller, Mark, Executive Director, Medicare Payment Advisory Commission, response for the record	312
Guidry, Orin F., M.D., President, American Society of Anesthesiologists, submission for the record	314

MEDICARE PHYSICIAN PAYMENT: HOW TO BUILD A PAYMENT SYSTEM THAT PROVIDES QUALITY, EFFICIENT CARE FOR MEDICARE BENEFICIARIES

TUESDAY, JULY 25, 2006

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:05 a.m., in Room 2125 of the Rayburn House Office Building, Hon. Nathan Deal (Chairman) presiding.

Members present: Representatives Bilirakis, Norwood, Shadegg, Pickering, Pitts, Ferguson, Rogers, Myrick, Burgess, Barton (ex officio), Towns, Pallone, Eshoo, Green, Capps, Allen, Dingell (ex officio), and Deal.

Staff Present: Melissa Bartlett, Counsel; Ryan Long, Counsel; Brandon Clark, Policy Coordinator; Chad Grant, Legislative Clerk; Bridgett Taylor, Minority Professional Staff Member; Amy Hall, Minority Professional Staff Member; and Jessica McNiece, Minority Research Assistant.

MR. DEAL. Good morning. We will call the committee to order. Today we will have a hearing entitled "Medicare Physician Payment: How to Build a Payment System that Provides Quality, Efficient Care for Medicare Beneficiaries." I am pleased to say that we will be hearing from three panels of witnesses over a two-day period.

Today's session will focus on the Medicare physician payment system, and we will hear from witnesses from the Congressional Budget Office, the Government Accountability Office, the Medicare Payment Advisory Commission, and the Commonwealth Fund.

The second session will begin on Thursday morning and will focus on quality measurement activities and the concept of pay-for-performance in physician payment. This hearing is intended to provide a forum for committee members to consider the current physician payment system, options for fixing or replacing the payment system, while constraining the continued growth in physician spending, and the costs associated with these options.

This hearing will also provide committee members an opportunity to hear CMS and physician representatives highlight their collaborative work on quality measurement and development in an effort to build a new payment system that pays physicians based on the quality and appropriateness of the care they provide.

As my colleagues are no doubt aware, this committee is the committee of primary jurisdiction on the issue of Medicare physician payment, and without question, this issue is one of the most important and daunting legislative tasks we will undertake. As always, I am looking forward to having a cooperative and productive conversation on this topic today, and to working with my colleagues on both sides of the aisle to come up with effective solutions to the problems addressed at this hearing. Again, I would like to thank all of our witnesses for participating today. We look forward to hearing from you and we have reviewed your testimony already.

At this time, I would like to ask for unanimous consent that all members be allowed to submit statements and questions for the record. Without objection, it is so ordered.

[The prepared statement of Hon. Nathan Deal follows:]

PREPARED STATEMENT OF THE HON. NATHAN DEAL, CHAIRMAN, SUBCOMMITTEE ON HEALTH

- The Committee will come to order, and the Chair recognizes himself for an opening statement.
- Today's hearing is entitled "Medicare Physician Payment: How to Build a Payment System that Provides Quality, Efficient Care for Medicare Beneficiaries" and I am proud to say that we will be hearing from three expert panels of witnesses over a two day period.
- appearing before us this morning that will help us examine the concerns raised by MedPAC, CMS, and others regarding the rapid growth of the use of imaging services in Medicare.
- Today's hearing will also provide a forum for witnesses to provide suggestions for how to determine what is proper versus improper growth of services, and how to best control for overutilization or misuse of services.
- Over the past few years, there has been rapid growth in the volume of imaging services paid under Medicare fee-for-service.
- MedPAC has found that Medicare spending for imaging services paid under the physician fee schedule nearly doubled between 1999 and 2004, from $5.4 billion per year to $10.9 billion per year.
- In addition, the volume of imaging services has grown at almost twice the rate of all other physician services.
- Clearly, this level of growth is unsustainable.
- Some growth in use of imaging services is argued to be attributable to technological innovations that allow physicians to better diagnose disease. However, many observers argue that such growth may reflect overuse or misuse of imaging services.
- MedPAC has determined that spending for MRI, CT, and nuclear medicine has grown faster than for other imaging services.

- Accordingly, MedPAC has identified some factors that may contribute to the rapid growth in volume and intensity of imaging services, including:
  1. The possible misalignment of fee schedule payment rates and costs
  2. Physicians' interest in supplementing their professional fees with revenues from ancillary services
  3. Patients' desire to receive diagnostic tests in more convenient settings.
- In its March 2005 report to Congress, MedPAC recommended that Congress direct the Secretary to set standards for physicians interpreting or performing diagnostic imaging services.
- This is a recommendation I hope my colleagues on this subcommittee will carefully consider as we start to look at possible solutions to this problem.
- As my colleagues are no doubt aware, the Deficit Reduction Act of 2005 (DRA), included a provision that caps reimbursement for the technical component for imaging services performed in a physician's office at the hospital outpatient payment rate.
- Imaging services paid under the physician fee schedule involve two parts, a technical component and a professional component. The technical component of the payment covers the cost of the equipment, supplies, and non-physician staff.
- The DRA provision capping the technical component of physician payment for imaging services was intended to move toward payment neutrality across sites of service delivery.
- This provision takes effect January 1, 2007, and will save the Medicare program almost $3 billion over 5 years.
- Of course, many physician groups and industry stakeholders are pushing for a delay in the effective date of this provision.
- However, it is important to remember that these savings were a major financial component in preventing physicians from taking the 4.4% reduction in fee schedule payments that was scheduled to be implemented under the SGR formula for 2006.
- Unfortunately, few groups are offering legitimate offsets in order to pay for this requested delay in implementation.
- It kinda reminds me of the lyrics of an old Bobbie Gentry song, "Everybody wants to go to Heaven…but nobody wants to die."
- I am looking forward to having a cooperative and productive conversation on this topic today and to working with my colleagues on both sides of the aisle to come up with effective solutions to the problems addressed at today's hearing.
- Again, I would like to thank all of our witnesses for participating today, and we look forward to hearing your testimony.
- At this time, I would also like to ask for Unanimous Consent that all Members be allowed to submit statements and questions for the record.
- I now recognize the Ranking Member of the Subcommittee, Mr. Brown from Ohio, for five minutes for his opening statement.

MR. DEAL. I am now pleased to recognize Mr. Pallone, who is our stand-in as the Ranking Member today, for 5 minutes for his opening statement.

Mr. Pallone.

MR. PALLONE. Thank you, Mr. Chairman, and let me begin by also thanking our witnesses today, and I appreciate your attendance. I know we are looking forward to hearing from you.

Mr. Chairman, since Medicare's inception, Congress and various administrations have struggled to determine a fair and appropriate way to

pay physicians for the services they provide, and in spite of these efforts, it is very clear that we are still very far from achieving that goal, and I have to admit I am still baffled by the fact that after 40 years, we still have not found a fair way to pay physicians for the actual costs.

Under the current system, physician payments continue to decline as costs skyrocket, and it creates an unsustainable situation that ultimately undermines what lies at the heart of Medicare, a program that ensures our Nation's seniors have access to affordable and quality healthcare.

Since 2002 when the problems with the current system first started to appear, this subcommittee has held hearing after hearing on the need to reform the current payment system. By now, I doubt that there are few, if any, members who aren't painfully aware of the problems that we face. And yet, there have been very few signs of progress in terms of enacting a permanent solution.

And year after year, the Republican majority has successfully avoided the issue by passing temporary payment increases. As we all know, these Band-Aid measures have actually made things worse, increasing the cuts physicians will face in future years under the current program, as well as the cost of any permanent solution that Congress eventually agrees upon.

Moreover, the Majority has managed to squander any extra time we bought with these quick fixes, and let us be clear, here we are in the last week before Congress recesses for the month of August. That leaves a handful of legislative days in the month of September and a lame duck session to enact a permanent solution, which we all know is unlikely.

We shouldn't make any mistake about it. The groundwork has already been laid for yet another stopgap measure to be enacted in the final days of the 109th Congress, probably in the lame duck, and of course, I am going to support such a measure, Mr. Chairman, simply because we can't afford not to pay our doctors.

However, we must begin to make progress on a permanent reform. And what is the biggest roadblock we face? Without a doubt, it is the overwhelming cost that is associated with overhauling the current payment system. Simply by freezing physician payments at their current level, instead of allowing the 4.6 percent cut scheduled for next year to take place, would increase net spending for Medicare in 2007 by $1.1 billion and $11 billion through 2011. Repealing the sustainable growth rate, the SGR, altogether would even be more expensive. Dr. McClellan of CMS previously testified such a proposal could amount to approximately $180 billion over 10 years, and CBO placed the cost around $218 billion.

Now, I highly doubt that any of my Republican friends have the appetite to support something so costly, and of course I always criticize

them because they have no problem enacting policies that drain our Treasury with tax cuts primarily for the wealthy, but I still think given all that, given the deficit, it is unlikely they are going to want to support this kind of a costly fix.

I would be remiss if I didn't highlight the fact that under the current system, which again the President and the Majority put together, Medicare spends 11 percent more for beneficiaries in Medicare Advantage Plans than for people in fee-for-service. When physicians come to Congress to ask why Medicare is paying them below costs and cutting their reimbursements, we should also be asking why Medicare is paying HMOs their full costs plus a bonus of 11 percent.

Now, Mr. Chairman, the other problem we face is that there doesn't seem to be any consensus on how to fix the current system. Do we keep the SGR in place with modifications? Should we strip it out altogether? And if so, what do we replace it with? And of course, most eyes have turned to a value-based purchasing system, which will be talked about more, I think, on Thursday's hearing. But I like the idea of paying physicians for providing quality and efficient healthcare, but like many physician groups, I have concerns about how we can move to such a system in a fair and timely manner.

Calls to move to such a system by January 2007 are unrealistic, and I think will place beneficiaries in harm's way, and I also have very serious concerns about how such a system would operate. Particularly, I remain unsatisfied about how we guard against doctors cherry-picking healthier patients simply to get better payments.

And again, Mr. Chairman, I know this isn't easy, and I do appreciate the fact that we are having this hearing today and Thursday. I hope that these 2 days will not simply be a forum to rehash what we have already heard before, but to provide the committee members, physicians, and beneficiaries with some hopeful solutions for the problems we face with the current payment system.

And I did want to mention that I support a bill that Congressman Stark has introduced, H.R. 4520, the Medicare Physician Payment Reform Act, which was introduced, I guess, last December. I think that would be something that we should certainly look at as a way to try to deal with this problem. But there are obviously other ways, and that is what we are here for today.

So, thank you again.

MR. DEAL. Thank you. Dr. Norwood, you are recognized for an opening statement.

MR. NORWOOD. Thank you very much, Mr. Chairman, for this hearing, and of course, as always, we thank the witnesses for taking their time. This should be a very interesting 2 days.

As a medical professional and as a Member of Congress, and a 65 year old American as of this week, I have a great interest in, indeed a duty, to see that Medicare beneficiaries maintain access to their doctor. Now, I would choose not to take Medicare, Mr. Chairman, but you know, you won't let me out. I have got to take it, so if I have got to take it, I would like for us to see that it is maintained.

I simply don't believe that we are going to be able to maintain this program if we continue to use the SGR formula, and don't start paying our providers a fair wage. I know that repealing SGR will be extremely costly, but in my view, the dangers we face in healthcare are much greater if we don't. Doctors in Medicare face a 4.6 percent cut next year.

I have worked very hard with my good friend Dr. Burgess on H.R. 5866. It replaces the SGR, and makes several important updates to Medicare. Dr. Burgess, I really thank you and your staff for all of your good work, and I was delighted to be able to assist in any small way.

As much as I have tried to get this committee to see the potential shortcomings of pay-for-performance plans, I know it is coming up again. You don't have to tell me the fee-for-service model has its problems. I know it does.

But I have not been able to get one person, to my satisfaction, to define what pay-for-performance would look like, how it would work across Medicare, or how much it actually might cost. It may improve outcomes in some test cases, but when government bureaucrats, not patients and doctors, start defining good medicine, it makes me automatically very suspicious.

How would you feel if you were expected to provide harder to provide expanded services while taking more patients as the Baby Boomers retire? A bunch of non-physician government clerks, and believe me, they are out there and they are at work, tell you how to do your job, and this is going to be even more so in the future. We are going to cut your paychecks, even though we pay no more than costs today, because some folks, who have never had any experience in medicine determine you aren't efficient enough. I wonder if anybody in the world would put up with that mess in their business in any other thing in the world but healthcare. I know I wouldn't.

Doctors are not machines. Work faster, do fewer tests, God forbid you use your imaging machine too much. You might diagnose something that we have to pay for. Spend less on physical exams. Doctors need to know how the payments will be updated, and Congress is going to address the larger issue. I know Dr. Burgess is with me. We are willing to roll up our sleeves, and do what it takes to get this done. Maybe Mr. Pallone will be with us, too.

I look forward to working with members on both sides of the aisle on this very important issue. Mr. Chairman, thank you again very much for having these hearings.

MR. DEAL. I thank the gentleman. Ms. Eshoo is recognized for an opening statement.

MS. ESHOO. Thank you, Mr. Chairman. This is an important hearing, and welcome to the important witnesses that are here today.

This committee has held a number of hearings examining the Medicare physician payment system over the last several years. Many of us have been calling for reforms for even longer, and there are a number of bills in Congress, and proposals from groups in our communities and our States that seek to do this.

In my view, there are two major reforms that should be made to the physician fee schedule. One, we should eliminate the sustainable growth rate, the SGR payment formula, and replace it with the Medicare Economic Index, the MEI. And two, we should update the Medicare geographic payment locality. I think we are fully cognizant that serious reforms to the SGR are necessary, and I think they need to be taken care of before Congress adjourns this year.

The SGR is inappropriately tied to a non-medical index, the GDP, which has resulted in proposed physician payment cuts of more than 4 percent each year since 2003. And Congress scrambles toward the end of the year, and throws something into some big bill. I think that we need to do it in a much more thoughtful way, so that it is thoughtful, so that it makes sense. We just keep revisiting this in kind of a haphazard way, to kind of quiet the many voices that are directed at us.

The MEI is an index which is based on actual medical practice costs, and it would be used to reimburse all other providers in the Medicare program, including hospitals and nursing homes. MedPAC and many State medical associations are supportive of a proposal to eliminate the SGR payment formula and adopt the MEI for physician payments.

Another issue of considerable concern to me is the geographic payment locality. Let me just use some examples. In Chairman Deal's district, Pickens County physicians are underpaid by 12 percent. In Chairman Barton's district, Ellis County physicians are underpaid by 7.5 percent. In Ranking Member Dingell's district, physicians in Monroe and Livingston Counties are underpaid by 4 percent, and in my Congressional district, in the Santa Cruz County portion, physicians are underpaid by 10.2 percent. It is driving doctors right out of Medicare, and the people that we represent are the ones that are left holding the bag. They have to travel long distances in order to get the care that they deserve.

To the gentleman from Georgia, who said that he is in Medicare, and he can't get out of it, if you pay for it out of your own pocket, you don't have to submit your claims to Medicare, and neither does anyone else. The fact of the matter is it is a system that I think we have a responsibility to make sure it works, and it is not. So, while it is not a national problem, it is a huge problem for the affected areas.

So, I hope that members of the committee will seriously consider the proposals that are out there, and make the changes that really need to be made. And I think the two hearings, Mr. Chairman, that you are having are going to underscore and highlight the changes that need to be made, and that we address them before the 109th Congress adjourns.

Thank you.

[The prepared statement of Hon. Anna Eshoo follows:]

PREPARED STATEMENT OF THE HON. ANNA ESHOO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. Chairman, this Committee has held a number of hearings examining the Medicare physician payment system over the last several years.

Many of my colleagues and I have been calling for reforms for even longer, and there are a number of bills in the Congress and proposals from groups in our communities that seek to do this.

In my view, there are two major reforms that must be made to the physician fee schedule:

1. eliminate the sustainable growth rate (SGR) payment formula and replace it with the Medicare Economic Index (MEI), and
2. update the Medicare Geographic Payment Locality.

I think we're fully cognizant that serious reforms to the SGR are necessary, and they're necessary now.

The SGR is inappropriately tied to a non-medical index, the Gross Domestic Product (GDP), which has resulted in proposed physician payment cuts of more than 4% each year since 2003.

The MEI is an index which is based on actual medical practice costs and is used to reimburse all other providers in the Medicare program (including hospitals and nursing homes).

MedPAC and many state Medical Associations are supportive of a proposal to eliminate the SGR payment formula and adopt the MEI for physician payments.

Another issue of considerable concern to me is the Geographic Payment Locality. Despite major demographic changes across the country since 1966, the Geographic Payment Locality hasn't been updated in any meaningful way. The result is that physicians in 32 states and 174 counties are inaccurately underpaid by up to 14% per year.

For example, in Chairman Deal's District, Pickens County physicians are underpaid by 12%.

In Chairman Barton's District, Ellis County physicians are underpaid by 7.5%.

In Ranking Member Dingell's District, physicians in Monroe and Livingston Counties are underpaid by 5.4%.

And in my District, Santa Cruz County physicians are underpaid by 10.2%. As of June 1st of this year, physicians in Santa Cruz County are no longer accepting new

Medicare patients. This means that patients in Santa Cruz must travel nearly 25 miles to neighboring Santa Clara County to receive care, if they can find a doctor who will accept new Medicare patients.

Although this is not a national problem, it's a huge problem for the affected localities. The California Congressional Delegation has proposed to update the payment localities and help these recently urbanized counties while holding the rural counties harmless from cuts. I urge you, Mr. Chairman and Members of this Committee to seriously consider this proposal and include it in any SGR fix, as well as a commitment to reform the Medicare Physician Payment system before the 109th Congress adjourns.

MR. DEAL. I thank the gentlelady. Dr. Burgess is recognized for an opening statement.

MR. BURGESS. Thank you, Mr. Chairman, and like everyone else, I want to thank you for holding this hearing. I look forward, in a couple of day's time, I guess this morning, we have four economists telling us how doctors should be paid, and on Thursday, we have got seven doctors telling us how to pay economists. And I think that is a good balance that we always ought to strive for on this committee.

Well, I am a healthcare professional. I do understand how crucial Medicare payments are to the future of healthcare. When in the practice of medicine, I can well remember the financial strain when the cost of providing Medicare services doubled relative to that which I was being reimbursed. I appreciate the witnesses taking time to share their views with us, and look forward to their testimony.

I do feel strongly that the current system needs reform, and to that end, I recently introduced H.R. 5866, legislation introduced with Congressman Norwood, along with Congressman Boustany and Congressman Weldon, that creates a framework to fix this problem. The Medicare Physician Payment Reform and Quality Improvement Act of 2006 has four main goals: to ensure that physicians receive full and fair payment for their services rendered; to create quality performance measures that allow patients to be informed consumers when choosing their Medicare provider; to improve quality improvement organization accountability and flexibility; and finally, to find reasonable methods of paying for these benefits.

Current law calculates an annual update for physician services based on the sustainable growth rate, as well as the Medicare economic index, and an adjustment to bring the MEI update in line with the SGR target. When expenditures exceed the SGR target, the update for a future year is reduced. If expenditures fall short, the update for a future year is increased. This is an economic incentive for physicians to limit healthcare spending, in other words, to ration healthcare in the treatment.

Unfortunately, this system doesn't work. Healthcare spending continues to grow, and physicians exceed their target expenditures every year. Subsequently, Medicare reimburses them less and less. This bill

ends application of the SGR on January 1, 2007. Instead, we propose using a single conversion factor for Medicare reimbursement, the MEI index. This eliminates the negative feedback loop that constantly creates a deficit in healthcare funding, and introduces a market sensitive system. For 2007, the MEI forecasts that the input prices for physician services will increase by approximately 2.8 percent. We have already heard testimony that that creates a 10 year budgetary charge of $218 billion, according to CBO. In order to accommodate the high cost, we propose Medicare-reimbursed physicians at an MEI minus 1 percent for this bill.

Regarding quality measures, the AMA and other physician organizations have been working to create a relevant evaluation system for outpatient care. This is a good thing. This bill does not attempt to reinvent the wheel. Those provisions establishing quality performance measures are designed to build on work undertaken by the AMA, by the specialty organizations, and by other groups. Each physician specialty organization will create their own quality measures applicable to core clinical services which they will submit to a consensus-building organization. Taken as a whole, these measures should provide a balanced overview of the performance of each physician.

To offset the cost of these changes, we are looking at multiple options. Redirecting the stabilization fund from the Medicare Modernization Act provides approximately $10 billion. Also, Medicare currently pays for indirect costs of medical education, but pays for them twice: directly, by inflating payments to Medicare Advantage Plans it pays directly; and by inflating payments to Medicare Advantage Plans. By paying only directly, we can find additional savings.

This bill, and its pay-fors, is just a start. We are trying to develop a product that will ultimately be satisfactory to all stakeholders, and we welcome the input from those that are interested in a dialogue.

Also, I would like to extend a particularly warm welcome to a fellow North Texan, Dr. Lynne Kirk, who will be testifying on Thursday--that is the day we set rates for economists. As both a physician and educator, she brings a unique perspective to this hearing. She is the Associate Dean for Graduate Medical Education at UT Southwestern, and an Associate Chief of Division of General Internal Medicine at UT Southwestern.

Thank you, Mr. Chairman. You have been very indulgent, and I look forward to working with members on H.R. 5866.

MR. DEAL. I thank the gentleman. Mr. Green is recognized for an opening statement.

MR. GREEN. With all due respect, I walked in after Ms. Capps.

MR. DEAL. It was order of seniority before we started the hearing.

MR. GREEN. Okay. Sorry. Thank you, Mr. Chairman. Mr. Chairman, I would like to have my full statement placed in the record.

I don't think any of us in this room that are elected officials haven't been educated by our local physician about the problems they have with the fee schedule and the rate reductions doctors are scheduled to receive over the next year.

It has been over a decade since the physician fee schedule was put into place to help control increases in Medicare payments to physicians. Since 1997, the fee schedule has utilized the sustainable growth rate system to set a spending target for Medicare expenditures. Despite the complicated formulas used to derive the SGR, the physician fee schedule, the idea behind the formula is fairly simple. If Medicare expenditures on physician services exceed a target in a given year, CMS will decrease the payments for physician services next year. If expenditures fall short of the target, physician payments will increase.

While Congress enacted these stopgap measures for rate cuts in 2002 through 2006, it is clear that the system contains some inherent flaws that must be addressed to ensure the long-term viability of Medicare access to beneficiaries. When the current system essentially penalizes physicians for increased volume of physician services, it does not distinguish between simple over-utilization or increase in healthcare utilization actually leads to better health outcomes.

In my hometown of Houston, we have a great many of the world's best medical facilities where the scope of care is unmatched. Yet, I meet physicians every day, in every working specialty, who say that this system threatens our Medicare beneficiaries' access to the healthcare they provide. Yet, according to the recent GAO report, we have not reached that breaking point yet, but I worry about a future where fewer doctors will be willing to treat Medicare beneficiaries simply because of the reimbursement problems. If we ever reach that point, Medicare would have failed its mission.

Mr. Chairman, that is why this hearing is so important. We have a number of distinguished panelists, both today and for Thursday, and again, I would hope that we would look at both the needs of our physicians, but also realize that beneficiaries are scheduled to pay $98.20 for their monthly Medicare Part B in 2007. We must take into account the effects on the beneficiaries and their ability to afford healthcare under Medicare Part B.

And again, I welcome our witnesses, and yield back my time.

MR. DEAL. I thank the gentleman. Mr. Ferguson is recognized for an opening statement.

MR. FERGUSON. Thank you, Mr. Chairman, and thank you for holding this hearing, and for your leadership on many healthcare issues.

Medicare physician payment is an issue that demands our attention, because it directly affects the ability of our Nation's physicians to provide care. If we fail to act by the end of the year, physicians will see a cut of almost 5 percent in payments for Medicare, and if the SGR were allowed to continue to be applied in subsequent years, the cuts will continue to mount by as much as 37 percent through 2015. And as physician payments go down, practice costs during the same period are expected to increase 22 percent. As medical liability premiums spiral upwards, and the Baby Boomers approach Medicare age, we cannot cut the legs out from under our doctors by slashing their Medicare payments.

The SGR is fatally flawed, and it is time we start writing its obituary today. Instead of the SGR, payment updates should be based on other factors, perhaps based on annual increases in practice costs. And I look forward to hearing from our distinguished panels today about their suggestions. I understand that the solution may be costly, and combined with other expensive priorities discussed in the past weeks in this committee, like restoring cuts to imaging services, we have a lot on our plates to address. But there is no doubt that we must find a comprehensive approach to solving this problem, and I believe that there are ways which we can craft a solution.

Our physicians deserve more than having to beg to be compensated justly for their services. It is our duty to address this issue, and I am happy that we are doing it with these two hearings this week.

Thank you, again, Mr. Chairman, and I look forward to working with you and other members of our committee to help solve our Nation's problems, particularly with regard to physicians, as we try to fix this mess. And I yield back.

MR. DEAL. I thank the gentleman. I now recognize the Ranking Member of the full committee, Mr. Dingell, for an opening statement.

MR. DINGELL. Mr. Chairman, thank you, and thank you for holding this hearing on physician payment issues under Medicare.

The vast majority of Medicare beneficiaries are satisfied with their doctor, and they would like to continue going to the doctor of their choice. We must protect this right by providing physicians with fair and adequate compensation. This week's hearings will examine this very critical issue in Medicare.

But once again, I would point out that the Majority has chosen to ignore another critical issue. For 4 months, the Majority has failed to afford the Minority the hearing on beneficiary issues with Medicare prescription drug benefits. We are entitled to these hearings under Rule XI. We have many witnesses that the committee should hear from.

But what we are addressing today is also very important to beneficiaries. Doctors are facing major payment cuts under Medicare for

the foreseeable future, and this is going to have a significant impact upon the practice of medicine, and upon the beneficiaries as well. Fixing the Medicare physician payment system is expensive, but it can and it should be done.

Last year, in an effort to head off a major problem, I offered an amendment in this committee during a markup of the Deficit Reduction Act that would have provided a minimum update consistent with MedPAC's recommendations for this year and the next, and protected beneficiaries from increased premium costs. Unfortunately, it was defeated, with only one Republican member joining us in our efforts to protect Medicare and Medicare beneficiaries.

This week, I intend to introduce legislation along these same lines, providing doctors with 2 years of updates based on MedPAC's recommendations, and protecting beneficiary premiums until a long-range solution can be found. I do find it curious that doctors are going to be given a 4.6 percent cut in payment, while year after year, HMOs in Medicare continue to receive overpayments. This is a scandalous situation. It appears that there are many who want to see Medicare as we know it ended by squeezing payments to the doctors who care for Medicare patients under fee-for-service, and forcing seniors into HMOs.

It is also, again, curious, I repeat, that we are giving what we acknowledge is more than they are entitled to to the HMOs, in the way of payments from the Federal government. Why should HMOs continue to prosper at the expense of doctors in a time of budget deficits? Of course, many changes to the physician payment system that increases Medicare spending should also protect beneficiaries against further out-of-pocket spending increases. Many seniors already see their entire cost-of-living payments adjustment in their Social Security check eaten up by record increases in Part B premiums.

On the second day of this hearing, we will hear about "pay-for-performance." This is one of the newest healthcare buzzwords. Linking payments to quality is a good goal, but I think that we must proceed in a measured fashion, and be sure that we know what we are doing. It is fair, I think, here that we should apply the abjuration to the doctors: "First, do no harm."

Jumping into a reporting system in 2007 without proper measures in place, and without understanding how those measures will work, and then attempting to base payments on this system, is almost certain to bring about worse rather than better quality care. This hastefully conceived movement to pay-for-performance, coupled with severe cuts to the doctors, is going to drive more seniors into managed care plans, not by choice, because they really don't want this, but by grim necessity. Many of these plans tend to be more expensive, not as efficient, and to

make biased medical decisions more beneficial to their shareholders than to patients. Poor medicine, indeed.

This Committee and the Administration should be moving to protect the ability of our seniors and people with disabilities to see their own doctor, and it should be noted that the committee last year failed when it had a chance, and all the hearings in the world will not hide that decision and its unfortunate consequences.

I thank the witnesses here today, and those who will be here on Thursday, for addressing these important issues, and I look forward to their testimony.

Thank you, Mr. Chairman.

MR. DEAL. I thank the gentleman. We now recognize the Chairman of the full committee, Mr. Barton, for an opening statement.

CHAIRMAN BARTON. Thank you, Mr. Chairman, and thank you for holding this very important hearing. I want to welcome our witnesses today. I look forward to hearing from their perspectives on the issue of physician payment for providing Medicare services.

Last week, your subcommittee heard about the rapid growth in physician spending for imaging services and the concerns of many groups regarding Medicare's payment for those services.

Today, we are going to examine more broadly the current Medicare fee-for-service physician payment system. We are going to hear from several payment policy experts about how the Federal government currently reimburses physicians for the Medicare services they provide, the trends in utilization of those services, the current problems associated with appropriate payment for the provision of those services, and the impact of how we reimburse physicians on beneficiary access to these services.

Medicare, as we all know, is the largest single purchaser of healthcare in the United States. In 2004, the last year we have complete records for, Medicare spent $300 billion, which is 19 percent of all the personal healthcare spending in this country. By itself, Medicare accounts for 3 percent of our national gross domestic product. In the last 25 years, Medicare has grown more than ninefold, from $37 billion in 1980 to $336 billion in 2005. As the Baby Boomers begin to retire, the projected spending growth for Medicare is estimated to be 7 to 8 percent annually until 2015. This would be roughly two to three times the rate of growth in the economy and the rate of growth in inflation.

These numbers leave little room to doubt that there is a trend of tremendous growth in Medicare. It is a big problem, but not all growth is bad. Some of this growth is due to advances in medical technology, which is good. We are doing a phenomenal job of keeping people alive today, and providing the best healthcare the world has to offer.

However, we must ensure that we can continue to offer this care for years to come. Therefore, a discussion on how to better reimburse physicians for the cost of care they provide should also include an appropriate volume control and quality check on the provision of these services.

Since 1997, physician payments have been linked to something called SGR, sustainable growth rate. Over the last several years, Congress has prevented negative updates in this system, pursuant to the SGR. What we have done is, year after year, intervened with a short-term fix. We did that last year. While affording some relief, these fixes have not been achieved. Last year, physicians faced a 4.4 percent cut. We intervened and replaced the cut with a one year freeze. This modest action, in budgetary terms, cost billions of dollars. To provide just a 1 year freeze again this year will cost billions more.

I don't believe that we can continue this Band-Aid approach to fixing the recurring physician payment problem. I don't think it is fair to the doctors who treat Medicare patients. I don't think it is fair to Medicare patients to see their premiums rise each year. I don't think it is fair to the taxpayers who see what we spend from the general fund go up year after year.

If at all possible, I think we need to fix the basic structure of the program for as long a term as possible. I think we need to consider how to build a payment system that adequately reimburses physicians for the care they provide. We need to account for the trend of rapid spending for physician services, particularly imaging. We need to ensure that proper volume controls are in place. In part two of this hearing, we are going to hear about quality measurements and pay-for-performance in physician payment. The current Medicare system does not account for whether or not the services provided by a physician are appropriate. The fact that Medicare reimburses a physician for services rendered, no questions asked, raises concerns with many people about overuse, underuse, and misuse.

I applaud Dr. McClellan's leadership and foresight with regards to his pay-for-performance initiative and quality measurement effort. I am eager to hear from him about his efforts to date and to hear from the physician representatives about their collaboration with Dr. McClellan and his associates. I want to hear from private payers and other people like that.

Mr. Deal, I want to thank you for holding this hearing. I think it is very important. I want to reiterate I think it is possible to fix the system and I think it is possible to fix it in this Congress, which means in the next 2 months.

Thank you for holding the hearing.

[The prepared statement of Hon. Joe Barton follows:]

PREPARED STATEMENT OF THE HON. JOE BARTON, CHAIRMAN, COMMITTEE ON ENERGY AND COMMERCE

Good morning. I would like to welcome all of our witnesses here today. I look forward to hearing your perspectives on the issue of physician payment for providing Medicare services.

Last week, in this subcommittee, we heard about rapid growth in physician spending for imaging services and the concerns of many regarding Medicare's payment for those services. Today we will have the chance to examine more broadly the current Medicare fee-for-service physician payment system. We will hear from several payment policy experts today about how the federal government currently reimburses physicians for the Medicare services they provide, the trends in utilization of these services, the current problems associated with appropriate payment for the provision of these services, and the impact of how we reimburse physicians on beneficiary access to these services.

Medicare is the largest single purchaser of health care in the United States. In 2004, Medicare spending was roughly $300 billion—19 percent of all the personal health care spending in this country. Presently, Medicare spending accounts for 3 percent of the national GDP.

In the last 25years, Medicare has grown more than nine-fold, from $37 billion in 1980 to $336 billion in 2005. As the baby boomers begin to retire, the projected spending growth for Medicare is estimated to be 7 to 8 percent annually until 2015.

These numbers leave little room to doubt that there is a trend of tremendous growth in the Medicare program. That's a big budget problem, but not all growth is bad. I hope some of it will be due to advances in medical technology. We are simply doing a phenomenal job of keeping people alive and providing the best health care the world has to offer.

However, we must ensure that we can continue to offer this care for years to come. Therefore, any discussion on how to better reimburse physicians for the costs of the care they provide should also include a consideration of appropriate volume controls and quality checks on the provision of these services.

Since 1997, with the passage of the Balanced Budget Act, physician payments have been linked to the Sustainable Growth Rate—the SGR. Over the last several years, Congress has prevented negative updates in physician payment pursuant to the SGR. Year after year, Congress intervenes with short-term fixes. While affording physicians some relief, however small, these fixes have not been cheap. Last year, physicians faced a 4.4 per cent cut. Congress again intervened and replaced the cut with a one-year freeze. This modest action cost billions of dollars.

To provide just a one-year freeze again this year will cost billions more. We simply cannot continue this Band-Aid approach to fixing this recurring physician payment problem. It is not fair to the doctors who treat Medicare patients; it is not fair to the patients who see their premiums rise each year; and it is not fair to the taxpayers who entrust us with their money. We need to fix the basic structure of this program for as long a term as is possible.

We need to consider how to build a payment system that appropriately reimburses physicians for the care they provide. We need to account for the trend of rapid spending for physician services, particularly imaging, and we need to ensure that the proper volume controls are in place. In part two of this hearing, we will hear about quality measurements and pay-for-performance in physician payment. The current Medicare payment system does not account for whether or not the services provided by a physician are appropriate. The fact that Medicare reimburses a physician for services rendered—no

questions asked—raises concerns with many people, myself included, about overuse, underuse, and misuse.

I applaud Dr. McClellan's leadership and foresight with regards to his pay-for-performance and quality measurement efforts. I am eager to hear from him about his efforts to date, and to hear from physician representatives about their collaboration with Dr. McClellan, private payors, and each other to develop appropriate quality measures.

I want to thank Chairman Deal for calling this hearing, and reiterate my thanks to all the witnesses for coming today and Thursday. I look forward to their testimony.

MR. DEAL. I thank the gentleman. Ms. Capps is recognized for an opening statement.

MS. CAPPS. Thank you, Mr. Chairman, and thank you for holding this hearing. It is an important one, as my colleagues have mentioned, and I appreciate the panel of witnesses we have before us.

We are one of the committees with oversight responsibility of the Medicare program, and thus, it is our responsibility to fix the physician reimbursement system. Every year, however, we find ourselves in the same situation. Because of a bad law that needs to be fixed systemically, physicians face significant cuts to their reimbursements, and Congress steps in at the last minute with a Band-Aid or two to save them temporarily. Just this past year, we once again prevented another cut, but these short term Congressional fixes really don't address the heart of the problem.

We should be making real reforms that would adequately reimburse physicians for services they provide in a way that ensures the very best care for Medicare beneficiaries. MedPAC and other leading nonpartisan experts have encouraged Congress to enact such fixes, and it is about time, I believe, that we follow their suggestions.

The first two changes I think we would all like to see are a replacement of the sustainable growth rate, the SGR, and an update to the geographic adjustment. I am pleased that we are going to take the time to discuss the SGR today, but we need to take an opportunity to urge this committee, and I hope panelists might do that, to look at the geographic adjustment issue as well, because until we do that piece of it, we are not going to address this problem. That is, the geographic adjustment is actually, after all, a huge factor in determining physician fees, and unfortunately, a huge barrier for physicians in many counties trying to run a practice. I represent two of these counties, San Luis Obispo and Santa Barbara, that currently receive reimbursements much lower than the actual geographic cost factors for those counties. In fact, there are 175 counties in 32 states where physicians are paid 5 to 14 percent less than their Medicare assigned geographic cost factors, because they are assigned to inappropriate localities.

I hope my colleagues are taking notice, and I am going to repeat some of the statistics that my colleague, Anna Eshoo, gave, because

several members of this subcommittee have such counties in their district, and this is just an indication of how pervasive it is. Chairman Barton was just here, and I know he knows that in Ellis County, Texas, his physicians are receiving 7.5 percent less than the true cost of practicing medicine. And my colleague already mentioned that Chairman Deal represents the poster child for this discrepancy, where physicians receive a staggering 12 percent less than the true cost of practicing medicine. After a period of time, it is going to tell you something about the quality of medicine being practiced in that county. Similarly, several of us, Mr. Norwood, Mr. Shimkus, Mr. Pickering, Ms. Myrick, Ms. Eshoo, Mr. Green, Ms. DeGette, Mr. Dingell all have counties where physicians are underpaid by over 5 percent.

Proposals have been put forward to correct the situation by moving those counties into localities that reflect the true geographic cost factors of those counties, but none of them have been acted upon. I hear about this problem of underpayment constantly from physicians and patients as well in my district. Physicians leave the area because they can't afford to practice there, and with each physician who leaves, the number of patients who are left have to find new doctors, wait longer for appointments, travel further for their visits.

So, I hope today is truly a dialogue that can lead to some real solutions for the problems that plague our Medicare physician system. And I yield back.

MR. DEAL. I thank the gentlelady. Mr. Bilirakis is recognized for an opening statement.

MR. BILIRAKIS. Thank you very much, Mr. Chairman.

Mr. Chairman, as we know, it is imperative that we discuss ways to improve the Medicare physician payment system, and that we do the improvement soon. I think it is time that we stop talking about it, and decide to do something about it.

Congress has specified a formula, again, as we know, known as the sustainable growth rate, SGR, to provide an annual update to the physician fee schedule. The problem is that the SGR formula upon which the updates are based is irreparably flawed, principally because it fails to link payments to what it actually costs doctors to provide services to Medicare beneficiaries. These and other shortcomings have precipitated cuts in reimbursement which threaten the access of Medicare beneficiaries to the critical care physicians provide.

I am pleased, of course, that the Deficit Reduction Act included provisions to stop this year's projected cuts, but we again find ourselves in the very familiar position of having to act in the waning days of a session to avoid potentially disastrous Medicare cuts next year.

Our colleague from Georgia, Mr. Norwood, has introduced legislation, which I have cosponsored, to stop future reimbursement cuts and guarantee that physicians would receive at least level payments until we can address this issue in a comprehensive manner. Dr. Burgess recently introduced a more comprehensive bill to address the problem, which we should study thoroughly, because these two Members speak from practical, real-world experience. The problem with providing temporary fixes, though they are much needed, and I have helped enact them previously, is that doing so adjusts future updates downward to make up for added program spending. It is clear to me that Congress must design an update system which ensures that Medicare payments keep pace with the true costs, the true costs, again, I underline, of providing care, and rewards physicians who provide high quality care as cost effectively as possible.

I certainly support the goal of improving quality and avoiding unnecessary healthcare costs. I supported including in the Medicare prescription drug law a pay-for-performance demonstration project, and again, I emphasize demonstration project, to study the feasibility of using technology and evidence-based outcome measures for improving care.

Dr. McClellan, who we will hear from on Thursday, has indicated that such projects may provide valuable information to help Congress determine whether performance measures can be crafted to create such a program. I am unsure, however, whether reasonable pay-for-performance measures can be crafted in conjunction with this year's effort to stop planned provider cuts in Medicare. I believe that we should proceed with caution in this area, seriously, Mr. Chairman, with great caution in this area, to ensure that we are not simply making more work for physicians without corresponding measurable increases in healthcare quality.

I look forward, as you know, to working with you and the others on a bipartisan basis, because it is going to take bipartisanship to design a more efficient payment system, and ensuring that the annual updates physicians receive for treating Medicare patients are sufficient to ensure that beneficiaries continue to have access to the high quality care they deserve.

Thank you for your consideration, Mr. Chairman.

MR. DEAL. I thank the gentleman. Mr. Allen is recognized for an opening statement.

MR. ALLEN. Mr. Chairman, thank you for convening this hearing.

The Budget Reconciliation Law froze Medicare physician payments at 2005 rates, averting a scheduled 4.4 percent reduction in payments. While this action maintained payment rates for this year, unless Congress fixes the current reimbursement formula, physicians can expect a 26

percent decline in payments over the next 6 years. By 2013, Medicare payment rates will be less than half of what they were in 1991, after adjusting for practice cost inflation.

We need to replace the current formula with one that more fully accounts for physicians' practice costs, new technology, and the age and health status of the patient population being served. Physicians are the only providers subject to the sustainable growth rate formula. Every other provider in Medicare gets increased payments based on their increased costs. Insufficient payment hurts rural States like Maine particularly hard, because they have a disproportionate share of elderly citizens, and patients have limited access to physicians, particularly specialists.

We have two challenges facing us today. One, how to fix the problem of negative payment updates, and two, how to pay for it. The burden of fixing this payment formula should not fall on the shoulders of Medicare beneficiaries, whose Part B premium has increased almost $12 this year, to $78.20 a month. Next year, it goes up a full $20, to $98.20 a month. This increase comes at a time when many beneficiaries will be facing an increased financial burden if they fall into the doughnut hole gap in drug coverage. Moreover, savings must not be squeezed from providers through hastily designed pay-for-performance targets.

I hope that our panelists can help us to understand the flaws of the current payment system, and how to ensure that Medicare patients across the U.S. have access to their doctors, and with that, Mr. Chairman, I yield back.

MR. DEAL. I thank the gentleman. Mr. Shadegg is recognized for an opening statement.

MR. SHADEGG. Thank you, Mr. Chairman, and I commend you for holding these hearings.

It seems to me that everyone in the room understands the current system is flawed. I believe the current system is flawed almost by design, that is to say, we consistently, as a Congress, promise benefits to the American people, and then, when the tab comes due to pay for those benefits, we discover we do not have the cash available to do that, and so, rather than going out and getting the money to accomplish the task, we decide we should shortchange the providers. That is an unacceptable system. It is not a service to the public, and it is not a service to the medical community providing the services.

We owe an obligation to the American people, I believe, Mr. Chairman, when we promise a level of benefits, to pay for that level of benefits, and it is unrealistic and inappropriate to expect providers to continue to provide care that we promise at rates less than provide them a

decent standard of living, or compensate them for the training they have received.

I understand that we are focused at the moment on a short-term solution, and I believe that it is very important that we do work out a short-term solution, but in the long run, Mr. Chairman, we need to redesign this system. I believe the system is fundamentally flawed in its structure, wherein it does not compensate providers for the real cost of providing the services or pay them at appropriate levels for their services. In the United States, we have what I think is unquestionably the best healthcare system in the world. However, we are in danger of losing that, if we continue to provide payment to providers at below market rates, or below what rates they should be paid, given their training and their services to the country.

The latest buzzword in this whole debate, Mr. Chairman, is pay-for-performance. I am a huge fan of the concept of pay-for-performance, and it sounds like a good idea. Indeed, I believe everywhere in our society, we have established that when you pay people to perform, they perform better. However, count me as a skeptic in pay-for-performance as currently proposed in the Medicare arena, and in this particular field, because I am afraid we are not going to establish pay-for-performance based on the performance delivered to the consumer, the patient, but rather, pay-for-performance measured by some government standard.

Again, disassociating the consumer from the payment, and measuring performance by some government-set standard, rather than by the accurate measure, that is, what the patient believes they received out of the care, will, I believe, set us once again on a track to distort what is the system. At the end of the day, I believe it is very important to get consumers back into the process. If we measure pay-for-performance based on whether or not patients are happy with their outcome, then I think we have taken the system in the correct direction. If we measure the system based on whether or not a government bureaucrat believes the physician met certain standards that the government bureaucrat set, I am not at all convinced we are aiding in the system.

I do believe this hearing is very, very important. I believe it is critical that we stop shortchanging providers in the whole structure. I believe we can create a better structure, and I believe we absolutely must at least provide an update for the current cycle, so that we do not continue to burden providers, essentially forcing them to provide services at below market rates, and cost shift to other consumers in the private.

Again, Mr. Chairman, I commend you for this hearing. I did have a written statement, which I would like to put into the record, and with that, I yield back.

[The prepared statement of Hon. John Shadegg follows:]

PREPARED STATEMENT OF THE HON. JOHN SHADEGG, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ARIZONA

Mr. Chairman, thank you for holding this hearing. Everyone knows we have a serious problem to deal with. The current system of physician payment under Medicare is not sustainable, nor is it reasonable to expect physicians to take a 4.6 percent reduction in payments, which is what will happen in 2007 if we fail to act this year. Moreover, failure to act now would result in a 5 percent reduction in payments in each year from 2008-2016 under current law.

I think we need to look at this issue, not just to enact a temporary fix but instead with an eye toward more permanent reform. It is evident that, over the last 20 years, the various standards to control physician payment under Medicare, volume performance standards, behavioral offsets, and sustainable growth rates simply have not worked. We need fundamental reform, but that will be "costly" under Congressional budget scores.

The question is not how much we pay physicians this year, the question is how do we fairly compensate physicians for the work the government asks them to do? I think there is even a more fundamental question and that is: can the government go on promising a level of benefits and then, when they discover the cost of that level of benefits is higher than anticipated, push that burden, shove that gap between cost and what they are willing to pay off on the providers?

I would suggest that, since the creation of this program, we have had that problem. Politicians have said well, we love to promise benefits to the public, tell them we will provide these services, outline vast expansive services and then when the bill comes home, they like to say, my gosh, I didn't realize it was going to cost that much, what can I do. I don't want to raise taxes so I will short change the providers. The effects of that in the short term and in the long term are extremely serious.

I believe this reality demonstrates that government-run health care fundamentally doesn't work. I think it demonstrates that government planners don't know the answer, and I think it demonstrates that politicians that promise benefits and refuse to pay for them don't belong in office.

I believe we need to pay physicians for the services they provide. But it seems to me that we are forever looking at one more government solution, one more government plan.

The latest buzz phrase is "pay-for-performance." I remain skeptical about what this term implies. I am skeptical about pay-for-performance because while we may think pay-for-performance sounds wonderful, I think we need to ask one more question: who is going to decide what level of performance we are going to pay for? And, in none of the plans presented is it the patient that is going to decide what performance they pay for.

To the contrary, it will be a government bureaucrat who is going to layout a set of practices and tell the doctor; perform to this standard, and then we will pay you.

If I wanted to get my health care from a government bureaucrat, I would go to a government bureaucrat for my health care, but I don't. I go to physicians whom I trust and whom I believe in, and I would rather pay them based on the quality of the care I believe they deliver.

Mr. Chairman, I commend you for holding this hearing, however, I don't think we will ever fully resolve this issue until patients are in control of their health care dollars. Only then will we have pay-for-performance. I look forward to hearing from our distinguished panelist on this important topic.

Mr. Chairman, I yield back my time.

MR. DEAL. I thank the gentleman. Without objection, it will be in the record.

Mr. Towns is recognized for an opening statement.

MR. TOWNS. Thank you very much, Mr. Chairman, first for holding this hearing, and I would also like to welcome our witnesses here today.

The importance of this hearing cannot be overstated. It is critical that we pay attention to how and what we pay our doctors under Medicare. A large part of the challenge is that we have been sending the wrong messages and giving the wrong incentives to our doctors. We want them to provide quality care, yet we pay them to see as many patients as possible as quickly as possible. We then reward them for providing the most expensive procedures they can provide.

This emphasis, in my view, is wrong. We should emphasize quality and effective care to extend the lives of our aging population. It is clear we have gone down the wrong road. Beneficiaries have seen increases in their monthly payments without an increase in their quality of care. Sometimes, seniors have already been priced out of the healthcare market. There is something wrong here. I hope today that we can look at quality of care issues, and include these in the mix of how we reward our physicians, which will make it possible to provide the right incentives for all concerned, lower the costs of providing care, and give the quality of care that our Medicare beneficiaries deserve.

Let me point out, Mr. Chairman, that cutting the pay of doctors is not the solution to the problem that we are facing. I am hoping that we will take this information that we are going to receive, look at this matter in a very careful fashion, and come back in a very bipartisan way, and work out a solution to the problem. I am really concerned that we are going to lose a lot of good and effective and committed physicians, because they want to feed their families, and will go into another area.

Thank you, Mr. Chairman, and I yield back on that note.

MR. DEAL. I thank the gentleman, and recognize Mr. Pickering for an opening statement.

MR. PICKERING. Mr. Chairman, I thank you for this hearing, and I hope it sets the groundwork for action on these critical issues in the near future.

I do want to join with other colleagues who have talked about the need to make sure that we get right our physician payment system, and that we find a way to reform it in a way that will be sustainable over the long term. As we look at performance, I want to make sure that we enhance performance, to get away from the bureaucratic compliance models, and go toward incentive-based outcome, a result oriented system that will give the physicians and the healthcare providers the flexibility and the freedom to do their job in the best way that they see fit, to give better healthcare. And I hope that we can move away from the past and

the old models, and find a new way to incent good care, quality care, and better performance.

I look forward to hearing the testimony today, and I thank you for all your work in bringing us to this point, and I hope that we can see action in the very near future on these critical issues.

Thank you, Mr. Chairman.

MR. DEAL. Thank you. Mr. Pitts is recognized for an opening statement. Mr. Pitts waives. Mr. Rogers?

MR. ROGERS. I waive.

MR. DEAL. All right. I believe we have covered all members for opening statements.

[Additional statements submitted for the record follow:]

PREPARED STATEMENT OF THE HON. FRED UPTON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. Chairman, thank you for convening today's hearing to explore options for reforming the Medicare physician fee schedule to ensure it accurately reflects the cost of providing high-quality, efficient care. Reform will be a daunting undertaking. There are no easy or cheap fixes to the current complex and unpredictable system that will get us to where we need to be—a system that accurately reimburses for the cost of quality care efficiently and prudently provided. But we cannot let things just roll along as they are, continuing to subject physicians to year-to-year uncertainly over whether or not their reimbursement will be significantly reduced and limiting their ability to provide care for their current Medicare patients and accept the onrush of new beneficiaries that will join the rolls as the Baby Boom retires.

Carefully crafted reform is particularly needed to preserving access to care for Michigan's Medicare beneficiaries. With 13.2 physicians per thousand Medicare beneficiaries, Michigan is below the national average, and that ratio is going to get worse. Further, about 33 percent of today's Michigan physicians are over 55 and approaching retirement.

According to a recently released study of Michigan's physician workforce, Michigan will see a shortage of specialists beginning in 2006 and a shortage of 900 physicians overall in 2010, rising to 2,400 in 2015 and 4,500 in 2020. Cuts in Medicare reimbursement will only exacerbate these shortages and seriously undermine access to care in our state.

Since coming to Congress in 1987, one of my top priorities has been strengthening access to health care for all Americans, and particularly for our senior citizens and persons with disabilities. I look forward to working with you and my colleagues on both sides of the aisle to develop a stable, predictable physician reimbursement system that links reimbursement to the true cost of care and the prudent delivery of quality care.

PREPARED STATEMENT OF THE HON. SHERROD BROWN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OHIO

Statement of Congressman Sherrod Brown
Ranking Member
Subcommittee on Health
Committee on Energy and Commerce

Thank you, Mr. Chairman, and thanks to our witnesses for joining us this morning.

I think it is important at the outset that we distinguish between two separate issues that too are offen are treated as one:

1) Physicians should be paid appropriately for the services they render; and 2) health care costs are rising.

Physicians are not to blame for rising health care costs, and they should not be penalized for rising health care costs.

And if we treat utilization and reimbursement as if they somehow balance each other out, we are living in a dream world.

There is no single formula that can perfectly balance changes in utilization and changes in per service reimbursement to achieve "fair" physician payment.

Good health care isn't achieved by "punishing" health care providers if utilization rates result in federal spending increases.

Whether or not the federal government can afford modern health care, whether or not modern health care can be modified to make it less expensive, and whether or not we are paying physicians appropriately are separate issues, and we should treat them that way.

If there is credible evidence that the current state of medicine involves a significant amount of "unnecessary" health care, then let's use that evidence to affect changes in the practice of medicine.

Personally, I don't believe "pay for performance" is a panacea, but at least it is an attempt to reduce costs by increasing health care efficiency. It's better than clinging to an arcane and patently unfair "sustainable growth rate" based physician payment system.

Let me modify that last statement slightly. Pay for Performance is better if we don't once again put in place an unfair payment system based on inadequate data and simplistic assumptions. If we're going to do it, we need to do it right.

Paying physicians appropriately is an expensive proposition. Not paying them appropriately is wrong.

Ensuring that seniors and people with disabilities have access to quality health care is an expensive proposition. For a nation that cares about the wellbeing of its members, not doing so is wrong.

The right thing to do is to pay physicians based on their time, their expertise, and their practice expenses, to do everything in our power to squeeze out unnecessary spending from our health care system, and to decide as a nation how much health care we can afford.

We can continue sitting in the cheap seats and confront these issues indirectly -- refusing to fix the SGR formula, but passing temporary fixes year after year; refusing to confront the actual forces pushing health care costs up, while dramatically overselling modest strategies like "pay for performance."

Unfortunately, the path of least resistance is also the path to a full-fledged health care crisis.

Let's not go there.

Thank you, Mr. Chairman.

It is my pleasure now to introduce our witnesses.

MS. ESHOO. Mr. Chairman. Mr. Chairman, I am sorry to interrupt. There were two pieces of paper that I wanted, or information that I wanted to include in the record, one from the California CMA, and another, a letter from the California bipartisan delegation relative to Medicare physician payments, for the record. I ask unanimous consent.

MR. DEAL. Without objection.

[The information follows:]

Members: Energy and Commerce Sub-Committee on Health

	District	Counties > 5%	State
Joe Barton	TX 6th District	**Ellis**	Multi-Locality
Nathan Deal	GA 10th District	**Pickens**	Multi-Locality
Mike Bilirakis	FL 9th District	None	Multi-Locality
Charlie Norwood	**GA 9th District**	**Barrow**	Multi-Locality
John Shimkus	**IL 19th district**	**Clinton, Madison, Jersey**	Multi-Locality
Paul Gillmor	OH 5th District	None	Single-Locality
Barbara Cubin	WY	None	Single-Locality
John Shadegg	AZ 3rd District		Single-Locality
Charles Pickering	**MS 3rd District**	**Hinds, Madison, Rankin**	Single-Locality
Steve Buyer	IN 4th District	None	Single-Locality
Joseph Pitts	PA 16th District	None	Multi-Locality
Mary Bono	CA 45th District	None	Multi-Locality
Sue Myrick	NC 9th District	**Gaston, Mecklenburg, Union**	Single-Locality
Mike Feguson	NJ 7th District	None	Multi-Locality
Mike Rogers	MI 8th district	None	Multi-Locality
Michael Burgess	TX 26th District	**Denton**	Multi-Locality
Sherrod Brown	OH 13th District	**Cayahoga**	Single-Locality
Henry Waxman	CA 30th District	None	Multi-Locality
Edolphus Towns	NY 10th District	None	Multi-Locality
Frank Pallone	NJ 6th District	None	Multi-Locality
Bart Gordon	TN 6th District	None	Single-Locality
Bobby Rush	IL 1st District	None	Multi-Locality
Anna Eshoo	**CA 14th District**	**Santa Cruz**	Multi-Locality
Gene Green	**TX 29th District**	**Harris**	Multi-Locality
Ted Strickland	OH 6th District	None	Single-Locality
Diana DeGette	**CO 1st District**	**Denver, Arapahoe**	Multi-Locality
Lois Capps	**CA 23rd District**	**Santa Barbara, San Luis Obispo**	Multi-Locality
Tom Allen	ME 1st District	None	Multi-Locality
Jim Davis	FL 11th District	None	Multi-Locality
Tammy Baldwin	WI 2nd District	Dane	Single-Locality
John Dingell	**MI -5th District**	**Monroe, Livingston**	Multi-Locality

*Provided by the California Medical Association
Friday, July 21, 2006

Congress of the United States
Washington, DC 20515

December 13, 2005

31

The Honorable William M. Thomas
Chairman
Committee on Ways & Means
1102 Longworth HOB
Washington, D.C. 25015

Dear Chairman Thomas:

We are writing to urge you, as a conferee on the Budget Reconciliation Act, to address the crucial Medicare physician payment issues before the Conference Committee. Specifically, we ask that you stop the projected Medicare physician payment cuts, which will total 26% over the next six years while physician practice costs increase 15%. As you are aware, all other providers participating in the Medicare program are receiving payment increases (as shown in the chart below), except physicians, due to a flawed physician payment formula.

2006 Medicare Provider Payment Updates			
Physicians	– 4.4 %	Health Plans	+4.8%
		Hospitals	+3.7%
		Home Health	+3.3%
		Nursing Homes	+2.7%

We respectfully urge you to adopt a payment update that truly reflects the costs to practice medicine and thereby preserves seniors' access to doctors. 60% of the physicians responding to a California Medical Association survey said they would be forced to stop accepting new Medicare patients if the cuts go into effect – almost double the national response. 40% said they could be forced to quit Medicare altogether. These cuts could have a devastating impact in California where access is already a problem.

In addition, physicians in our state and many other states are experiencing serious inequities in their Medicare geographic payments. Over the past several years, counties across the country have become more urbanized and therefore, practice costs have increased. However, because of Medicare's geographic locality requirements, physicians in these transitioning counties cannot be reimbursed for their higher practice costs without reducing payments to physicians in rural areas. CMS has left the Medicare payment locality issues unattended for almost a decade. Therefore, some physicians are being paid as much as 10% less than Medicare's own geographic formula says they should be paid. We urge you to adopt the following Medicare Geographic Payment Locality proposal because it would improve access to physicians in areas with dramatically

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changing demographics without penalizing senior access in rural areas. The cost is a minor $115 million to fix nearly ten years of neglect.

- Allow any county whose geographic costs exceeds its Medicare Payment Locality costs by 5% to move to its own individual county Medicare Payment Locality and be reimbursed according to its individual costs.

- Hold harmless physicians in counties remaining in the originating Medicare Payment Locality at their 2006 Medicare payment levels plus any SGR updates.

Thank you for your consideration of these crucial Medicare issues.

Sincerely,

Rep. Sam Farr

Rep. Darrell Issa

Rep. Susan Davis

Rep. Jane Harman

Rep. Bob Filner

Rep. Dan Lungren

Rep. Elton Gallegly

Rep. Dana Rohrabacher

Rep. Tom Lantos

Rep. Doris Matsui

Rep. Howard P. "Buck" McKeon

Rep. Howard Berman

Rep. Ed Royce

Rep. Ken Calvert

Rep. Wally Herger

Rep. Lynn Woolsey

Rep. Jerry Lewis

Rep. Lois Capps

Rep. Mike Honda

Rep. Grace Napolitano

Rep. Hilda Solis

Rep. Loretta Sanchez

Rep. Xavier Becerra

Rep. Brad Sherman

Rep. Ellen Tauscher

Rep. Dennis Cardoza

Rep. Joe Baca

Rep. Mike Thompson

Rep. Mary Bono

Rep. Anna Eshoo

Rep. Gary Miller

cc: Speaker Dennis Hastert

MS. ESHOO. Thank you, Mr. Chairman.

MR. DEAL. We are pleased to have Donald B. Marron, who is the Acting Director of the Congressional Budget Office; Mr. A. Bruce Steinwald, who is the Director of Health Care of the Government Accountability Office; Mr. Mark Miller, who is the Executive Director of the Medicare Payment Advisory Commission; and Mr. Stuart Guterman, who is the Senior Program Director of the Program on Medicare's Future of the Commonwealth Fund.

Gentlemen, you are our first panel. Your written testimony has been made a part of the record, and we would ask in your 5 minutes if you

would summarize your testimony. We will proceed to questions following the completion of the testimony of the entire panel.

Mr. Marron, we are pleased to have you start.

STATEMENTS OF DONALD B. MARRON, ACTING DIRECTOR, CONGRESSIONAL BUDGET OFFICE; A. BRUCE STEINWALD, DIRECTOR, HEALTH CARE, GOVERNMENT ACCOUNTABILITY OFFICE; MARK E. MILLER, EXECUTIVE DIRECTOR, MEDICARE PAYMENT ADVISORY COMMISSION; AND STUART GUTERMAN, SENIOR PROGRAM DIRECTOR, PROGRAM ON MEDICARE'S FUTURE, THE COMMONWEALTH FUND

MR. MARRON. Thank you, Mr. Chairman, members of the subcommittee. It is a pleasure to be here today to discuss Medicare's physician payment rates, and in particular, the sustainable growth rate mechanism.

As you know, Medicare spending is projected to grow rapidly in coming years. Because of rising healthcare costs and the aging of the Baby Boomers, Medicare is projected to take up an increasing share of the Federal budget and of the overall economy. The task of setting physician payment rates thus raises challenging issues of balancing increasing fiscal pressures, on the one hand, with the goal of ensuring beneficiaries adequate access to care on the other.

The SGR is the most recent of a series of efforts to control spending on physician services in Medicare. As you know, the SGR attempts to limit spending by setting target amounts for both annual spending and cumulative spending, and then adjusts payment rates over time to bring spending into line with those targets. Recent spending on physician services has significantly exceeded those targets. In 2005, for example, expenditures were more than $94 billion, about $14 billion more than the $80 billion target for that year. At the end of 2005, total spending on physician services had exceeded the cumulative SGR target by about $30 billion, and that figure is growing rapidly. Bringing spending back into line with the SGR targets would thus require significant reductions in physician fees. Indeed, the SGR calls for sizable reductions in payment rates, 4 to 5 percent per year, for at least the next 5 years.

As this hearing demonstrates, however, there is significant debate about whether those payment reductions will actually come to pass. Recent history suggests that it would not be surprising if policymakers stepped in to override the SGR payment update. CBO has estimated the Federal budget impacts of a variety of proposals to change the way that physician fees are determined. The appendix to my written testimony

reports estimates for a variety of possible changes, each of which would increase physician payments relative to current law, at least in the near term.

Such increases have three main budget impacts. First and most obvious, increased fees result in higher physician payments in the near term. The longer term impact depends on whether the SGR would recoup these increases by cutting fees in the future. Second, higher physician spending implies higher receipts from beneficiary premiums. Those receipts reduce the budgetary impact of raising physician fees. Third, the changes in physician payments also affect payments made for Medicare Advantage plans. CBO's budget estimates take all of these effects into account.

Now, let me just go through quickly three possible options and the budgetary impacts of them. One option would be to override the SGR for a single year, as has happened in recent years. For example, Congress could specify that physician payment rates would increase 1 percent in 2007, rather than being cut, as required by current law. This change would increase physician payments in the next few years, but it would not change the underlying SGR targets. The additional spending would thus eventually be recouped by the SGR mechanism in later years. Of course, this implies that payment rates in those future years would be lower than scheduled under current law. CBO estimates that this option would increase Federal outlays by about $13 billion over the 5 year budget window. The cost over a 10-year budget window, however, would be only $6 billion, because future payment cuts under the SGR would recoup the extra costs. Of course, there is some question whether that recoupment would actually happen.

A second approach would be to override the payment update for a single year, and in addition, raise the target levels of spending, so that the update would not be recouped. This could be done, for example, by specifying that the update is a change in law for purposes in calculating the SGR targets. CBO estimates that this approach would cost $13 billion over 5 years, the same as the first option. These costs are the same, because under current law, no new recoupment could begin until after the 5 year budget window. In the absence of recoupment, costs would continue to grow in subsequent years, so that over a 10 year budget window, this option would cost significantly more, at $31 billion.

A third approach would be to eliminate the SGR entirely, and replace it with annual updates based on inflation, as measured by the Medicare Economic Index. Instead of being reduced by 4 to 5 percent annually for the next several years, payment rates would increase between 2 and 3 percent annually, CBO estimates. Those updates would not be subject to further adjustments, and spending increases would not be recouped.

CBO estimates that this approach would increase net Federal outlays by $58 billion over the next 5 years and by $218 billion over 10 years.

Thank you. I look forward to any questions.

[The prepared statement of Donald B. Marron follows:]

PREPARED STATEMENT OF DONALD B. MARRON, ACTING DIRECTOR, CONGRESSIONAL BUDGET OFFICE

CBO TESTIMONY

Statement of
Donald B. Marron
Acting Director

Medicare's Physician Payment Rates and the Sustainable Growth Rate

before the
Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives

July 25, 2006

This document is embargoed until it is delivered at 10:00 a.m. (EDT), Tuesday, July 25, 2006. The contents may not be published, transmitted, or otherwise communicated by any print, broadcast, or electronic media before that time.

CONGRESSIONAL BUDGET OFFICE
SECOND AND D STREETS, S.W.
WASHINGTON, D.C. 20515

Mr. Chairman, Congressman Brown, and Members of the Subcommittee, I am pleased to appear before you today to discuss the Sustainable Growth Rate (SGR) mechanism for setting Medicare's physician payment rates.

The Supplemental Medical Insurance program (Part B of Medicare) uses a fee schedule to pay for covered medical services provided by physicians. According to CBO's projections, payments to physicians under the fee schedule represent 16 percent of Medicare's total spending for benefits in fiscal year 2006—$60 billion of total expenditures of $375 billion.

Today, I am here to discuss how those fees are updated each year. My testimony will cover the following topics:

- The current mechanism for updating payment rates for physicians' services—the Sustainable Growth Rate method—has two key components: a target level of expenditures (measured on both an annual and a cumulative basis) and a method for adjusting payment rates in an attempt to bring expenditures in line with the targets over time. If the SGR method as currently specified is allowed to operate without legislative changes, the Congressional Budget Office (CBO) estimates that fees for physicians' services will be reduced by between 4 percent and 5 percent annually for at least the next several years.

- Legislation has prevented such cuts in recent years, and the Congress may choose to override the SGR mechanism again or may choose to change or replace it in the future. However, replacing projected reductions in payment rates with annual increases would be costly.

- Setting appropriate fees for physicians' services entails balancing the need to pay providers enough to ensure beneficiaries' access to care against the budgetary pressures created by ever-growing health care costs and an aging population.

- The Congress has a wide range of options for changing or replacing the SGR mechanism. One important question is whether payment rates in the future should be reduced to recoup the spending already incurred that exceeded the SGR targets, along with any future spending above the targeted amounts. I will discuss CBO's estimates of the impact of three illustrative approaches, including a one-year override of the scheduled 2007 reduction with the additional costs recouped in future years, a one-year override without such recoupment, and replacing the SGR mechanism with automatic updates to payment rates based on inflation.

The task of setting payment rates for Medicare services must be addressed in the context of challenging long-run budgetary trends. The aging of the baby-boom generation will significantly boost Medicare spending. If the nation spent the

same fraction of gross domestic product (GDP) on each Medicare beneficiary in 2030 that is spent today—a proposition that reflects only the increased number of beneficiaries at that point (along with their projected mix by age and sex)—Medicare spending in that year would reach a 5 percent share of GDP, compared with today's share of 3 percent, CBO projects. The fiscal implications of the baby boomers' aging are compounded by the fact that health care costs per beneficiary have also been growing significantly faster than the economy as measured on a per capita basis. If those trends continue and current law remains unchanged, Medicare spending could climb to 7 percent of GDP—or higher—by 2030.

Historical Background

Since the Medicare program was created in 1965, several ways of determining how much it pays physicians for each covered service have been used. Initially, the program compensated physicians on the basis of their charges and allowed them to bill beneficiaries for the full amount above what Medicare paid for each service. In 1975, Medicare payments were still linked to what physicians charged, but the annual increase in fees was limited by the Medicare economic index, or MEI.[1] Because those changes were not enough to prevent total payments from rising more than desired, from 1984 though 1991 the yearly change in fees was determined by legislation.

Starting in 1992, the charged-based payment system was replaced by the physician fee schedule. The fee schedule bases payment for individual services on measures of the relative resources used to provide them. The schedule itself was not intended to control spending—it was designed to redistribute spending among various physicians' specialties. The schedule was updated using a combination of the MEI and an adjustment factor designed to counteract changes in the volume of services being delivered per beneficiary. That adjustment factor, known as the volume performance standard (VPS), was based on the historical trend in volume. However, the VPS mechanism led to highly variable changes in payment rates, and the Congress replaced it with the current Sustainable Growth Rate method starting in 1998.[2]

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1. The Medicare economic index measures changes in the cost of physicians' time and operating expenses; it is a weighted sum of the prices of inputs in those two categories. Most of the components of the index come from the Bureau of Labor Statistics. Changes in the cost of physicians' time are measured using changes in nonfarm labor costs. Changes in "all-factor" productivity are also incorporated into the index as a way of accounting for improvements in physicians' productivity. In practice, since there are usually gains in productivity from one year to the next, including the productivity adjustment as part of the MEI results in a smaller rate of growth than the price adjustments by themselves.

2. For a more detailed discussion of the history of payment rates, see the statement of Douglas Holtz-Eakin, Director, Congressional Budget Office, *Medicare's Physician Fee Schedule*, before the Subcommittee on Health, House Committee on Energy and Commerce (May 5, 2004).

Experience Under the SGR Mechanism

The SGR mechanism aims to control spending on physicians' services provided under Part B of Medicare. It does so by setting an overall target amount of spending (measured on both an annual and a cumulative basis) on certain types of goods and services provided under Part B: payments for physicians' services as well as payments that Medicare makes for items—such as laboratory tests, imaging services, and physician-administered drugs—that are furnished "incident to" (in connection with) physicians' services. Payment rates are adjusted annually to reflect differences between actual spending and the spending target—upward if spending is below the target, downward if spending is above the target.

The Congress had two main goals when it adopted the SGR mechanism: ensuring adequate access to physicians' services and controlling federal spending on those services in a more predictable way than the VPS mechanism did. The SGR mechanism has a mixed record with regard to those goals.

More than 90 percent of physician and nonphysician providers agree to participate in Part B, and surveys generally show that beneficiaries do not experience significant difficulties in getting access to care. However, that situation may change if payment rates are significantly reduced, as will occur if the SGR mechanism operates as currently specified in law.

From 1997 (which is when the SGR method started measuring expenditures) through 2005, per-beneficiary spending on services paid for under the physician fee schedule grew by 65 percent, or about 6.5 percent per year. In contrast, per-beneficiary spending in the rest of Medicare (excluding Medicare Advantage) grew by about 35 percent over that same time period.

Aside from growth in Part B enrollment, which has averaged about 1 percent annually since 1997, increases in spending subject to the fee schedule can be attributed mainly to increases in the fees themselves and in the volume and intensity of services being provided by physicians. Since 1997, the fees that Medicare pays for each service have increased annually by an average of about 2 percent. Although some of the remaining increase has resulted from the addition of covered services, most of the rest is attributable to growth in the volume and intensity of services, which has averaged about 4.5 percent per year over the period.

Since 2002, spending measured by the SGR method has consistently been above the targets established by the formula. In 2005, expenditures counted under the SGR method totaled $94.5 billion, about $14 billion more than the $80.4 billion expenditure target for that year. Total spending since the SGR method was put into place in 1997 now stands at about $30 billion above the system's cumulative

target.[3] As a result, the SGR mechanism, under current law, will substantially reduce payment rates for physicians' services over the next several years. Payment rates could decline by a total of 25 percent to 35 percent during that period if physicians continue to provide services at the current rate.

Projected Spending for Physicians' Services

Because of the impending reductions in payment rates required under current law, Medicare spending on services provided by physicians is projected to grow relatively slowly for the next several years. CBO estimates that the decline in payment rates will be slightly more than offset by increases in enrollment and growth in the volume and intensity of services being delivered. As a result, CBO projects, Medicare spending on physicians' services will grow in coming years, but in 2012 it will be only 13 percent higher than it was in 2005, reflecting an average annual growth rate of less than 2 percent. In contrast, from 1997 through 2005, such spending grew by an average of about 7.7 percent annually.

Considerable evidence exists that a reduction in payment rates leads physicians to increase the volume and intensity of the services they perform. Although their participation rates are currently very high, CBO also expects that some physicians are likely to respond to continuing reductions in payment rates by declining to participate in the Medicare program.[4] Such responses to changes in payment rates do not explicitly affect CBO's projections of spending on physicians' services over the long-term because the SGR mechanism will adjust payment rates to offset changes in the volume of physicians' services furnished to Medicare patients. As a result, the reductions in payment rates will be smaller than the estimated 25 percent to 35 percent if the volume of physicians' services provided to Medicare participants declines because of either changes in the number of participating physicians or in the volume of services being provided.

From 1997 through 2001, cumulative spending governed by the SGR mechanism was slightly below the expenditure target set by the formula (see Figure 1). Starting in 2002, cumulative spending rose above the cumulative target. According to CBO's projections through 2016, if the current SGR mechanism is

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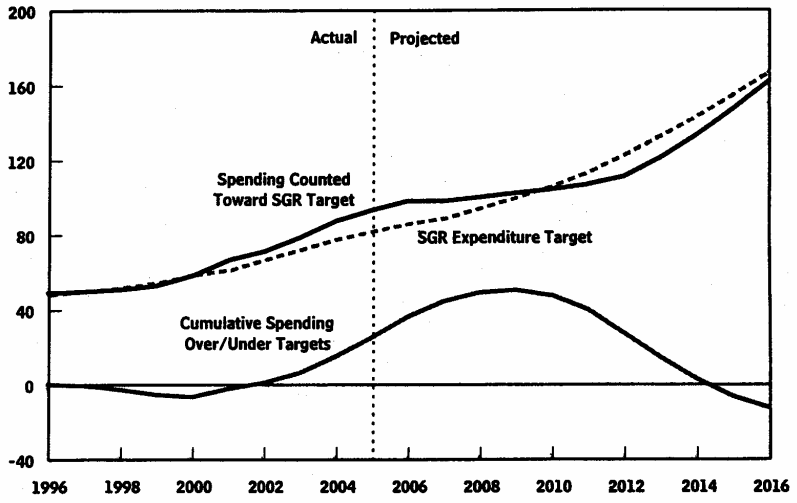
3. Those figures include both spending by the Medicare program and beneficiaries' cost-sharing obligations for services. Cost sharing amounts to roughly 20 percent of the total spending counted under the targets.

4. It is uncertain when such responses to declining payment rates would have a significant negative effect on Medicare patients' access to physicians' services. Several organizations, including the Government Accountability Office, the Medicare Payment Advisory Commission, and the Center for Studying Health System Change, are monitoring changes in the willingness of physicians to participate in Medicare and to accept new Medicare patients.

Figure 1.

Sustainable Growth Rate Spending Compared with Expenditure Targets

(Billions of dollars)



Source: Congressional Budget Office.

Note: SGR = sustainable growth rate.

permitted to operate, the cumulative deficit will continue to grow for several more years but will then shrink as the annual growth in spending is slowed by the reductions in payment rates called for by the SGR mechanism. Toward the end of the period, CBO's projections show cumulative spending coming back into line with the cumulative target.[5] The SGR mechanism is designed in such a way so that if viewed over a long enough period of time, cumulative spending will equal the cumulative target.

How the SGR Mechanism Works

The SGR mechanism consists of three components, each of which is based on statutory formulas:

5. CBO projects that cumulative spending will fall slightly below the cumulative target in 2015 and remain below for a short period of time. That is the result of the gradual nature of the adjustments to bring spending in line with the expenditure targets.

- Expenditure targets, which are established by applying a growth rate (calculated by formula) to spending during a base period;
- The growth rate; and
- Annual adjustments to payment rates for physicians' services, which are designed to bring spending in line with the expenditure targets over time.

The Expenditure Targets

The SGR mechanism establishes both year-by-year and cumulative spending targets (the law refers to the target spending levels as "allowed expenditures"). Included in the targets is Medicare's spending on services covered by the physician fee schedule and services provided "incident to" a visit to a physician. The fee schedule determines how much physicians get paid for each of the services they provide. The "incident-to" goods and services include laboratory tests and physician-administered drugs, such as chemotherapeutic ones; payment rates for those services are not determined by the physician fee schedule.[6] Services on that fee schedule accounted for about 85 percent of all spending counted toward the SGR target in 2005.

The SGR method uses spending that occurred between April 1, 1996, and March 31, 1997, as the base for all future spending counted toward the targets. During that base period, the amount of spending counted under the method totaled $48.9 billion. Each year, the spending target is updated from the base level to reflect the growth rate determined by the SGR formula. That formula produced a sustainable growth rate of 3.2 percent for 1998. Consequently, the expenditure target that year was $50.5 billion ($48.9 multiplied by 1.032).

The annual targets are added together (along with the original base amount) to produce a cumulative target. The cumulative target in 1998 was $99.4 billion ($48.9 billion plus $50.5 billion); according to the Centers for Medicare and Medicaid Services (CMS), the cumulative target in 2005 had reached $611.8 billion.

The Growth Rate

The expenditure targets are updated each year by applying a growth rate (the SGR) that is designed to account for various factors that contribute to changes in Part B spending. That growth rate incorporates the following factors:

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6. Payments for some services, such as laboratory tests, are based on their own fee schedules, which are usually updated annually for inflation. Payments for physician-administered drugs are based on market prices.

- First, it includes an adjustment for inflation that takes into account changes in the prices of goods and services used by physicians' practices and in the prices that Medicare pays for "incident-to" services. The change in prices of goods and services used by physicians' practices is measured by the Medicare economic index, which incorporates an adjustment for changes in productivity, as measured by the change in "all-factor" productivity in the economy as a whole. (When productivity rises, that adjustment reduces the MEI below where it would be if based on price increases alone.) The aggregate of those factors will be 2.6 percent for 2007, according to CMS's estimate.

- Second, the rate incorporates changes in enrollment in Medicare's fee-for-service sector, which CMS estimates will be a decline of 2.9 percent for 2007.

- Third, the SGR incorporates the estimated 10-year average annual growth rate in real (inflation-adjusted) gross domestic product per capita, which CMS estimates will be 2.2 percent.

- Fourth, the growth rate takes into account the effect of changes in law or regulation that would affect spending for services subject to the SGR mechanism—such as adding coverage of new benefits—which CMS estimates will be -1.0 percent.[7]

Those four factors are multiplied to yield an overall growth rate that CMS estimates will be 0.7 percent in 2007:

> Change in physicians' prices (**1.026**) x change in enrollment (**0.971**) x change in real GDP per capita (**1.022**) x changes in law or regulation (**0.990**) = **1.007**

The expenditure target for services covered by the physician fee schedule in 2006 is $81.7 billion. (That amount includes both spending by the Medicare program and cost-sharing obligations of beneficiaries.) Increasing the 2006 target by 0.7 percent results in an expenditure target of $82.3 billion for 2007.

In essence, the SGR method allows spending per beneficiary to grow with inflation, with these additional adjustments:

- A reduction that assigns the benefits of productivity improvements to the Medicare program;

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7. The reduction in the SGR due to changes in law or regulation is mainly attributable to provisions enacted in the Deficit Reduction Act (P.L. 109-362), most notably reductions in payment rates for imaging services.

- An increase—which could be considered an allowance for growth in the volume and intensity of services—equal to the real change in GDP per capita; and

- An increase or decrease to reflect any changes in the coverage offered by the program.

Once a determination of the SGR has been made for a given calendar year (usually around November 1 of the preceding year), it is not necessarily fixed. If actual experience for one or more of the four growth factors differs from the estimates in the original calculation, the SGR for that year can be changed. In other words, if the SGR for 2007 is set assuming that fee-for-service enrollment will decrease by 2.9 percent and in actuality it changes by a different amount, the SGR for that year will subsequently be adjusted. In that case, the rates paid in 2007 would not change, but the cumulative target for subsequent years would be adjusted. The SGR—and therefore the expenditure targets—for a particular year can be retroactively adjusted for up to two years.

Annual Adjustments to Payment Rates

The annual update to payment rates under the physician fee schedule involves two components: an inflation adjustment according to the MEI and an "update adjustment factor." The adjustment factor is based on the relationship between actual spending for services subject to the SGR and the formula's expenditure targets. If actual spending under the SGR does not deviate from the expenditure targets, payment rates under the physician fee schedule are simply increased by the MEI.

If actual spending deviates from the expenditure targets, annual updates to payment rates for physicians' services are adjusted. Those adjustments are designed so that, over a period of several years, cumulative spending will be brought back into line with the cumulative expenditure target. The update adjustment formula takes into account both the relationship between spending in a given year and that year's expenditure target and the relationship between cumulative spending and the cumulative expenditure target.

If actual spending is more than the targets, the update adjustment factor will be negative (that is, it will reduce the amount of the increase that would otherwise occur to reflect inflation); if actual spending is less than the targets, the update adjustment factor will be positive. The law sets an upper and lower limit on the update adjustment factor—it cannot exceed an increase of 3 percent or a reduction of 7 percent. For 2006, CMS determined that cumulative spending was about $30 billion above the expenditure targets and that the update adjustment factor determined by the formula would have been -21 percent; thus, the statutory limit

of -7 percent was used. Consequently, in 2006, payment rates for physicians were scheduled to decrease by 4.4 percent: a 2.8 percent inflation adjustment was more than offset by an update adjustment factor of -7 percent.[8] However, the Deficit Reduction Act overrode the formula for 2006 and held payment rates constant at their 2005 level.

Looking forward, CBO projects that spending for physicians' services will continue to exceed the cumulative target for the next several years. Unless it is modified again, the SGR method will reduce payment rates beginning in 2007 and will keep updates below inflation through at least 2012.

It is important to note that under the SGR mechanism, the adjustment factor applies only to the physician fee schedule and not to payment rates for "incident-to" services, which account for about 15 percent of the spending counted toward the SGR targets. Consequently, the SGR mechanism will adjust payment rates for physicians' services in future years to offset any difference between the rate of growth of spending for "incident-to" services and the growth rate of the SGR expenditure targets. If spending for the "incident-to" services grows faster than the SGR targets, payment rates for physicians' services will be reduced to compensate for that increase. Prior to changes in the way physician-administered drugs were paid for in 2004, such "incident-to" spending experienced several years of double-digit growth. The share of SGR-related spending accounted for by physician-administered drugs increased from about 7 percent in 2001 to 9 percent in 2005.

Recent Legislation Affecting the SGR

Since 2002, the SGR method has called for reductions in physician payment rates. In 2002, payment rates were cut by 4.8 percent, and CMS determined that rates would be further reduced by 4.4 percent in 2003. In the Consolidated Appropriation Resolution of 2003 (P.L. 108-7), the Congress responded to that imminent reduction by allowing the Administration to boost the cumulative SGR expenditure target, thereby producing a 1.6 percent increase in payment rates for physicians' services in 2003.

Spending continued to exceed the target and—if it had been allowed to operate—the SGR mechanism would have reduced payment rates in 2004. The Congress and the President acted to prevent such a reduction. As part of the Medicare Modernization Act (P.L. 108-173), they replaced the scheduled rate reduction with increases of 1.5 percent in both 2004 and 2005. The Deficit Reduction Act (P.L. 109-362) held 2006 payment rates at their 2005 level, overriding an impending reduction of 4.4 percent.

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8. $(1 + 0.028) \times (1 - 0.07) = 0.956$.

The budgetary effect of legislative actions to override cuts in 2004, 2005, and 2006 was twofold. Federal spending on Medicare Part B benefits grew more than it would have otherwise. In addition, because of the specification that increases in the payment rates should not be considered a change in law or regulation for purposes of determining the expenditure target, the gap between cumulative spending and the cumulative target became larger than it would have been otherwise. Under the current SGR rules, growth in spending occurring as a result of those rate increases will eventually be recouped by future adjustments to payment rates. Consequently, the budgetary cost of any future legislative increases in payment rates was increased.

Budgetary Implications of Changing the SGR

With the application of the SGR mechanism in current law likely to reduce physician payment rates by between 4 percent and 5 percent annually for the next several years, various options have been put forward to modify that mechanism. This testimony presents estimates for three illustrative examples, including fully replacing the SGR targets with annual updates based on inflation (the appendix includes estimates for a number of other options). Each policy option would increase payments for physicians' services relative to those that would be made under current law and, thereby, also increase the Part B premiums that beneficiaries pay to the government and the payments that the government makes for beneficiaries enrolled in Medicare Advantage.[9] The budget estimates reflect all three of those effects. (The upcoming graphs, however, focus solely on the gross changes in spending for physicians' services.)

Option 1: Increase payment rates by 1 percent in 2007 but do not treat the update as a change in law or regulation. This option would override the update adjustment factor during 2007 and increase the payment rate under the physician fee schedule by 1 percent that year. If that action was not considered a change in law or regulation, the SGR expenditure targets would remain the same, and the difference between cumulative spending and the cumulative expenditure targets would be larger than is estimated under current law. Thus, the increase in spending attributed to the higher payment rate would eventually be recouped by the SGR mechanism, causing payment rates to be lower in the future than they would otherwise have been. Because the maximum adjustment factor of

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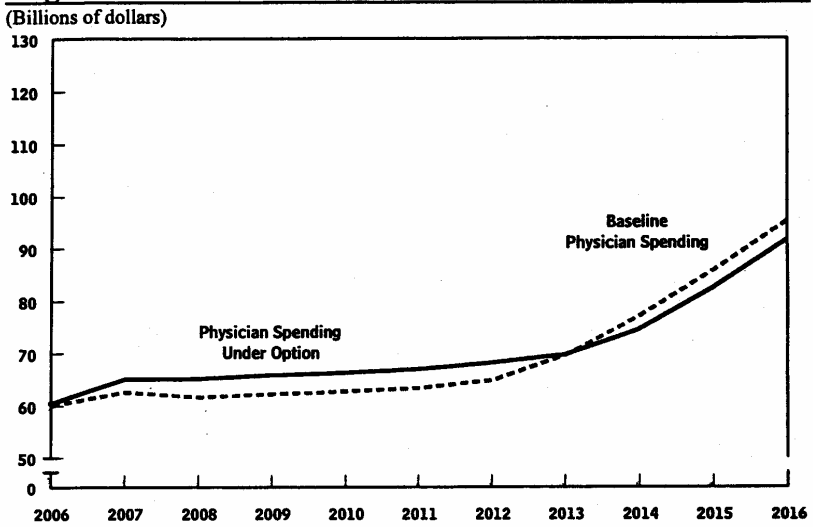
9. Any increase in spending for physicians' services would increase the "benchmarks" that Medicare uses to determine how much the program pays for beneficiaries in the Medicare Advantage program. At the same time, about one-quarter of the changes in spending for physicians' services and for Medicare Advantage would be offset by changes in receipts from premiums that beneficiaries pay the government. However, legislation could specify that Part B premiums would not be adjusted to reflect changes in spending resulting from changes in payment rates for physicians' services. But such a "premium hold-harmless" provision would increase federal costs by about 30 percent. The appendix includes estimates for several options that would include such a provision.

Figure 2.

Spending on Physicians' Services with a 1 Percent Update in 2007 That Is Not Considered a Change in Law or Regulation



Source: Congressional Budget Office.

-7 percent is projected to apply for the next several years, recouping the costs of this option would begin after that period has ended.

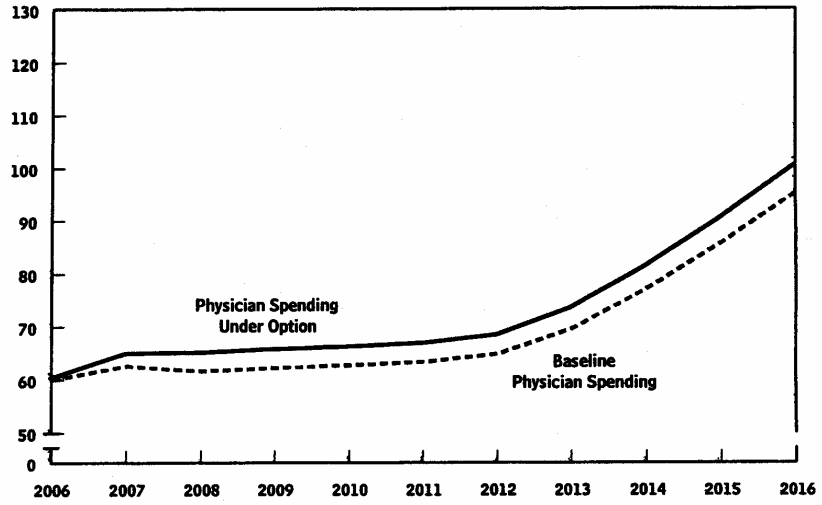
Spending for physicians' services under this option would be higher through 2012 and lower in subsequent years than the amount projected under current law (see Figure 2). According to CBO's estimates, this option would increase net federal outlays by $13 billion over the 2007-2011 period and by $6 billion over the 2007-2016 period. Under this option, spending per beneficiary would be about 5 percent lower in 2016 than it would be under current law.

Option 2: Increase payment rates by 1 percent in 2007 and do treat the update as a change in law or regulation. This option would override the update adjustment factor during 2007 and increase payment rates under the physician fee schedule by 1 percent that year. If that action was considered a change in law or regulation, the SGR would be adjusted to account for the increased payment rate, and the difference between cumulative spending and the cumulative targets would be

Figure 3.

Spending on Physicians' Services with a 1 Percent Update in 2007 That Is Considered a Change in Law or Regulation

(Billions of dollars)



Source: Congressional Budget Office.

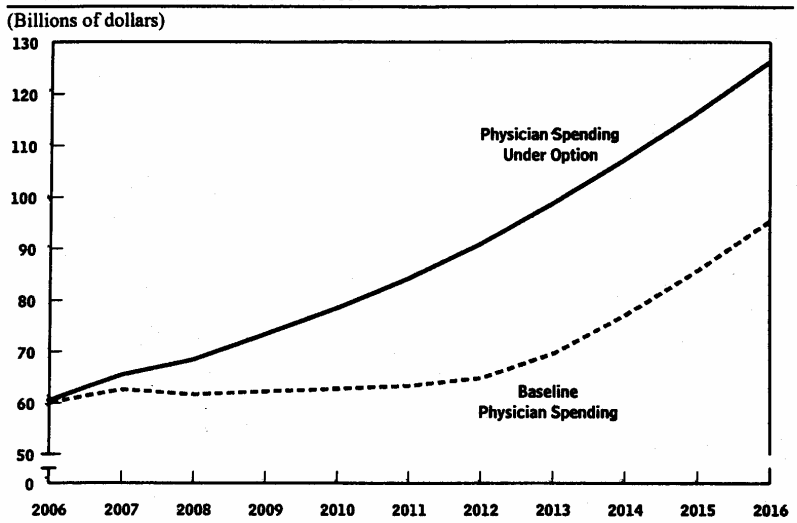
largely unchanged from current law. Spending increases resulting from this option would not be recouped by the SGR mechanism.

Spending for physicians' services under this option would be higher in every year than under current law (see Figure 3). By CBO's estimates, this option would increase net federal outlays by $13 billion over the 2007-2011 period and by $31 billion over the 2007-2016 period. Under this option, spending per beneficiary would be about 5 percent higher in 2016 than it would be under current law.

Option 3: Allow payment rates to increase by medical inflation. This option would repeal the current SGR mechanism and increase payment rates each year by the Medicare economic index. Instead of being reduced by 4 percent to 5 percent annually for the next several years, payment rates would increase by between 2 percent and 3 percent annually. Those updates would not be subject to further adjustments, and spending increases would not be recouped.

Figure 4.

Spending on Physicians' Services If the Sustainable Growth Rate Is Replaced with Updates Based on the Medicare Economic Index



Source: Congressional Budget Office.

Spending for physicians' services under this option would grow at an average annual rate of about 7.4 percent over the next 10 years, CBO estimates, compared with a 4.5 percent increase projected under current law. According to CBO's estimates, this option would increase net federal outlays by $58 billion over the 2007-2011 period and $218 billion over the 2007-2016 period. Under this option, spending per beneficiary would be about 30 percent higher in 2016 than it would be under current law (see Figure 4).

Appendix A

Budget Estimates for Proposals to Change Physician Payment Rates

Table A-1.

Estimated Changes in Net Federal Outlays from Alternative Proposals for Changing Physician Payment Rates

(Billions of dollars, by fiscal year)

Proposal	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2007-2011	2007-2016
0 Percent Update in 2007	1.1	2.4	2.4	2.5	2.5	2.2	-0.1	-2.3	-2.8	-3.2	10.8	4.7
0 Percent Update in 2007 and Premium Hold Harmless	1.7	3.1	3.1	3.1	3.1	2.7	-0.5	-3.0	-3.6	-4.0	14.1	5.6
0 Percent Update in 2007 and 2008	1.1	3.7	4.9	4.9	5.0	4.7	2.1	-2.5	-5.0	-5.7	19.6	13.2
0 Percent Update in 2007 and 2008 and Premium Hold Harmless	1.7	5.0	6.2	6.2	6.3	5.9	2.1	-3.6	-6.4	-7.3	25.4	16.1
0.5 Percent Update in 2007	1.2	2.7	2.7	2.7	2.7	2.5	-0.1	-2.6	-3.3	-3.6	12.0	4.9
1 percent Update in 2007	1.3	2.9	2.9	3.0	3.0	2.7	*	-2.7	-3.6	-4.0	13.1	5.5
1 Percent Update in 2007 and Premium Hold Harmless	2.0	3.7	3.7	3.8	3.8	3.4	-0.4	-3.6	-4.6	-5.1	17.0	6.6
1.5 Percent Update in 2007	1.4	3.2	3.2	3.2	3.2	3.0	0.3	-2.8	-3.8	-4.3	14.2	6.7
1.5 Percent Update in 2007 and Premium Hold Harmless	2.2	4.0	4.0	4.1	4.1	3.7	-0.1	-3.7	-4.9	-5.4	18.4	8.0
1.5 Percent Update in 2007 and 2008	1.4	4.9	6.5	6.5	6.6	6.4	3.7	-1.5	-5.9	-7.8	25.9	20.7
1.5 Percent Update in 2007 and 2008 and Premium Hold Harmless	2.2	6.6	8.2	8.2	8.3	8.0	4.2	-2.6	-7.9	-10.0	33.6	25.3
Automatic MEI Update (Replace SGR)	1.6	6.3	11.1	16.4	22.7	27.7	31.9	33.0	33.5	34.2	58.0	218.2
Automatic MEI Update (Replace SGR) and Premium Hold Harmless	2.4	8.3	14.3	20.9	28.7	35.0	39.8	41.1	41.7	42.5	74.7	274.7
Freeze Physician Payment Rates at 2006 Level Through at Least 2016	1.1	4.2	7.3	10.8	15.0	18.3	20.4	20.1	16.8	13.1	38.4	127.1

Source: Congressional Budget Office.

Notes: Except for the last three options, estimates assume that the SGR mechanism would apply after the specified period. They also assume that proposed changes to updates are not considered changes in law or regulation, and therefore increases in spending would be subject to being recouped by application of the SGR mechanism. Proposals that include a "premium hold-harmless" provision would exclude increases or decreases in spending attributable to them from calculations of the Part B premium.

* = cost or savings of less than $50 million.

MEI = Medicare economic index; MA = Medicare Advantage; SGR = sustainable growth rate.

MR. DEAL. Thank you. Mr. Steinwald.

MR. STEINWALD. Thank you, Mr. Chairman, members of the subcommittee.

MR. DEAL. Pull the microphone closer, and make sure it is on.

MR. STEINWALD. I will. Is that all right?

MR. DEAL. Yes.

MR. STEINWALD. Thank you for inviting me here today to participate in your discussion of how to build a more efficient and effective Medicare payment system. Given the fiscal crisis facing the Medicare program, I commend you for undertaking this difficult challenge.

I would like to begin my remarks with a brief look at the trends that have led us to the situation we face today. With all the negative publicity that SGR has received, it may be worth remembering why we have it in the first place. First slide.

[Slide]

The slide before you shows the annual trends in physician service spending per Medicare beneficiary, beginning in the 1980s, due to increases in the volume and intensity of services received. Volume refers to the number of services, and intensity to the complexity or expensiveness of those services. During the 1980s, efforts made by the Congress to limit physician spending increases were largely unsuccessful, and Medicare spending per beneficiary on physician services increased rapidly. Next slide.

[Slide]

OBRA in 1989 created a national fee schedule and a system of spending targets, which together first affected physician fees in 1992, and from 1992 through 1999, volume and intensity growth was moderated, and as a result, spending on physician services grew much more slowly than in the '80s. During this period, the Balanced Budget Act put into place the SGR system, which was first used to adjust fees in 1999. Next slide. No, previous slide, please.

[Slide]

Beginning in 2000, physician spending per beneficiary began trending upward again. The increases over the 2000 to 2005 period were more than the SGR formula permits, triggering the system's automatic response to reduce fees in order to bring spending on physician services in line with the system's spending targets. Next slide.

[Slide]

Now, let us look at the fee updates under the SGR system, from 2001 through 2005. Through 2001, the system produced positive updates, generally in excess of inflation in the cost of running a medical practice. However, in 2002, because of the rising trends in volume and intensity of services, the SGR system called for a fee decrease of 4.8 percent. Further fee cuts in subsequent years were averted by Congressional action. Not shown on the chart is the fee freeze in 2006. Next slide.

[Slide]

Now, I have added the trend in physician spending per Medicare beneficiary next to the fee updates. As you can see, while physician fees

rose only a cumulative 4.5 percent over this period, physician spending per beneficiary rose 44 percent. The beneficiary increase suggests that, despite the low fee updates, there had been no deterioration in access to physician services. In fact, GAO has just issued a study that examines beneficiary access over this time period. The next slide provides some highlights from that study.

We found that the proportion of beneficiaries who received services from a physician over the period, grew 9 percent, and for treated beneficiaries the number of services also grew, in this case, 14 percent. The amounts were lower in rural areas, but the trend was virtually identical. Our study also showed that the intensity increases were as important a contributor to spending increases as these trends in volume, and by way of example, when more comprehensive office visits replace routine office visits, that is an intensity increase. When CAT scans replace X-rays, that is also an intensity increase. Next slide.

[Slide]

Finally, our study found that over this time period, the number of physicians billing Medicare rose 11 percent. This increase exceeded the rise in the number of Medicare beneficiaries over the same period, which was about 8 percent.

In conclusion, Mr. Chairman, let me say I appreciate the difficulty of the dual problem you face with respect to Medicare physician payment. As you know, the SGR system will require fee cuts of about 5 percent per year for multiple years, beginning in 2007. Although we haven't seen a problem to date, successive years of fee cuts could undermine beneficiary access to physician services.

As many have suggested, Congress could repeal SGR, and hope that pay-for-performance and related initiatives could have their desired effect, and spending will be moderated as it was during the '90s. Alternatively, spending controls different from SGR could be imposed.

But the recent spending trends are alarming, Mr. Chairman, and if left unchecked, could compromise the Medicare program's ability to serve its beneficiaries in the future.

We look forward to working with the subcommittee and with other Members of Congress as policymakers seek to find ways to moderate spending growth while ensuring appropriate physician payments.

Mr. Chairman, this concludes my remarks. I would be happy to answer your questions, or those of the other subcommittee members.

[The prepared statement of A. Bruce Steinwald follows:]

PREPARED STATEMENT OF A. BRUCE STEINWALD, DIRECTOR, HEALTH CARE, GOVERNMENT ACCOUNTABILITY OFFICE

United States Government Accountability Office

GAO

Testimony

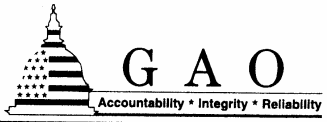
Before the Subcommittee on Health, Committee on Energy and Commerce, House of Representatives

For Release on Delivery
Expected at 10:00 a.m. EDT
Tuesday, July 25, 2006

MEDICARE PHYSICIAN PAYMENTS

Trends in Service Utilization, Spending, and Fees Prompt Consideration of Alternative Payment Approaches

Statement of A. Bruce Steinwald
Director, Health Care



GAO-06-1008T

July 25, 2006

GAO
Accountability·Integrity·Reliability

Highlights

Highlights of GAO-06-1008T, a testimony before the Subcommittee on Health, Committee on Energy and Commerce, House of Representatives

MEDICARE PHYSICIAN PAYMENTS

Trends in Service Utilization, Spending, and Fees Prompt Consideration of Alternative Payment Approaches

Why GAO Did This Study

In 2002, the system Medicare uses to determine annual changes to physician fees—the sustainable growth rate (SGR) system—reduced fees by almost 5 percent. Subsequent administrative and legislative actions averted fee declines in 2003 through 2006. Absent additional actions, fee reductions are projected for 2007 through 2015. Consequently, the appropriateness of the SGR system has been questioned. At the same time, there are concerns about the impact of increased physician services spending on the long-term fiscal sustainability of Medicare.

GAO was asked to discuss the SGR system and Medicare physician payments. This statement addresses (1) how the SGR system is designed to moderate the growth in spending for physician services, (2) why physician fees are projected to decline under the SGR system, (3) trends in the use of services provided by physicians and spending for those services from 2000 through 2005, and (4) options for revising or replacing the SGR system. This statement is based on two GAO reports: *Medicare Physician Services: Use of Services Increasing Nationwide and Relatively Few Beneficiaries Report Major Access Problems* (GAO-06-704, July 21, 2006), and *Medicare Physician Payments: Concerns about Spending Target System Prompt Interest in Considering Reforms* (GAO-05-85, Oct. 8, 2004).

www.gao.gov/cgi-bin/getrpt?GAO-06-1008T.

To view the full product, including the scope and methodology, click on the link above. For more information, contact A. Bruce Steinwald at (202) 512-7101 or steinwalda@gao.gov.

What GAO Found

To moderate Medicare spending for physician services, the SGR system sets spending targets and adjusts physician fees based on the extent to which actual spending aligns with specified targets. If growth in the number of services provided to each beneficiary—referred to as volume—and in the average complexity and costliness of services—referred to as intensity—is high enough, spending will exceed the SGR target. While the SGR system allows for some volume and intensity spending growth, this allowance is limited. If such growth exceeds the average growth in the national economy, as measured by the gross domestic product per capita, fee updates are set lower than the estimated increase in the average cost of providing physician services. A large gap between spending and the target may result in fee reductions.

There are two principal reasons why physician fees are projected to decline under the SGR system. Recent growth in spending due to volume and intensity increases has been more than double that allowed under the SGR system, resulting in excess spending that must be recouped through reduced fee updates. Legislative actions that specified minimum updates for 2004 through 2006 have also contributed to future physician fee cuts. These actions, which averted fee reductions, did not revise the spending targets. Therefore, the SGR system must offset the additional spending resulting from the excess volume and intensity and the minimum fee updates by reducing fees beginning in 2007.

From 2000 through 2005, Medicare spending for services provided by physicians grew rapidly. Our analysis of Medicare claims submitted during the first 28 days of April in these years shows that an increasing proportion of beneficiaries obtained services and the volume and intensity of the services provided increased. While Medicare physician fees rose by 4.5 percent over the period, program spending on physician services per beneficiary grew by approximately 45 percent. The number of physicians billing Medicare and total allowed charges per billing physician also increased, as did the proportion of claims for which physicians accepted Medicare payment as payment in full.

Potential alternatives to the SGR system cluster around two basic approaches: (1) ending the use of spending targets as a method for updating physician fees and encouraging fiscal discipline and (2) retaining spending targets but modifying the current SGR system to address perceived shortcomings. Either approach could be complemented by focused efforts to moderate volume and intensity growth directly. Because multiple years of projected 5 percent fee cuts are incorporated in Medicare's budgeting baseline, almost any change to the SGR system is likely to increase program spending above the baseline.

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today as you discuss Medicare's payments to physicians and consider potential payment reforms to help moderate spending growth while ensuring that beneficiaries have appropriate access to high-quality physician services and physicians receive fair compensation for providing those services. As you know, Medicare uses a system based on spending targets, known as the sustainable growth rate (SGR) system, to annually update physician fees. From 1999—the first year that the SGR system was used to update Medicare's physician fees—through 2001, annual fee increases ranged from 2.3 percent to 5.5 percent. However, in 2002 the SGR system reduced physician fees by nearly 5 percent. Fee declines in subsequent years were averted only by administrative and legislative actions that modified or temporarily overrode the SGR system.[1] In the absence of additional administrative or legislative action, the Medicare trustees project that the SGR system will likely reduce fees by about 5 percent per year for 9 years beginning in 2007.[2]

The potential for a sustained period of declining fees has raised policymakers' concerns about the appropriateness of the SGR system for updating physician fees and about physicians' continued participation in the Medicare program. At the same time, there are also concerns about Medicare spending growth and the long-term fiscal sustainability of the program.

As you requested, my comments today describe the issues that Medicare faces in annually updating physician fees, recent growth in the provision of physician services, and considerations for potential physician fee update reforms. Specifically, I will discuss (1) how the SGR system is designed to moderate the growth in spending for physician services, (2) why physician fees are projected to decline under the SGR system, (3) trends in the use of services provided by physicians and spending for

[1]For example, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) specified a minimum update of 1.5 percent for both 2004 and 2005. Pub. L. No. 108-173, § 601(a)(1), 117 Stat. 2066, 2300.

[2]Boards of Trustees of the Federal Hospital Insurance (HI) and Federal Supplementary Medical Insurance (SMI) Trust Funds, *2006 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds* (Washington, D.C.: May 1, 2006).

those services from 2000 through 2005, and (4) options for revising or replacing the SGR system.

My testimony today is based on two previously issued GAO reports. Specifically, my comments on the SGR system, its projected effect on physician fees, and potential alternatives for that system are based on findings contained in our October 2004 report on the SGR system.[3] We updated these findings to include information on Medicare physician fee updates and spending in 2005 from the 2006 report of the Medicare trustees.[4] My comments on trends in physicians' provision of services and spending for those services are derived from our July 2006 report on Medicare physician services.[5,6] To study trends, we analyzed 100 percent of physician claims for services performed during the first 28 days of April in each year from 2000 through 2005. Whereas our 2004 report included all physician services regardless of whether they were performed by a physician or a physician replacement—such as physician assistant—our 2006 report focused exclusively on services performed by a physician. All references to physicians, beneficiaries, services, and spending in this statement pertain exclusively to Medicare's traditional fee-for-service (FFS) program, except where otherwise noted. Our work to update our 2004 report was performed during July 2006; all work was done according to generally accepted government auditing standards.

In summary, the SGR system is designed to apply financial brakes whenever spending for physician services and certain other items and services commonly performed by physicians or furnished in a physician's office exceeds predefined spending targets. The SGR system allows for some increases in the number of services delivered to each beneficiary—known as volume—and the complexity or costliness of those services—known as intensity. However, if spending growth caused by increases in volume and intensity exceeds the average growth in the national economy,

[3]GAO, *Medicare Physician Payments: Concerns about Spending Target System Prompt Interest in Considering Reforms*, GAO-05-85 (Washington, D.C.: Oct. 8, 2004).

[4]Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.

[5]GAO, *Medicare Physician Services: Use of Services Increasing Nationwide and Relatively Few Beneficiaries Report Major Access Problems*, GAO-06-704 (Washington, D.C.: July 21, 2006).

[6]Unless otherwise noted, the term "physician services" in this statement refers to items and services listed in Social Security Act § 1848(j)(3).

as measured by the gross domestic product (GDP) per capita, the SGR system reduces fee updates to help moderate spending growth.

There are two principal reasons why physician fees are projected to decline under the SGR system beginning in 2007. One reason is that volume and intensity spending increases have been growing at more than double the rate allowed under the SGR system. The other reason is that legislation mandated minimum physician fee updates for the years 2004 through 2006, but did not raise the spending targets for those years. The SGR system, which is designed to keep spending in line with its targets, must reduce fees beginning in 2007 to offset the excess spending attributable to both volume and intensity increases and the legislated fee updates.

From 2000 through 2005, Medicare spending for physician services grew rapidly. Our analysis of Medicare claims shows that an increasing proportion of beneficiaries obtained care from physicians and the volume and intensity of the services provided increased from April 2000 to April 2005. Similarly, the number of physicians billing Medicare and the total allowed charges per billing physician also increased.

In general, proposals to reform Medicare's method for updating physician fees would either (1) eliminate spending targets and establish new considerations for the annual fee updates or (2) retain spending targets, but modify certain aspects of the current system. Either approach could be complemented by focused efforts to moderate volume and intensity growth directly.

Medicare faces the challenge of moderating the growth in spending for physician services while ensuring that physicians are paid fairly so that beneficiaries have appropriate access to their services. Concerns have been raised that access to physician services could eventually be compromised if the SGR system is left unchanged and the projected fee cuts become a reality. Although the trend could be reversed if fees were to decline substantially, our analysis of data from April 2000 to April 2005 indicates that in recent years beneficiary access to physicians and the services they provide has increased. The increased use of physician services, however, raises concerns about the accompanying growth in Medicare spending for those services.

Because multiple years of projected 5 percent fee cuts are incorporated in Medicare's budgeting baseline, almost any change to the SGR system is likely to increase program spending above the baseline. As policymakers consider options for updating physician fees, it is important to be mindful of the serious financial challenges facing Medicare and the need to design policies that help ensure the long-term sustainability and affordability of the program.

Background

Although the current focus of concern is largely on the potential for several years of declining physician fees, the historic and continuing challenge for Medicare is to find ways to moderate the rapid growth in spending for physician services. Before 1992, the fees that Medicare paid for those services were largely based on physicians' historical charges.[7] Spending for physician services grew rapidly in the 1980s, at a rate that the Secretary of Health and Human Services (HHS) characterized as out of control. Although Congress froze fees or limited fee increases in the 1980s, spending continued to rise because of increases in the volume and intensity of physician services. From 1980 through 1991, for example, Medicare spending per beneficiary for physician services grew at an average annual rate of 11.6 percent.

The ineffectiveness of fee controls alone led Congress to reform the way that Medicare set physician fees. The Omnibus Budget Reconciliation Act of 1989[8] required the establishment of both a national fee schedule[9] and a system of spending targets, which together first affected physician fees in 1992.[10] From 1992 through 1997, annual spending growth for physician services was far lower than in the previous decade. The decline in spending growth was the result in large part of slower volume and

[7]Medicare paid physicians on the basis of "reasonable charge," defined as the lowest of the physician's actual charge, the customary charge (the amount the physician usually charged for the service), or the prevailing charge (based on comparable physicians' customary charges).

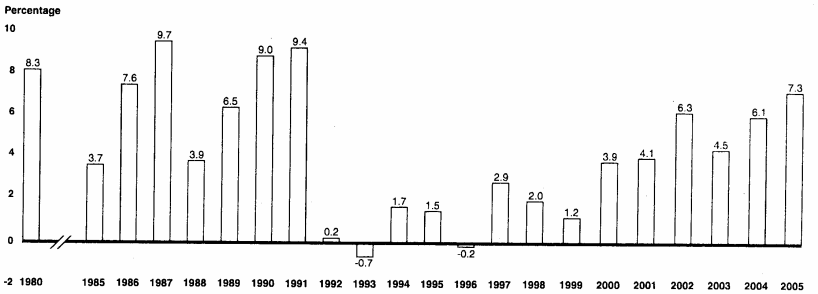
[8]See Pub. L. No. 101-239, § 6102, 103 Stat. 2106, 2169-89.

[9]Medicare sets fees for more than 7,000 physician services based on the resources required to provide each service, adjusted for differences in the costs of providing services across geographic areas.

[10]The first system of spending growth targets, known as the Medicare Volume Performance Standard (MVPS), was in effect from 1992 through 1997. In 1998, the SGR system of spending targets replaced MVPS.

intensity growth. (See fig. 1.) Over time, Medicare's spending target system has been revised and renamed. The SGR system, Medicare's current system for updating physician fees, was established in the Balanced Budget Act of 1997 (BBA) and was first used to adjust fees in 1999.[11]

Figure 1: Growth in Volume and Intensity of Medicare Physician Services per Beneficiary, Selected Years, 1980-2005



Source: GAO analysis of data from CMS and the Boards of Trustees of the Federal HI and SMI Trust Funds.

Note: Represents combined effect of volume and intensity growth. Data are for beneficiaries in the traditional FFS program. Spending for end-stage renal disease patients is not included. From 1980 through 1992, volume and intensity of services changes are based on Medicare outlays for all physician services. From 1993 through 2005, volume and intensity of services changes are based on Medicare outlays for physician services covered by the fee schedule.

Following the implementation of the fee schedule and spending targets in 1992 through 1999, average annual growth in volume and intensity of service use per beneficiary fell to 1.1 percent. More recently, volume and intensity growth has trended upward, rising at an average annual rate of more than 5 percent from 2000 through 2005. Although this average annual rate of growth remains below that experienced before spending targets were introduced, the recent increases in volume and intensity growth are a reminder that inflationary pressures continue to challenge efforts to moderate growth in physician expenditures.

[11]See Pub. L. No. 105-33, § 4503, 111 Stat. 251, 433-34. BBA set a specific fee update for 1998. See BBA, § 4505, 111 Stat. 435-37.

SGR System Designed to Limit or Reduce Physician Fee Updates in Response to Excess Growth in Volume and Intensity

The SGR system establishes spending targets to moderate spending increases caused by excess growth in volume and intensity. Services covered by the SGR system's spending targets include physician services and other items and services, such as clinical laboratory services, specified by the Secretary of HHS, that are commonly performed or furnished by physicians or in a physician's office. The SGR system's spending targets do not cap expenditures for SGR-covered services. Instead, spending in excess of the target triggers a reduced fee update or a fee cut. In this way, the SGR system applies financial brakes to spending for SGR-covered services and thus serves as an automatic budgetary control device. In addition, reduced fee updates signal physicians collectively and Congress that spending because of volume and intensity has increased more than allowed.

To apply the SGR system, every year the Centers for Medicare & Medicaid Services (CMS) follows a statutory formula to estimate the allowed rate of increase for spending on SGR-covered services and uses that rate to construct the spending target for the following calendar year.[12] The sustainable growth rate is the product of the estimated percentage change in (1) input prices for physician services and other SGR-covered services;[13] (2) the average number of Medicare beneficiaries in the traditional fee-for-service program; (3) national economic output, as measured by real (inflation-adjusted) GDP per capita; and (4) expected expenditures for physician services and other SGR-covered services resulting from changes in laws or regulations. SGR spending targets are cumulative. That is, the sum of all spending for SGR-covered services since 1996 is compared to the sum of all annual targets since the same year to determine whether spending has fallen short of, equaled, or exceeded the SGR targets. The use of cumulative targets means, for example, that if actual spending has exceeded the SGR system targets, fee updates in future years must be lowered sufficiently both to offset the accumulated excess spending and to slow expected spending for the coming year.

[12]This allowed rate is the sustainable growth rate from which the SGR system derives its name. We use the abbreviation SGR when referring to the system and the full term of sustainable growth rate when referring to the allowed rate of increase.

[13]CMS calculates changes in physician input prices based on the growth in the costs of providing physician services as measured by the Medicare Economic Index, growth in the costs of providing laboratory tests as measured by the consumer price index for urban consumers, and growth in the cost of Medicare Part B prescription drugs included in SGR spending.

Under the SGR system, the volume and intensity of physician services and other SGR-covered services—that is, spending per beneficiary adjusted for the estimated underlying cost of providing those services—is allowed to grow at the same rate that the national economy grows over time on a per capita basis. When the SGR system was established, economic growth was seen as a benchmark that would allow for affordable increases in volume and intensity. Currently, the SGR system's benchmark for volume and intensity growth is projected to be about 2.2 percent annually.[14] Consequently, volume and intensity growth that exceeds 2.2 percent causes Medicare SGR-covered spending to exceed the SGR system's target, while slower volume and intensity growth leads to spending that falls below the SGR target.

If cumulative spending on SGR-covered services is in line with the SGR system's target, the physician fee schedule update for the next calendar year is set equal to the estimated increase in the average cost of providing physician services as measured by the Medicare Economic Index (MEI). If cumulative spending exceeds the target, the annual physician fee update will be less than the change in MEI or may even be negative. Conversely, if cumulative spending falls short of the target, physicians benefit because the update will exceed the change in MEI. The SGR system places limits on the extent to which fee updates can deviate from MEI. In general, with an MEI of about 2 percent, the largest allowable fee decrease would be about 5 percent and the largest fee increase would be about 5 percent.

[14]To reduce the effect of business cycles on physician fees, MMA modified the SGR system to require that economic growth be measured as the 10-year moving average change in real per capita GDP beginning in 2003.

Rapid Growth in Volume and Intensity and Legislated Minimum Updates Contribute to Projected Decline in Medicare Physician Fees under SGR System

Recent growth in spending due to volume and intensity increases has been larger than SGR targets allow, resulting in excess spending that must be recouped by reducing fees to lower future spending. From 2000 through 2005, based on an analysis of physician services claims from April of each year, average annual growth in the volume and intensity of Medicare physician services exceeded 5 percent—more than double the approximately 2.2 percent growth rate permitted under the SGR system. To offset the resulting excess spending, the SGR system calls for reductions in physician fees.

Additional downward pressure on physician fees arises from the growth in spending for other Medicare services that are included in the SGR system, but that are not paid for under the physician fee schedule. Such services include laboratory tests and many Part B outpatient prescription drugs that physicians provide to patients.[15] Because physicians influence the volume of services they provide directly—that is, fee schedule services—as well as other items and services commonly performed by physicians or furnished in a physician's office, expenditures for both types of services were included when spending targets were introduced. To the extent that spending for these other services grows larger as a share of overall SGR spending, additional pressure is put on fee adjustments to offset excess spending and bring overall SGR spending in line with the system's targets. This occurs because the SGR system attempts to moderate spending only through the fee schedule, even when the excess spending is caused by expenditures for SGR-covered services which are not paid for under the fee schedule.

Legislated minimum updates for 2004 through 2006 have also contributed to future physician fee cuts. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA)[16] and the Deficit Reduction Act of 2005 (DRA)[17] averted fee reductions projected for 2004 through 2006 by specifying minimum updates to physician fees for those years. The MMA-specified minimum annual increase of 1.5 percent

[15]Most of the Part B drugs that Medicare covers fall into three categories: those typically provided in a physician office setting (such as chemotherapy drugs), those administered through a durable medical equipment item (such as a respiratory drug given in conjunction with a nebulizer), and those that are patient administered and covered explicitly by statute (such as certain immunosuppressives).

[16]Pub. L. No. 108-173, §601 (a)(1), 117 Stat. 2066, 2300.

[17]Pub. L. No. 109-171, §5104(a)(2), 120 Stat. 4, 40-1 (2006).

replaced SGR system fee reductions of 4.5 percent in 2004 and 3.3 percent in 2005. DRA had the effect of replacing a fee reduction of 4.4 percent in 2006 with a 0.2 percent fee increase. These legislated minimum fee updates have resulted in additional aggregate spending. Because neither MMA nor DRA made corresponding revisions to the SGR system's spending targets, the SGR system must offset the additional spending by reducing fees beginning in 2007.

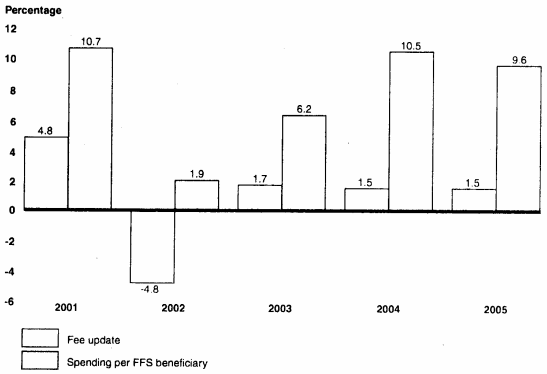
Medicare Spending on Physician Services Increased Substantially as Physicians Provided More Services and More Costly Types of Services

From 2000 through 2005, Medicare spending on physician services grew far faster than the growth in physician fees and the number of eligible beneficiaries. Our analysis of Medicare claims data for services provided during the first 28 days of April of each year indicates that from April 2000 to April 2005 a growing percentage of beneficiaries obtained services from physicians. Among those beneficiaries who obtained such services, there were increases in the average number of services provided. Overall, the volume of services provided increased as well as the intensity (and thus costliness) of the services provided. Our analysis also found that the number of physicians billing Medicare and allowed charges per physician increased over the period as did the proportion of claims for which physicians accepted Medicare payment as payment in full.

Growth in Spending for Physician Services Exceeded Growth in Medicare Fees

From 2000 through 2005, while Medicare physician fees rose by 4.5 percent, program spending on physician services grew by nearly 60 percent. On a per beneficiary basis, spending for physician services grew by approximately 45 percent. Annual per beneficiary spending increases ranged from a low of 2 percent in 2002 to a high of about 11 percent in both 2001 and 2004. (See fig. 2.) It is important to note that even in 2002, a year in which fees were reduced by nearly 5 percent, Medicare spending per beneficiary for physician services went up.

Figure 2: Percentage Change from Previous Year in Physician Fee Update and Physician Services Spending per Beneficiary, 2001-2005



Source: GAO analysis of data from the Boards of Trustees of the Federal HI and SMI Trust Funds.

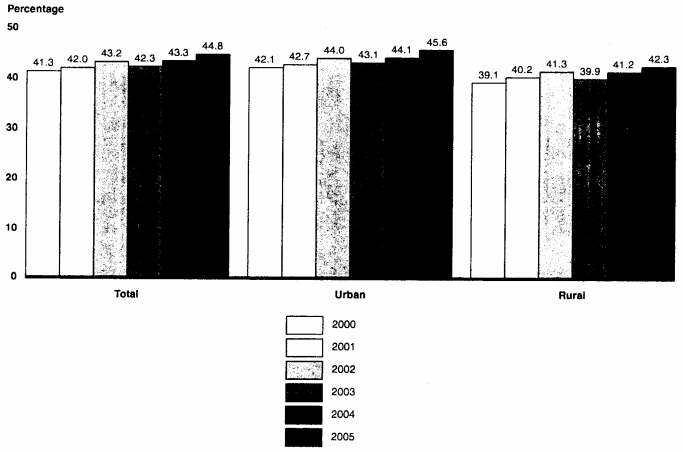
Note: Spending per beneficiary represents Medicare spending for beneficiaries in the traditional FFS program, net of beneficiary cost sharing. Spending for end-stage renal disease patients is not included. The physician fee schedule update figures shown do not reflect additional required adjustments, such as those for legislated changes and for budget neutrality.

Proportion of Beneficiaries Receiving Physician Services Grew

In general, the proportion of beneficiaries who received services from a physician rose during the period covered in our review. (See fig. 3.) Specifically, from 2000 through 2005, the proportion of beneficiaries receiving services during the month of April rose from about 41 percent to about 45 percent. Although this measure declined slightly in April 2003, the proportion of beneficiaries receiving services remained a percentage point higher than in April 2000 and the upward trend resumed in 2004.

Nationwide, this measure increased in both urban and rural areas.[18] The proportion of beneficiaries receiving services rose from about 42 percent in April 2000 to about 46 percent in April 2005 in urban areas and from about 39 percent in April 2000 to about 42 percent in April 2005 in rural areas.

Figure 3: Percentage of Medicare Beneficiaries Receiving Physician Services in April, 2000-2005



Source: GAO analysis of Medicare Part B claims and enrollment data from CMS

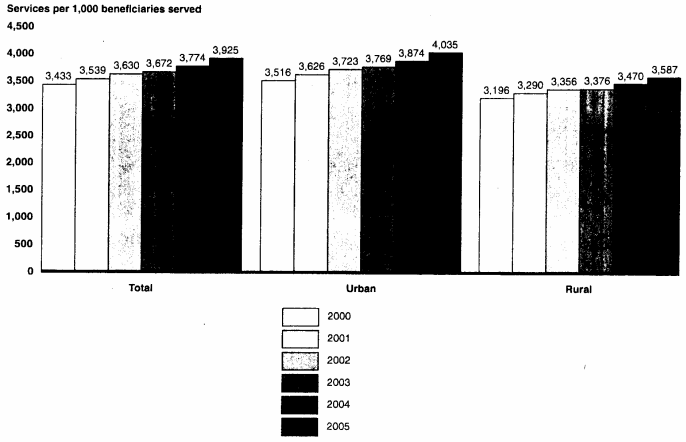
Note: Beneficiaries were included if they received a physician service in the first 28 days of April

[18]Using the Office of Management and Budget's system for defining metropolitan statistical areas, we classified the nation's counties as urban or rural. We consolidated the urban counties and rural counties in each state and the District of Columbia, and created 99 geographic areas. There were 51 urban areas and 48 rural areas. There are no rural areas in New Jersey, Rhode Island, and the District of Columbia.

Physician Services Increased in Volume and Intensity

From April 2000 to April 2005, an increasing number of services were provided to beneficiaries who were treated by a physician. Specifically, in that period, the average number of services provided per 1,000 beneficiaries who were treated rose by 14 percent—from about 3,400 to about 3,900. (See fig. 4.) The number of services provided per 1,000 beneficiaries was higher in urban areas (3,516 services per 1,000 beneficiaries who received services in 2000) relative to rural areas (3,196 services per 1,000 beneficiaries who received services in 2000). However, in percentage terms, the urban and rural areas experienced similar increases in the number of services per treated beneficiary—15 percent in urban areas, compared with 12 percent in rural areas.

Figure 4: Number of Physician Services Provided per 1,000 Medicare Beneficiaries Served in April, 2000-2005



Source: GAO analysis of Medicare Part B claims and enrollment data from CMS.

Note: Beneficiaries and services were included if services were provided during the first 28 days of April.

Because there were increases in both the proportion of beneficiaries obtaining services from physicians and the number of services provided to each beneficiary who obtained care, the overall volume of services increased from 2000 through 2005. That is, the number of physician services per beneficiary, including beneficiaries who obtained care and those that did not, increased. Volume generally increased across broad categories of services—evaluation and management, procedures, imaging services, and tests. On average, volume for all physician services increased at an annual rate of 4.4 percent. (See table 1.) The volume of evaluation and management services, a category that includes office visits, increased at an average annual rate of 2.4 percent. There was a small average annual decline in the volume of major procedures (less than 1 percent), although minor procedures grew at an average annual rate of 6.3 percent. Volume grew most rapidly (9.1 percent average annual rate) for tests.

Table 1: Changes in Volume and Intensity of Physician Services Provided per Medicare Beneficiary, April 2000 to April 2005

Type of service	Annual percentage change in the number of services per beneficiary (volume)	Annual percentage change in the intensity of services per beneficiary, as measured in relative value units (RVU)
All services	4.4	5.2
Evaluation and management services	2.4	3.7
Procedures	5.7	4.3
Major	-0.7	2.3
Minor	6.3	5.2
Imaging	6.9	10.5
Tests	9.1	13.9

Source: GAO analysis of Medicare Part B claims and enrollment data from CMS

Notes: Services were included in the calculation of average annual percentage changes if the services were provided during the first 28 days of April. To account for complexity of services, we used RVU weights for 2005.

From April 2000 to April 2005, the services that physicians provided to beneficiaries also increased in intensity. The fee schedule expresses this intensity through relative value units (RVU), which account for the amount of physician time, expertise, and resources required to deliver a service

compared to other services.[19] Because Medicare's fee for a service is based on the number of RVUs associated with it, more intense services are also more costly. Overall, physician services per beneficiary rose in intensity, as measured in RVUs, at an average annual rate of about 5 percent. Intensity increases occurred among all categories of services, including major procedures. Intensity grew most rapidly among imaging services (10.5 percent average annual rate) and tests (13.9 percent average annual rate). Thus, taken as a whole, beneficiaries' increased utilization of physician services has manifested itself in both increased volume and increased intensity of services for the 6 years reviewed.

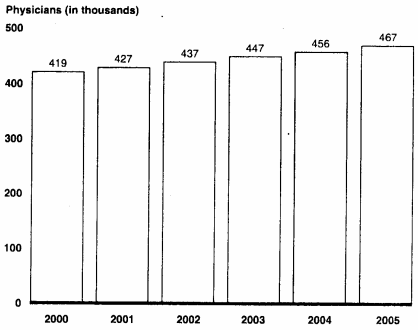
Number of Physicians Serving Medicare Beneficiaries and Allowed Charges per Physician Increased

An increasing number of physicians billed Medicare from April 2000 to April 2005. (See fig. 5.) In April 2000, the number of physicians billing Medicare was about 419,000, and in April 2005, that number had increased to a little more than 467,000. While Medicare experienced an 11 percent increase in the number of physicians billing the program, the number of beneficiaries in Medicare—FFS and managed care combined—rose by 8 percent.[20]

[19]The relative intensiveness or complexity—as measured by the costliness—of each service is compared to a benchmark service, defined as a midlevel office visit. For example, if a midlevel office visit had an RVU value of 1.000, a service with 1.475 RVUs is estimated to be 47.5 percent more costly to provide than the midlevel office visit; while a service with 0.925 RVUs is estimated to be 7.5 percent less costly than the midlevel office visit. In this way, RVU weights quantify the complexity of services provided.

[20]Because the majority of physicians serving FFS Medicare beneficiaries also likely serve beneficiaries in Medicare managed care, we report the change in the total number of Medicare beneficiaries—FFS and managed care combined. The number of FFS beneficiaries increased by 13 percent, an increase driven in part by a decline of about 18 percent in the number of enrollees in managed care, from 6.8 million to 5.6 million.

Figure 5: Number of Physicians Billing Medicare for Services Provided to Medicare Beneficiaries in April, 2000-2005



Source: GAO analysis of Medicare Part B claims data from CMS.

Notes: Physicians were included if they served a beneficiary in the first 28 days of April. We counted each occurrence of the unique physician identification number once.

On average, total allowed charges per physician billing Medicare increased by about 41 percent from April 2000 to April 2005.[21] A portion of this increase can be attributed to the changes in Medicare's fees, which increased by about 4.5 percent over the period. However, most of the increase was the result of physicians providing more services and more intense, and thus more costly, services.

Proportion of Services for Which Physicians Accepted Medicare Payment in Full Increased

From April 2000 to April 2005, the vast majority of Medicare physician services were performed by participating physicians—that is, physicians who formally agreed to submit all claims on assignment.[22] The percentage of services submitted by participating physicians increased from 95 percent to over 96 percent. (See fig. 6.) By submitting all Medicare claims on assignment, these physicians agreed to accept Medicare's fee as

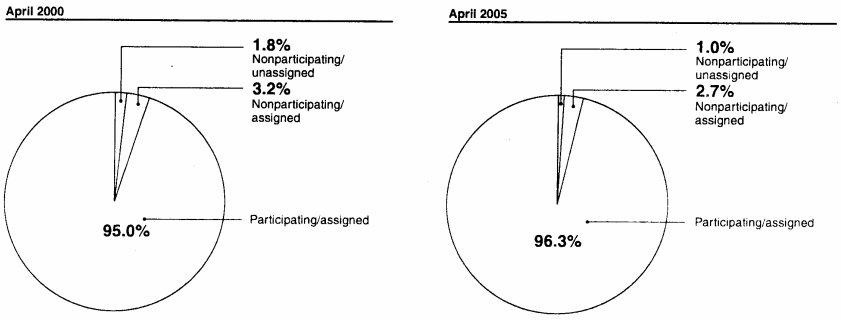
[21]Includes charges for services that were provided during the first 28 days of April in 2000 and 2005.

[22]Physicians may decide annually whether they will be Medicare participating physicians.

payment in full for all of the services they provided. This includes the coinsurance amount (usually 20 percent) paid by the beneficiary. Nonparticipating physicians could choose for each service they provided to submit an assigned claim, thereby accepting Medicare's fee as payment in full, or an unassigned claim. Nonparticipating physicians who submitted an unassigned claim could charge the beneficiary an additional amount, within set limits, for that service—a practice referred to as balance billing.

During the same period, the overall percentage of services paid on assignment—that is, services performed by both participating and nonparticipating physicians who accepted assignment—also increased. In April 2000, 98.2 percent of services were paid on assignment, and in April 2005, 99.0 percent of services were paid on assignment. Fewer beneficiaries were likely to be subject to balance billing for physician services in 2005 than in 2000 as the percentage of services for which physicians were permitted to balance bill Medicare beneficiaries fell from 1.8 percent to 1.0 percent.

Figure 6: Proportion of Physician Services by Medicare Participation and Assignment Status, April 2000 and April 2005



Source: GAO analysis of Medicare Part B claims data from CMS.

Note: Services were included if they were provided during the first 28 days in April.

Alternatives for Updating Physician Fees Would Eliminate Spending Targets or Revise Current SGR System

The projected sustained period of declining physician fees and the potential for beneficiaries' access to physician services to be disrupted have heightened interest in alternatives for the current SGR system. In 2005, we testified that potential alternatives cluster around two basic approaches.[23] One approach would end the use of spending targets as a method for updating physician fees and encouraging fiscal discipline. The other would retain spending targets but modify the current SGR system to address its perceived shortcomings.

Eliminate Spending Targets, Base Fee Updates on Physician Cost Increases

The Medicare Payment Advisory Commission (MedPAC) has recommended replacing the SGR system with a system that bases the annual fee updates on changes in the cost of efficiently providing care as measured by MEI.[24,25] Under this approach, efforts to control aggregate spending would be separate from the mechanism used to update fees.

The advantage of eliminating spending targets would be greater fee update stability. Although basing physician fee updates on changes in MEI would limit the annual increases in the price that Medicare pays for each service, this approach does not contain an explicit mechanism for constraining aggregate spending resulting from increases in the volume and intensity of services physicians provide. If no other actions were taken, Medicare spending for physician services would rise relative to projected spending under the SGR system.

An annual fee update system based on MEI that considered multiple objectives, such as the moderation of spending growth or quality of care improvements, could be implemented. For example, H.R. 3617, introduced in 2005, would base physician fee updates on the MEI and also gradually phase in a pay-for-performance system under which fee updates would be linked to quality and efficiency performance objectives.[26] In 2005 testimony, MedPAC stated that fee updates for physician services should

[23]GAO, *Medicare Physician Payments: Considerations for Reforming the Sustainable Growth Rate System*, GAO-05-326T (Washington, D.C.: Feb. 10, 2005).

[24]See Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* (Washington, D.C.: March 2001, 2002, 2003, and 2004).

[25]MedPAC suggested that other adjustments to the update might be necessary, for example, to ensure overall payment adequacy, correct for previous MEI forecast errors, and address other factors.

[26]See H.R. 3617, 109th Cong. § 2 (2005).

not be automatic, but should be informed by changes in beneficiaries' access to services, the quality of services provided, the appropriateness of cost increases, and other factors, similar to those that are considered for other provider payment updates.[27]

Retain Spending Targets, Modify Current SGR System

An alternative approach for modifying the current SGR system would retain spending targets but modify one or more elements of the system. The key distinction of this approach, in contrast to basing updates on MEI, is that fiscal controls designed to moderate spending would continue to be integral to the system used to update fees. Although spending for physician services would likely also rise under this approach, the advantage of retaining spending targets is that the fee update system would automatically work to moderate spending if volume and intensity growth began to increase above allowable rates.

As presented in our 2004 report,[28] the SGR system could be modified in a number of ways. For example, Congress could raise the allowance for increased spending due to volume and intensity growth by some factor above the percentage change in real GDP per capita. The Secretary of HHS could, under current authority, consider excluding Part B drugs from the definition of services furnished "incident to" physician services for the purposes of the SGR system. DRA mandated that MedPAC study a variety of SGR reforms, such as setting regional, instead of national, spending targets.[29] The effects on overall Medicare spending for physician services, relative to projected spending under the current SGR system, would depend on whether the reforms simply allowed for higher fees or provided meaningful incentives for physicians to moderate volume and intensity growth.

[27]Medicare Payment Advisory Commission, *Medicare Payments to Physicians*, testimony before the Subcommittee on Health, House Committee on Energy and Commerce (Nov. 17, 2005).

[28]GAO-05-85.

[29]See Pub. L. No. 109-171, § 5104(c), 120 Stat. 4, 41.

Mr. Chairman, this concludes my prepared statement. We look forward to working with the Subcommittee and others in Congress as policymakers seek to moderate program spending growth while ensuring appropriate physician payments. I will be happy to answer questions you or the other Members of the Subcommittee may have.

Contact and Acknowledgements

For further information regarding this testimony, please contact A. Bruce Steinwald at (202) 512-7101 or steinwalda@gao.gov. James Cosgrove, Assistant Director; Todd Anderson; Jessica Farb; and Eric Wedum contributed to this statement. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement.

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MR. DEAL. Thank you. Mr. Miller, you are recognized.

MR. MILLER. Chairman Deal, Congressman Pallone, distinguished members of the subcommittee. The Medicare Payment Advisory Commission advises Congress on a range of Medicare issues, and in so doing, tries to balance three objectives: that beneficiaries get access to high quality care, that the program pay the efficient provider fairly, and that the greatest value is delivered to the taxpayer.

We see several issues with Medicare's current payment system. Medicare physician expenditures, as you have already heard, are growing

rapidly at annual rates between 8 and 12 percent in recent years. This results in higher out-of-pocket costs for beneficiaries, and higher Part B premiums for beneficiaries. Part B premium increases have been as high as 13 and 17 percent in the last few years. For the taxpayer and for future Medicare beneficiaries, this raises questions about the long-run sustainability of the Medicare program, and obviously, increases pressure on the Federal budget.

The volume of services provided has also been increasing as well. Over the last few years, it has accounted for at least half of the growth in the expenditures, and often more. This rapid growth in service volume has no clear linkage to quality of care. Recent research by the RAND Group found that the elderly receive about half of recommended care. Service volume also varies substantially across the country, and again, there is no clear linkage to quality of care. Rather, it appears to be more closely linked to supply of physicians, the number of specialists, and practice styles of individual physicians.

Unfortunately, there is nothing in Medicare's payment systems that rewards higher quality. Physicians are dissatisfied with the current payment system, because under current law volume controls they are slated to receive 4 and 5 percent negative updates for the next several years. While beneficiary access to physician services is good, several years of negative updates will obviously make physicians less willing to serve Medicare beneficiaries.

MedPAC does not support the SGR. We have recommended that it be eliminated, because it does not truly control volume, it is unfair to those physicians who do provide high quality care and are parsimonious in the use of their resources, and it treats all services, whether necessary or unnecessary, the same.

Each year, MedPAC evaluates what is needed for the physician payment update, and in so doing, considers a range of factors, such as the number of physicians serving Medicare beneficiaries, whether increase in practice costs are consistent with the increases for an efficient provider, and what rate is necessary to assure beneficiary access. I would like to be clear that MedPAC's analysis does not have to result in a full MEI update.

We recognize that Congress must ultimately decide that expenditures are appropriate, and we view MedPAC's work as one input to that process. We also recognize that Congress may wish to retain some budget mechanism linked to volume growth, and to that end, Congress has asked MedPAC to report in March of '07 on alternative mechanisms for the SGR. We are currently doing that work.

However, over the last few years, MedPAC has made several recommendations designed to improve value in the Medicare program,

and by value, I mean getting more for the dollars that are currently being spent. One direction is for Medicare to differentiate among providers on the basis of their performance. For example, we have made recommendations for hospitals, physicians, HMOs, to link a small percentage of current payments, and redistribute it to the providers with the highest quality scores, or with the greatest increase in their quality scores.

MedPAC has also recommended that physician resource use be measured and fed back to physicians to allow them to assess their performance relative to that of their peers. Over the longer run, and with additional experience, the Commission is considering the idea of reimbursing more to those providers who produce the highest quality of care with the fewest resources.

I won't go through it. Last week, you had a hearing on imaging, so I won't go back through what was found there, but suffice it to say that we have made recommendations to set accreditation standards for those people who provide Medicare imaging services, and recommended coding edits to restrain unnecessary volume.

The Commission's work is also focused on improving the accuracy of the physician fee schedule. We think that if prices are not set properly, that can also send signals that result in volume growth. We have raised questions about some of the technical assumptions in the fee schedule related to imaging services. We have recommended new policies to assure that certain physician services are not assigned inappropriately high values, and we have pointed out the need to systematically collect new practice expense data in order to properly calibrate the fee schedule.

All of these ideas involve significantly more administrative effort on the part of CMS, and in each instance, we have asked Congress to assure that CMS has the necessary resources to implement these ideas, if Congress chooses to go forward.

Thank you. I look forward to your questions.

[The prepared statement of Mark Miller follows:]

PREPARED STATEMENT OF MARK MILLER, EXECUTIVE DIRECTOR, MEDICARE PAYMENT ADVISORY COMMISSION

Chairman Deal, Ranking Member Brown, distinguished Subcommittee members. I am Mark Miller, executive director of the Medicare Payment Advisory Commission (MedPAC). I appreciate the opportunity to be here with you this morning to discuss payments for physician services in the Medicare program.

Medicare expenditures for physician services are growing rapidly. In 2005 spending on physician services increased 8.5 percent, while the number of beneficiaries in FFS Medicare increased only 0.3 percent. Medicare expenditures for physician services are the product of the number of services provided, the type of service, and the price per unit of service. The number of services is often referred to as service volume, the type of

services as intensity. For example, substituting an MRI for an X-ray would be an increase in intensity. To get good value for the Medicare program, the payment system should set the relative prices for services accurately. Providing incentives to control unnecessary growth in volume and intensity would be desirable, but it is much more difficult. (For simplicity, in the remainder of this testimony we will use the term volume as shorthand for the combined effect of volume and intensity.)

In this testimony we briefly outline the history of the Medicare physician payment system and discuss several ideas for getting better value in the Medicare program including differentiating among providers through pay for performance and measuring physician resource use, better managing imaging services, and improving the internal accuracy of the physician fee schedule.

Historical concerns about physician payment

Physicians are the gatekeepers of the health care system; they order tests, imaging studies, surgery, and drugs as well as provide patient care. Yet the payment system for physicians is fee for individual service; it does not reward coordination of care or high quality—by definition it rewards high volume. Several attempts have been made to address this tendency to increase volume and payments.

The Congress established the fee schedule that sets Medicare's payments for physician services as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA 89). As a replacement for the so-called customary, prevailing, and reasonable (CPR) payment method that existed previously, it was designed to achieve several goals. First, the fee schedule decoupled Medicare's payment rates and physicians' charges for services. This was intended to end an inflationary bias in the CPR method that gave physicians an incentive to raise their charges.

Second, the fee schedule corrected distortions in payments that had developed under the CPR method—payments were lower, relative to resource costs, for evaluation and management services but higher for surgeries and procedures and there was wide variation in payment rates by geographic area that could not be explained by differences in practice costs. (As we discuss later, there is evidence that relative prices in the fee schedule may have once again become distorted.)

The third element of OBRA 89 focused on volume control, which is still a significant issue for the Medicare program. Rapid and continued volume growth raises three concerns: Is some of the growth related to provision of unnecessary services? Is it a result, at least in part, of mispricing? Will it make the program unaffordable for beneficiaries and the nation?

Some volume growth may be desirable. For example, growth arising from technology that produces meaningful improvements in care to patients, or growth where there is currently underutilization of services, may be beneficial. But one indicator that not all services provided may be necessary is the range of geographic variation in the volume of services provided, coupled with the finding that there is no clear relationship between increased volume of services and better patient outcomes.

Volume varies across geographic areas. As detailed in our June 2003 Report to the Congress, the variation is widest for certain services, including imaging, tests, and other procedures. Researchers at Dartmouth have reached several conclusions about such variation:

- Differences in volume among geographic areas is primarily due to greater use of discretionary services (e.g., imaging and diagnostic tests) that are sensitive to the supply of physicians and hospital resources, and less due to differences in the volume of non-discretionary services such as major procedures.
- On measures of quality, care is often no better in areas with high volume than in areas with lower volume. The high-volume areas tend to have a physician

workforce composed of relatively high proportions of specialists and lower proportions of generalists.

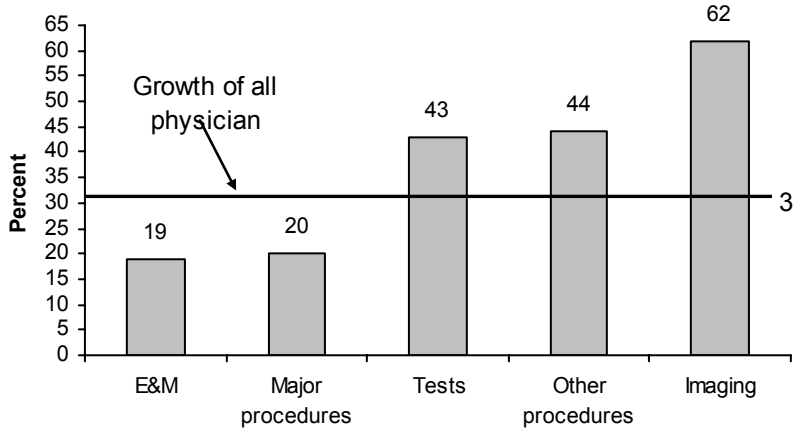
The Dartmouth researchers focus on variation in the level of volume. Growth in volume also varies among broad categories of services: Cumulative growth in volume per beneficiary ranged from about 19 percent for evaluation and management to almost 62 percent for imaging, based on our analysis of data comparing 2004 with 1999 (Figure 1), and growth rates were higher for services which researchers have characterized as discretionary.

Impact on beneficiaries—For beneficiaries, increases in volume lead to higher out-of-pocket costs in the form of coinsurance, the Medicare Part B premium, and any premiums they pay for supplemental coverage. For example, volume growth increases the monthly Part B premium. Because it is determined by average Part B spending for aged beneficiaries, an increase in the volume of services affects the premium directly. From 1999 to 2002 the premium went up by an average of 5.8 percent per year. By contrast, cost-of-living increases for Social Security benefits averaged only 2.5 percent per year during that period. Since 2002 the Part B premium has gone up faster still—by 8.7 percent in 2003, 13.5 percent in 2004, 17.4 percent in 2005, 13.2 percent in 2006, and a projected 11.2 percent in 2007. Beneficiaries also pay coinsurance of 20 percent for most Part B services and supplemental insurance premiums will eventually reflect higher volumes of coinsurance.

Impact on taxpayers— Volume growth also has implications for taxpayers and the federal budget. Increases in volume lead to higher Medicare Part B program expenditures that are supported by the general revenues of the Treasury. (The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) established a trigger for legislative action if general revenues exceed 45 percent of total outlays for the Medicare program.) Medicare is growing faster than the nation's output of goods and services, as discussed in the Medicare trustees' report, and will continue to put pressure on the federal budget, raising questions about the long run sustainability of Medicare.

FIGURE 1

Imaging shows highest cumulative growth in services per beneficiary, 1999–2004



Note: E&M (evaluation and management).
Source: MedPAC analysis of Medicare claims data.

OBRA 89 established a formula based on achievement of an expenditure target—the volume performance standard (VPS). This approach to payment updates was a response to rapid growth in Medicare spending for physician services driven by growth in the volume of those services. From 1980 through 1989, annual growth in spending per beneficiary, adjusted for inflation, ranged widely, from a low of 1.3 percent to a high of 15.2 percent. The average annual growth rate was 8.0 percent.

The VPS was designed to give physicians a collective incentive to control the volume of services. But, experience with the VPS formula showed that it had several methodological flaws that prevented it from operating as intended. Those problems prompted the Congress to replace it with the sustainable growth rate system in the Balanced Budget Act of 1997.

The sustainable growth rate (SGR) system

Under the SGR, the expenditure target allows growth for factors that should affect growth in spending on physician services namely:

- inflation in physicians' practice costs,
- changes in enrollment in fee-for-service Medicare, and
- changes in spending due to law and regulation.

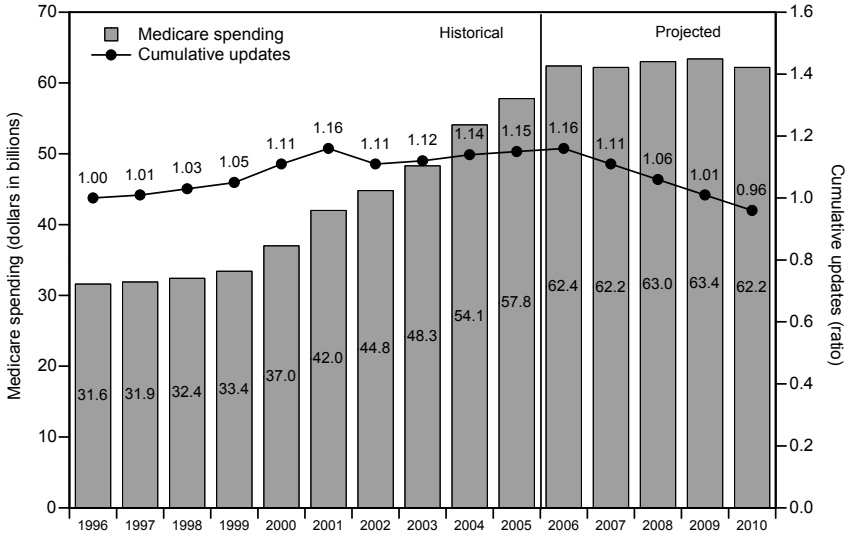
The SGR also has an allowance for growth above those factors based on growth in real gross domestic product (GDP) per capita. GDP, the measure of goods and services produced in the United States, is used as a benchmark of how much additional growth in volume society can afford. The basic SGR mechanism only lowers the update when cumulative actual spending exceeds target spending.

Like the VPS, the SGR approach has run into difficulties. The SGR formula is based on a cumulative spending target. If actual spending exceeds the SGR system's allowance for growth, excess spending continues to accumulate until it is recouped by reduced updates. The SGR system calculated negative updates beginning in 2002. In 2002 the update was negative 5.4 percent. However, from 2003 on, legislative actions modified or

overrode the negative updates calculated by the SGR system, resulting in fee increases in 2003 (1.6 percent), 2004 (1.5 percent), and 2005 (1.5 percent) and in flat fees for 2006. Volume has continued to grow strongly throughout this period. Figure 2 shows that Medicare spending for physician services has been growing rapidly despite the restraint on fee increases since 2002. The conversion factor in 2006 is the same as in 2001, yet spending is 49 percent higher. This rapid growth has created an ever-larger gap between target and actual spending. CMS estimates that by the end of 2006, actual spending will exceed allowed spending by more than $47 billion. To work off this excess, according to the Medicare trustees, the SGR will call for annual updates of about negative five percent (the largest allowed under the system) for nine consecutive years. The trustees have characterized this series of updates as "unrealistically low." In terms of budget scoring, these projections make legislative alternatives to the SGR very expensive.

FIGURE 2

FFS Medicare spending and payment updates for physician services, 1996–2010



Note: FFS (fee-for-service). Dollars are Medicare spending only and do not include beneficiary coinsurance. For 2006, the Deficit Reduction Act froze the fee schedule's conversion factor, but refinements in relative value units resulted in a small increase in payment rates.

Source: 2006 annual report of the Boards of Trustees of the Medicare trust funds.

The SGR approach has other flaws as well:

- It is a flawed volume control mechanism. Because it is a national target, there is no incentive for individual physicians to control volume.
- It is inequitable because it treats all physicians and regions of the country alike regardless of their individual volume-influencing behavior.
- It treats all volume increases the same, whether they are desirable or not.

The underlying assumption of an expenditure target approach, such as the SGR, is that increasing updates if overall volume is controlled, and decreasing updates if overall

volume is not controlled, provides physicians a collective incentive to control the volume of services. However, physicians do not respond to nationwide incentives. An efficient physician who reduces volume does not realize a proportional increase in payments. In fact, such a physician stands to lose twice, receiving lower income from both lower volume and the nationwide cut in fees. Not surprisingly, there is evidence that in such circumstances physicians have increased volume in response to fee cuts.

MedPAC has consistently raised concerns about the SGR—both when it set updates above and when it set updates below the change in input prices. Instead of relying on a formula, MedPAC recommends that updates should be considered each year to ensure that payments for physician services are adequate to maintain Medicare beneficiaries' access to care.

The Commission recognizes the desire for some control over rapid increases in volume particularly given the evidence that higher volume is not always associated with better quality. Volume growth must be addressed by determining its root causes and designing focused policy solutions. A formula such as the SGR that attempts to control volume through global payment changes that treat all services and physicians alike will produce inequitable results for physicians.

Improving value

We recommend a series of steps to improve payment for physician services. They will not, by themselves, solve the problem of rapidly growing expenditures for physician services. However, they are important steps that will improve quality for beneficiaries and lay the groundwork for obtaining better value in the Medicare program. MedPAC recommends the following steps, which we discuss in more detail below:

- A year-to-year evaluation of payment adequacy to determine the update.
- Approaches that would allow Medicare to differentiate among providers when making payments as a way to improve the quality of care. Currently, Medicare pays providers the same regardless of their quality or use of resources—Medicare should pay more to physicians with higher quality performance and less to those with lower quality performance.
- Measuring physicians' use of Medicare resources when serving beneficiaries and providing information about practice patterns confidentially to physicians.
- With regard to imaging, a rapidly growing sector of physician services, ensuring that providers who perform imaging studies and physicians who interpret them meet quality standards as a condition of Medicare payment.
- Ensuring that the physician fee schedule sets the relative price of services accurately.

A different approach to updating payments

In our March 2002 report we recommended that the Congress replace the SGR system for calculating an annual update with one that balances a range of factors. A new system should update payments for physician services based on an analysis of payment adequacy, which would include the estimated change in input prices for the coming year, less an adjustment for growth in multifactor productivity. Updates would not be automatic (required in statute) but be informed by changes in beneficiaries' access to physician services, the quality of services being provided, the appropriateness of cost increases, and other factors, similar to those MedPAC takes into account when considering updates for other Medicare payment systems. Furthermore, the reality is that in any given year the Congress might need to exercise budget restraints and MedPAC's analysis would serve as one input to Congress's decision making process.

For example, we used this approach in our recommendation on the physician payment update in our March 2006 Report to the Congress. Our assessment was that Medicare beneficiaries' access to physician care, the supply of physicians, and the ratio

of private payment rates to Medicare payment rates for physician services, were all stable. Surveys on beneficiary access to physicians continue to show that the large majority of beneficiaries are able to obtain physician care and nearly all physicians are willing to serve Medicare beneficiaries. In August and September of 2005, for example, we found that among beneficiaries seeking an appointment for illness or injury with their doctor, 83 percent reported they never experienced a delay. This rate was higher than the 75 percent reported for privately insured people age 50 to 64.

A large national survey found that among office-based physicians who commonly saw Medicare patients, 94 percent were accepting new Medicare patients in 2004. We have also found that the number of physicians furnishing services to Medicare beneficiaries has kept pace with the growth in the beneficiary population, and the volume of physician services used by Medicare beneficiaries is still increasing. CMS has found that two subpopulations of beneficiaries more likely to report problems finding new physicians are those who recently moved to a new area and those who state that they are in poor health. The Center for Studying Health Systems Change has found that rates of reported access problems by market area are generally similar for Medicare beneficiaries and privately insured individuals. This finding suggests that when some beneficiaries report difficulty accessing physicians, their problems may not be attributable solely to Medicare payment levels, but rather to other factors such as population growth.

Differentiating among providers

In our reports to the Congress we have made several recommendations that taken together will help improve the value of Medicare physician services. Our basic approach is to differentiate among physicians and pay those who provide high quality services more, and pay those who do not less. As a first step, we make recommendations concerning: pay for performance and information technology (IT), and measuring physician resource use.

Pay for performance and information technology

Medicare uses a variety of strategies to improve quality for beneficiaries including the quality improvement organization (QIO) program and demonstration projects, such as the physician group practice demonstration, aimed at tying payment to quality. In addition, CMS has announced a voluntary quality reporting initiative for physicians. MedPAC supports these efforts and believes that CMS, along with its accreditor and provider partners, has acted as an important catalyst in creating the ability to measure and improve quality nationally. These CMS programs provide a foundation for initiatives tying payment to quality and encouraging the diffusion of information technology.

However, other than in demonstrations, Medicare, the largest single payer in the system, still pays its health care providers without differentiating on quality. Providers who improve quality are not rewarded for their efforts. In fact, Medicare often pays more when poor care results in unnecessary complications.

To begin to create incentives for higher quality providers, we recommend that the Congress adopt budget neutral pay-for-performance programs, starting with a small share of payment and increasing over time. For physicians, this would initially include use of a set of measures related to the use and functions of IT, and next a broader set of process measures.

The first set of measures should describe evidence-based quality- or safety-enhancing functions performed with the help of IT. Some suggest that Medicare could reward IT adoption alone. However, not all IT applications have the same capabilities and owning a product does not necessarily translate into using it or guarantee the desired outcome of improving quality. Functions might include, for example, tracking patients with diabetes and sending them reminders about preventive services. This approach

focuses the incentive on quality-improving activities, rather than on the tool used. The performance payment may also increase the return on practices' IT investments.

Process measures for physicians, such as monitoring and maintaining glucose levels for diabetics, should be added to the pay-for-performance program as they become more widely available from administrative data. Using administrative data minimizes the burden on physicians. We recommend improving the administrative data available for assessing physician quality by combining clinical laboratory values with prescription data and physician claims to provide a more complete picture of patient care. As clinical use of IT becomes more widespread, even more measures could become available.

Measuring physician resource use

For Medicare beneficiaries living in regions of the country where physicians and hospitals deliver many more health care services there is no clear relationship with better quality of care or outcomes. Moreover, they do not report greater satisfaction with care than beneficiaries living in other regions. This finding, and others by researchers such as Wennberg and Fisher, are provocative. They suggest that the nation could spend less on health care, without sacrificing quality, if physicians whose practice styles are more resource intensive moderated the intensity of their practice.

MedPAC recommends that Medicare measure physicians' resource use over time, and feed back the results to physicians. Physicians could then start to assess their practice styles, and evaluate whether they tend to use more resources than their peers. Moreover, when physicians are able to use this information with information on their quality of care, it will provide a foundation for them to improve the efficiency of the care they and others provide to beneficiaries. Once greater experience and confidence in this information is gained, Medicare might begin to use the results in payment, for example as a component of a pay-for-performance program.

In our June 2006 Report to the Congress we discuss early results from using episode groupers to measure Medicare resource use. An episode grouper links all the care a beneficiary receives that is related to a particular spell of illness or episode.

Managing the use of imaging services

The last several years have seen rapid growth in the volume of diagnostic imaging services when compared to other services paid under Medicare's physician fee schedule. In addition some imaging services have grown even more rapidly than the average (Figure 3). To the extent that this increase has been driven by technological innovations that have improved physicians' ability to diagnose and treat disease, it may be beneficial. However, other factors driving volume increases could include: possible misalignment of fee schedule payment rates and costs, physicians' interest in supplementing their professional fees with revenues from ancillary services, patients' desire to receive diagnostic tests in more convenient settings, and defensive medicine.

There is an ongoing migration of imaging services from hospitals, where institutional standards govern the performance and interpretation of studies, to physician offices, where there is less quality oversight. In addition, according to published studies and private plans, some imaging services are of low quality. Therefore, we recommended that Medicare develop quality standards for all providers that receive payment for performing and interpreting imaging studies. These standards should improve the accuracy of diagnostic tests and reduce the need to repeat studies, thus enhancing quality of care and helping to control spending.

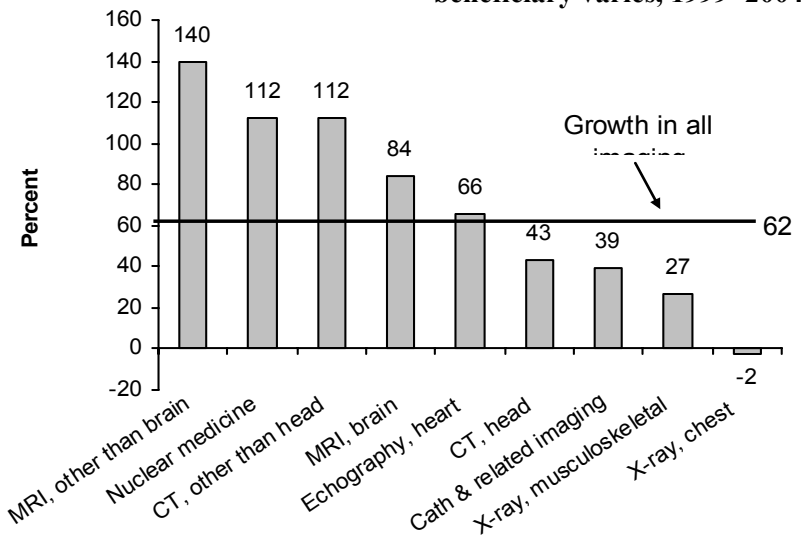
- In addition to setting quality standards for facilities and physicians, we recommended that CMS:
- measure physicians' use of imaging services so that physicians can compare their practice patterns with those of their peers,

- expand and improve Medicare's coding edits for imaging studies and pay less for multiple imaging studies performed on contiguous parts of the body during the same visit, and
- strengthen the rules that restrict physician investment in imaging centers to which they refer patients.

CMS adopted some of these recommendations in the 2006 final rule for physician payment by prohibiting physician investment in nuclear medicine facilities to which they refer patients and reducing payments for multiple imaging studies performed in the same session on contiguous parts of the body. The Congress (as part of the Deficit Reduction Act) also adopted our recommendation to reduce payments for multiple imaging services. (Please see our July 18 testimony to this Committee for a fuller discussion of managing the use of imaging services.)

FIGURE 3

Cumulative growth in imaging volume per beneficiary varies, 1999–2004



Note: MRI (magnetic resonance imaging), CT (computed tomography), cath (cardiac catheterization).
Source: MedPAC analysis of Medicare claims data.

Improving the physician fee schedule

As progress is made on the steps discussed above, it is also important to assure that the relative rates for physician services are correct. Medicare pays for physicians' services through the physician fee schedule. The fee schedule sets prices for over 7,000 different services and physicians are paid each time they deliver a service. It is important to get the prices right because otherwise, Medicare would pay too much for some services and therefore not spend taxpayers' and beneficiaries' money wisely. In addition, inaccurate rates can distort the market for physician services. Services that are overvalued may be overprovided. Services that are undervalued may prompt providers to increase volume in order to maintain their overall level of payment or opt not to furnish services at all, which can threaten access to care. Over time, whole groups of services may be undervalued, making certain specialties more financially attractive to new physicians than others, potentially affecting the supply of physicians.

The Commission is examining several issues internal to the physician fee schedule that could be causing the fee schedule to misvalue relative prices.

In our March 2006 Report to the Congress we examined the system for reviewing the relative value units (RVUs) for physician work which determine much of the fee schedule prices. Changes to the review process are necessary because it does not do a good job of identifying services that may be overvalued. The Commission recommended improvements that will help reduce the number of physician fee schedule services that are misvalued, thereby making payment more accurate. We recommended that the Secretary establish a standing panel of experts to help CMS identify overvalued services and to review recommendations from the American Medical Association's relative value scale update committee (RUC), and that the Congress and the Secretary ensure that this panel has the resources it needs to collect data and develop evidence. In consultation with this expert panel, the Secretary should initiate reviews for services that have experienced substantial changes in factors that may indicate changes in physician work, and identify new services likely to experience reductions in value. Those latter services should be referred to the RUC and reviewed in a time period as specified by the Secretary. Finally, to ensure the validity of the physician fee schedule, the Secretary should review all services periodically.

In our June 2006 Report to the Congress we reviewed the data sources that CMS uses to derive practice expense payments—another important determinant of pricing accuracy in the physician fee schedule. One source, a multispecialty survey on the costs of operating physicians' practices, dates from the 1990s. Several specialties have submitted more recent data, but updating the physician fee schedule using newer data from some but not all specialties may introduce significant distortions in relative practice expense payments across specialties. We recognize that collecting and updating practice cost data will substantially increase demands on CMS. However, because it will improve the accuracy of Medicare's payments and achieve better value for Medicare spending, the Congress should provide CMS with the financial resources and administrative flexibility to undertake the effort.

We are also concerned about the accuracy of Medicare's payment rates for imaging studies. In a recent proposed rule, CMS proposed basing payments for the technical component of imaging services on resource use (these rates are currently based primarily on historical charges). These resources include clinical staff, medical equipment, and supplies. Equipment is a large share of the cost of many imaging services, such as MRI and CT. CMS's estimate of the cost of imaging equipment per use may be too high. The agency assumes that imaging machines (and all other types of equipment) are used 50 percent of the time a practice is open for business. We surveyed imaging providers in six markets and found they were using MRI and CT machines much more frequently, which should lead to lower costs per use. In addition, CMS assumes that providers pay an interest rate of 11 percent per year when purchasing equipment, but more recent data suggest that a lower interest rate may be more appropriate (a lower interest rate would reduce the estimated cost of equipment). CMS should revisit the assumptions it uses to price imaging equipment.

Creating new incentives in the physician payment system

MedPAC has consistently raised concerns about the SGR as a volume control mechanism and recommended its elimination. We believe that the other changes discussed previously—pay for performance, encouraging use of IT, measuring resource use, setting quality standards for imaging services, and improving payment accuracy—can help Medicare beneficiaries receive high-quality, appropriate services and help improve the value of the program. Although the Commission's preference is to directly target policy solutions to the source of inappropriate volume increases, we recognize that the Congress may wish to retain some budget mechanism linked to volume. An ideal

volume control mechanism would overcome the incentive under fee-for-service to increase volume and instead create incentives for physicians to practice in ways that improve care coordination and quality while prudently husbanding Medicare resources. The Congress has tasked the Commission to evaluate several alternative volume control mechanisms including differing levels of application such as group practice, hospital medical staff, type of service, geographic areas, and outliers. We will report on these alternatives in March 2007.

MR. DEAL. Thank you. Mr. Guterman.

MR. GUTERMAN. Thank you, Chairman Deal, Congressman Pallone, and members of the committee, for the opportunity to discuss Medicare physician payment with you today.

As all of the member statements and the previous statements on this panel indicate, Congress is facing a challenging dilemma in considering how much to pay physicians. The problem arises from the fact that the Sustainable Growth Rate mechanism offers no control over the volume and intensity provided by the individual physician.

There appears to be no relationship between the physician fee update in any given year and the rate of increase in physician spending. Between 1997 and 2001, according to the letter that was sent from CMS to MedPAC detailing their plans for physician fee updates, fees increased at a rate of 3.4 percent a year, and spending per beneficiary increased at a rate of 7.4 percent a year. Between 2001 and 2005, fees decreased at a rate of 0.7 percent a year, and spending per beneficiary rose at the same rate of 7.4 percent a year that it had in the previous 5 years.

Increasing physician spending puts more burden on Medicare beneficiaries, especially the most vulnerable ones by raising the Part B premium and the deductible. In 2006, the Part B premium increased in double digits for the third consecutive year, and by 2015, CMS actuaries project it will raise to $122.40. Almost 40 percent higher than its current level, which is almost 9 percent of the average Social Security check.

However, it might be necessary to avoid the kinds of steep cuts that physicians are facing in the future that have been referred to by the previous speakers, to protect beneficiaries' access to care. Even though, as GAO reports, there doesn't seem to be a problem at present. However, regardless of what we pay physicians, we need to get more for our money. Quality and coordination in care are lacking in the system, both absolutely and in comparison to other countries. There is a lot at stake, both in terms of beneficiaries' health and Medicare spending.

Life expectancy at age 65 in the U.S. is worse than any other OECD countries. Adult patients, as referred to before, receive only about half of recommended care. Medical error rates are high. Communications are poor between doctors and patients, and among the multiple doctors who treat a growing chronically ill population in Medicare. The continuity of care is lacking.

About 20 percent of Medicare beneficiaries have five or more chronic conditions, and they account for two-thirds of Medicare spending each year. That is about $300 billion on the table in 2007, to treat these people with very complicated conditions and high health needs. We could hardly do worse than we are doing now in addressing the needs of this population, and that affects both beneficiaries' health and Medicare spending.

There is wide variation around the country in Medicare spending per beneficiary. When spending and quality in any measure are compared across areas, there does not seem to be any apparent relationship between those two factors.

Current pay-for-performance initiatives show promise for improving quality, but the designs of those systems and the best ways to implement them will require careful thought and analysis. I support the tendency in Congress to avoid the use of pay-for-performance as a term and to focus on value-based purchasing. Pay-for-performance makes it seem like we are grading doctors and downgrading them for poor care. Value-based purchasing puts the emphasis on buying the services that help beneficiaries achieve better care, and doesn't put the implication out there that physicians are poor performers by nature.

There are almost 100 quality improvement initiatives with financial incentives currently underway, and some have begun to show promising results, and we need to track those initiatives carefully, and we need to evaluate what works and what doesn't, and when it works and when it doesn't. Medicare has a number of these initiatives underway and others in development. These initiatives should be encouraged and given a chance to feed into policy changes on an ongoing basis. That doesn't mean waiting until we have the perfect system, but it means using what we know now, tomorrow, and the next day to continually improve healthcare quality.

Financial incentives need to focus on aligning what we pay with what we want from our healthcare providers. I believe providers generally want to provide good care for their patients, but they need a financing system that pays for best practices, encouragement in adopting those practices, and a quality improvement oriented environment in which to apply them. Not punishing doctors, but making payment consistent with the care that they would like to provide for their patient. I think the goal should not be to ask them to do more, but ask them to do more of what helps patients. Both costs and quality need to be considered together, rather than separately. Efficiency improvements should be encouraged and rewarded.

I think there are lots of ways we can accomplish these goals, and I would be glad to talk more about them in the question and answer period. Thank you.

[The prepared statement of Stuart Guterman follows:]

PREPARED STATEMENT OF STUART GUTERMAN, SENIOR PROGRAM DIRECTOR, PROGRAM ON MEDICARE'S FUTURE, THE COMMONWEALTH FUND

Summary of Major Points

The Congress faces a challenging dilemma in considering how much to pay physicians, arising from the fact that the Sustainable Growth Rate (SGR) mechanism offers no control over the volume and intensity provided by the individual physician.

Increasing physician payments would put more burden on Medicare beneficiaries—especially the most vulnerable ones—by raising the Part B premium. It may be necessary to raise fees in the future to protect beneficiaries' access to care, however, although that doesn't seem to be a problem at present.

Regardless of what we pay physicians, we need to pay more attention to what we get for our money—quality and coordination of care are lacking, both absolutely and in comparison to other countries.

Current pay-for-performance initiatives show promise for improving quality, but the designs of those systems and the best ways to implement them will require careful thought and analysis.

Both cost and quality need to be considered—but together rather than separately; efficiency improvements (which consider both quality and cost) should be encouraged and rewarded.

Cost and quality should be evaluated on a broader basis than individual services or providers, to encourage better performance and coordination across health care settings and for the whole person.

Potential improvements in payment policy should be evaluated for their long-run impact, and not necessarily discarded based on short-term resource requirements or lack of immediate impact.

Other tools, in addition to payments, are available to improve performance, such as information collection and dissemination, securing better cooperation and coordination among providers, and the provision of support to providers to enhance their ability to improve, such as through Medicare's Quality Improvement Organizations.

In addition to serving an important role in providing access to care for aged and disabled beneficiaries, Medicare can be a useful and important platform for developing and implementing improvements in the performance of the health care system.

Sufficient resources should be devoted to research on best practices, development and application of quality standards, and the development of other knowledge and tools to improve the performance of the health care system, for Medicare and all Americans.

Thank you, Chairman Deal, Congressman Brown, and Members of the Committee, for this invitation to testify on Medicare physician payment. I am Stuart Guterman, Senior Program Director for the Program on Medicare's Future at the Commonwealth Fund. The Commonwealth Fund is a private foundation that aims to promote a high performing health care system that achieves better access, improved quality, and greater efficiency, particularly for society's most vulnerable, including low-income people, the uninsured, minority Americans, young children, and elderly adults. The Fund carries out

this mandate by supporting independent research on health care issues and making grants to improve health care practice and policy.

The Congress faces a challenging dilemma in considering how much to pay physicians: on the one hand, Medicare spending is rising at a rate that threatens the program's continued ability to fulfill its mission; on the other, the sustainable growth rate (SGR) mechanism, which is intended to address that problem, produces annual reductions in physician fees that are equally difficult to accept. This dilemma arises from the underlying mismatch between the primary cause of rising spending, which is the volume and intensity of services provided by physicians, and the focus of the SGR, which is to set the fees that physicians receive for each service they provide. Because the SGR offers no control over the volume and intensity provided by the individual physician—and, in fact, may create an incentive to increase volume and intensity to offset reductions in fees—it does not address the underlying cause of physician spending growth.

Determining how much to pay physicians certainly is an important issue, but of at least equal importance is determining how to pay physicians so that the Medicare program gets the best care possible for its beneficiaries. While the payment amount may have an effect on beneficiaries' access to physician services, the payment mechanism (as well as other tools) can be used to make sure that the quality and appropriateness of medical care is maximized, so that beneficiaries' health status is enhanced and the Medicare program gets the most for the money it spends. In fact, there is evidence that, at least given the current state of the health care system, improved quality and reduced cost may both be achievable, and we can, at least in a relative sense, have our cake and eat it, too.

In this testimony, I will first discuss Medicare physician payment and some issues related to the SGR mechanism and the problems that it fails to address. I then will discuss the imperative for Medicare to become a better purchaser of health care, rather than remaining a payer for health services, and suggest some areas on which initiatives in this direction should focus. Finally, I will briefly discuss some of the promising initiatives that currently are underway, and offer some opinions as to how they might be used to improve the Medicare program and the health care system in general.

Why Physicians Are Different Than Medicare's Other Service Providers

Physicians are unique among Medicare providers in being subject to an aggregate spending adjustment. By contrast, most Medicare services now are paid through prospective payment systems that set a price for a bundle of services. In these systems, the provider is free to make decisions about the volume of services provided to the patient, but the payment for the bundle is fixed.

Physicians are unique in their role in determining the volume of services they can provide. Physicians are the gatekeepers and managers of the health care system; they direct and influence the type and amount of care their patients receive. Physicians, for example, can order laboratory tests, radiological procedures, and surgery.

Moreover, the units of service for which physicians are paid under the Medicare are frequently very small. The physician therefore may receive payment for an office visit and separate payment for individual services such as administering tests and interpreting x-rays—all of which can be provided in a single visit. Contrast this with the hospital, which receives payment for each discharge, with no extra payment for additional services or days (except for extremely costly cases).

Further, once a physician's practice is established, the marginal costs of providing more services are primarily those associated with the physician's time. That means that any estimates of the actual cost of providing physician services are extremely malleable, because they are largely dependent on how the physician's time is valued. Even at that, there is no routinely available and auditable source of data on costs for individual physicians or even practices, such as there is for hospitals via the Medicare Cost Report.

Attempts to Control Spending by Adjusting for Volume

In an attempt to control total spending for physicians' services driven by volume, the Congress in the Omnibus Budget Reconciliation Act of 1989 established a mechanism that set physician fees for each service and tied the annual update of those fees to the trend in total spending for physicians' services relative to a target. Under that approach, physician fees were to be updated annually to reflect increases in physicians' costs for providing care and adjusted by a factor that reflected the volume of services provided per beneficiary. The introduction of expenditure targets to the update formula in 1992 initiated a new approach to physician payments. Known as the volume performance standard (VPS), this approach provided a mechanism for adjusting fees to try to keep total physician spending on target.

The method for applying the VPS was fairly straightforward but it led to updates that were unstable. Under the VPS approach, the expenditure target was based on the historical trend in volume. Any excess spending relative to the target triggered a reduction in the update two years later. But the VPS system depended heavily on the historical volume trend, and the decline in that trend in the mid-1990s led to large increases in Medicare's fees for physicians' services. The Congress attempted to offset the budgetary effects of those increases by making successively larger cuts in fees, which further destabilized the update mechanism. That volatility led the Congress to modify the VPS in the Balanced Budget Act of 1997, replacing it with the sustainable growth rate mechanism in place today.

Like the VPS, the SGR method uses a target to adjust future payment rates and to control growth in Medicare's total expenditures for physicians' services. In contrast to the VPS, however, the target under the SGR mechanism is tied to growth in real (inflation-adjusted) gross domestic product (GDP) per capita—a measure of growth in the resources per person that society has available. Moreover, unlike the VPS, the SGR adjusts physician payments by a factor that reflects cumulative spending relative to the target.

Policymakers saw the SGR approach as having the advantages of objectivity and stability in comparison with the VPS. From a budgetary standpoint, the SGR method, like the VPS, is effective in limiting total payments to physicians over time. GDP growth provides an objective benchmark; moreover, changes in GDP from year to year have been considerably more stable (and generally smaller) than changes in the volume of physicians' services.

Problems with the Current Approach

A key argument for switching from the VPS approach to the SGR mechanism was that over time, the VPS would produce inherently volatile updates. But updates under the SGR method have proven to be volatile as well. Through 2001, that volatility was to the benefit of physicians—overall, the increase in fees in the first three years during which the SGR method was in place was more than 70 percent higher than the MEI over the same period.

The pattern since then has been considerably different. In 2002, Medicare physician fees declined for the first time, by 3.8 percent (Figure 1). Notably, however, physician expenditures per beneficiary increased—although at the lowest rate in four years. In succeeding years, the Congress has wrestled with a succession of negative updates produced by the SGR formula that they enacted. In the Medicare Modernization Act, they froze physician fees for two years beginning in 2004 (which actually was an increase relative to the reductions called for by the SGR formula)—but physician expenditures per beneficiary continued to rise. In fact, while physician fees actually fell over the period between 2001 and 2005, physician expenditures per beneficiary actually rose at the same rate as in the previous four years (Figure 2).

Impact on Beneficiaries

Decisions about how much to pay physicians under Medicare affect the program's beneficiaries in two ways: rising spending for physicians' services mean higher Part B premiums, which exacerbates the financial burden they face, particularly among the more vulnerable groups with low incomes, fragile health, disabilities, or chronic illnesses; on the other hand, rates that are too low may affect access to needed physician care, either because physicians will refuse to treat new Medicare patients (or stop treating any Medicare patients at all) or because they will refuse to take the Medicare payment rates as payment in full for their services, which could mean that the beneficiary is responsible for some additional payment to the physician.

Medicare Part B, which covers physician, outpatient hospital, and other ambulatory services, is voluntary (although the Medicare beneficiary is automatically enrolled in most cases unless he/she indicates a desire to "opt out") and requires payment of a monthly premium (generally deducted from the beneficiary's Social Security check), which currently is $88.50, or almost nine percent of the average Social Security check.[1] Because the premium is set so that it covers 25 percent of projected Part B costs, every increase in physician payments has a proportional effect on the Part B premium.

In 2006, the Part B premium increased by more than 10 percent for the third consecutive year, causing concern among beneficiaries and their advocates.[2] Overall, the Part B premium has increased from $43.80 in 1998 to $88.50 in 2006—at an annual rate of more than nine percent (Figure 3); by 2015, it is projected to rise to $122.40—climbing at a much slower rate than in the past few years, but still almost 40 percent higher than its current level.[3]

The potential impact on Medicare beneficiaries—particularly those who are most vulnerable because of low incomes or other economic or health-related factors—can put further financial pressure on those who can least withstand it. Medicare beneficiaries tend to be particularly vulnerable to the financial pressures of health care costs: 78 percent of the Medicare aged are in fair or poor health or have a chronic condition or disability (compared with 31 percent of the population under 65 with employer coverage) and 46 percent of them have incomes below 200 percent of the federal poverty level (compared with 21 percent of the younger population with employer coverage) (Figure 4). In fact, these twin problems of low income and poor health—two-thirds of beneficiaries have one or the other of these problems—are the major reason that Medicare was enacted in the first place.

Even typical aged beneficiaries had out-of-pocket costs that were more than 20 percent of their incomes on average (Figure 5). That burden was projected to rise to almost 30 percent by 2025—although that number may be somewhat reduced by the availability of prescription drug coverage under Medicare Part D. Beneficiaries with physical or cognitive health problems and no other health insurance were paying 44 percent of their incomes on average for their health care costs out of their own pockets, with that burden projected to grow to more than 60 percent by 2025—although again, the availability of Medicare Part D may reduce that number somewhat, beneficiaries in that category clearly are in a precarious position.

Access to physicians does not seem to be a problem—at least, so far. Telephone surveys conducted for the Medicare Payment Advisory Commission (MedPAC) indicate that 74 percent of beneficiaries never had a delay in getting an appointment for routine

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[1] Social Security Administration, *OASDI Monthly Statistics, June 2006*, accessed through www.ssa.gov/policy/docs/statcomps/oasdi_monthly.

[2] See W. Novelli, *Statement by AARP CEO Bill Novelli on the 2006 Social Security COLA*, accessed through www.aarp.org/reserach/press-center/presscurrentnews/2006_social_security_cola.html.

[3] Beginning in 2007, the premium will be higher for beneficiaries with incomes above a certain threshold.

care, and 83 percent had the same response in cases of illness or injury (Figure 6); these percentages were about the same as in the previous two years—and somewhat higher than for people who were privately insured. Similarly, the vast majority of beneficiaries reported no problems finding a new physician—either primary care or specialist—with the numbers being about the same across years and source of insurance coverage.

MedPAC also reports that, although Medicare physician payments overall are only 83 percent of the rates paid by private insurers in 2004, that ratio has been fairly stable over the past five years and, if anything, has increased slightly.[4] Moreover, 99 percent of allowed charges for physician services were assigned in 2002, which means that essentially all physicians accept the Medicare payment rates as full payment for their services.[5]

Nonetheless, given the cuts scheduled in every year from 2007 through 2011, MedPAC concludes that: "We are concerned that such consecutive annual cuts would threaten access to physician services over time, particularly primary care services."[6] In addition, they state that: "The Commission considers the SGR formula a flawed, inequitable mechanism for volume control and plans to examine alternative approaches to it in the coming year."[7]

The Congress will need to evaluate these alternatives in light of three potentially conflicting concerns: the desire to control the growth of Medicare spending, the desire to provide a fair rate of payment to physicians and preserve access for Medicare beneficiaries, and the desire to keep the financial burden on the most vulnerable beneficiaries from becoming worse.

What Are We Getting for Our Money?

Regardless of the ultimate decision as to how much to pay physicians under Medicare, there is a basic issue that needs to be addressed for the good of the Medicare program, its beneficiaries, and the rest of the health care system. It is by now well-known that adult patients in the U.S. receive only 55 percent of recommended care overall, with even lower proportions for patients with some conditions—such as hip fracture, with only 23 percent (Figure 7). This poor performance is particularly striking given the fact that the U.S. devotes 16 percent of its GDP to health services—by far, the highest in the world.[8,9]

Not surprisingly, the poor performance of the health care sector in general has implications for Medicare. Life expectancy at age 65 in the U.S. is among the lowest in the industrialized countries (Figure 8).

This general poor performance is the product of many specific aspects of the way health care is structured and provided in the U.S. that need improvement. The complexity and fragmentation of our health care system, specialization of physicians, intensive use of medications, and poor coordination of care make health care in the U.S. more costly and less safe. The Commonwealth Fund has found that 34 percent of patients in the U.S. surveyed in 2005 reported a medical mistake, medication error, or test error in the past two years, compared with 22 percent in the United Kingdom (the lowest rate among the survey countries) and 30 percent in Canada (the next highest rate) (Figure 9).

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[4] Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* (Washington, DC: MedPAC, March 2006), p. 91.
[5] Ibid., p. 90.
[6] Ibid., p. 99.
[7] Ibid., p. 99.
[8] S. Heffler, S. Smith, S. Keehan, C. Borger, M.K. Clemens, and C. Truffer, "U.S. Health Spending Projections for 2004-2014" *Health Affairs* Web Exclusive, February 23, 2005, p. W5-74-W5-85.
[9] G.F. Anderson, B.K. Frogner, R.A. Johns, and U.E. Reinhardt, "Health Care Spending and Use of Information Technology in OECD Countries" *Health Affairs* (25,3) May/June 2006, p. 819-831.

Interpersonal aspects of health care also are lacking: 35 percent of community-dwelling adults age 65 and older reported that health providers did not always listen carefully to them, 41 percent reported that health providers did not always explain things clearly (Figure 10). In addition, 31 percent of sicker adults in the U.S. surveyed in 2002 reported that they had left a doctor's office in the past two years without getting important questions answered, compared with 19 percent in the U.K. (Figure 11).

Coordination is an important dimension of health care delivery, with a rising proportion of the population—especially seniors—having multiple chronic conditions and correspondingly being treated by multiple doctors. More than 20 percent of Medicare beneficiaries have five or more chronic conditions, and they are treated by an average of almost 14 different doctors in a given year.[10] In our current payment system, there is nothing to encourage physicians to communicate with each other about patients they may have in common. Although there have been some efforts to change this, fee-for-service Medicare is still largely based on the acute care model, in which a patient becomes ill and is treated by a doctor in the office or in the hospital until the discrete episode is over and the patient can resume his/her normal life.[11] Moreover, until recently, there were substantial barriers to the appropriate coordination of care even in the Medicare+Choice program.[12]

Difficulties in care coordination are evident around the world, but nowhere as much as in the U.S.: 33 percent of adults with health problems reported that in the past two years a doctor had ordered tests for them that had already been done or that test results or records were not available to their doctor at the time of their appointment, compared with 19 percent in the U.K. and Australia (the lowest proportions) and 26 percent in Germany (the highest next to the U.S.) (Figure 12). Although most U.S. adults (84 percent) with health problems reported having a regular doctor, only half of them had been with that doctor for five years or more (Figure 13).

The number of doctors treating a patient, not surprisingly, is correlated with coordination problems: In the U.S., 22 percent of patients with one doctor had experienced at least one of these problems, while 43 percent of patients with four or more doctors had experienced those problems—almost twice as many (Figure 14). This pattern held in all of the countries in which the survey was conducted.

Addressing the lack of care coordination in the U.S. is not just a quality issue—as I mentioned before, about 20 percent of Medicare beneficiaries have five or more chronic conditions, but this group also accounts for two-thirds of Medicare spending each year (Figure 15). That means that about $300 billion is going to be spent for this group of people next year, and the evidence is that it could be spent much more productively than it is being spent now.[13]

The Role of Health Information Technology

One factor that is commonly pointed to as a tool for improving both the quality and coordination of care is health information technology. It is also widely recognized that the diffusion of health information technology across the health care sector has been much slower than would be desired: researchers at RAND found that only 20 to 25 percent of hospitals across the country have adopted electronic medical records (EMRs), while EMRs were in use in only 15 to 20 percent of physicians' offices.[14] In fact, the use

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[10] Partnership for Solutions, "Medicare: Cost and Prevalence of Chronic Conditions", Fact Sheet, July 2002.

[11] See S. Guterman, "U.S. and German Case Studies in Chronic Care Management: An Overview" *Health Care Financing Review* (27,1) Fall 2005, p. 1-8.

[12] Ibid.

[13] See Board of Trustees, Federal HI and Federal SMI Trust Funds, *2006 Annual Report*.

[14] See K. Fonkych and R. Taylor, *The State and Pattern of Health Information Technology Adoption* (Santa Monica, CA: RAND, 2005).

of electronic technology in physicians' offices is fairly common, but that technology may have many applications that fall short of the comprehensive quality-enhancing EMR that proponents of health information technology envision. In a 2003 survey of physicians, the Commonwealth Fund found that almost 80 percent of all physicians used electronic billing in their offices, and almost 60 percent used health information technology for access to test results (Figure 16). Only 27 percent used the technology for electronic ordering, however, and about the same proportion had electronic medical records.

In most instances, larger practices make more use of health information technology. In 2004 and 2005, the Commonwealth Fund supported a study of solo and small group practices, to investigate the business case for technology adoption in those settings; that study found that adopting, installing, and using electronic health records could be substantial (Figure 17). In addition to the initial costs, which averaged almost $44,000 per provider, there were ongoing costs of almost $8,500 per provider per year. There were also substantial financial benefits, and the average practice recouped its costs in about two and a half years.

It is important here to note that the financial benefits of adoption which averaged about $33,000 per provider per year, came from two main sources: increased efficiency, which accounted for almost $16,000 per provider per year; and increased coding levels, which accounted for almost $17,000 per provider per year (Figure 18). It is also noteworthy that of the 14 practices in the study, only two reported any quality performance rewards, and they were nominal. Some quality improvement activities were implemented at almost all of the practices, but these varied in focus and intensity.[15]

Can We Get More for What We Spend?

The Dartmouth Atlas has produced a chart that is by now well-known, which shows the wide variation in Medicare spending per beneficiary among different areas in the U.S. (Figure 19). In 1996, the 20 percent of areas with the highest spending were about 60 percent higher than their counterparts at the low end; by 2000, that ratio had not changed much, and it is the same today (as of 2003). In fact, these numbers conceal the tremendous amount of variation in spending across individual regions: in 2003, spending in Miami, Florida—the area with the highest Medicare spending per beneficiary—was more than two and a half times that in Salem, Oregon—the area with the lowest spending.

Similar variation in spending was found in data recently analyzed by the Commonwealth Fund on Medicare spending for beneficiaries with all three of the following conditions: diabetes, chronic obstructive pulmonary disease, and congestive heart failure. Using the same area definitions used by the Dartmouth Atlas, we found that median spending per patient across all areas was almost $30,000, but the variation across areas ranged from less than $15,000 to almost $80,000 (Figure 20). Those costs then were compared to a composite measure of several indicators of quality of care that are relevant to the three study conditions; this comparison indicates that there is no obvious correlation between cost and quality across areas—some areas with high quality scores had low costs, and some had high costs; in addition, some areas with high costs had lower-than-average quality scores.

While the quality measures represented in the previous figure are process measures—that is, measures that represent what doctors do—the same relationship appears to hold between spending and outcomes—that is, what happens to beneficiaries. Data from the Dartmouth Atlas show that Medicare beneficiaries in states with higher

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[15] See R. Miller, C. West, T.M. Brown, I. Sim, and C. Ganchoff, "The Value of Electronic Health Records in Solo or Small Group Practices" *Health Affairs* (24,5) September/October 2005, p. 1127-1137.

Medicare spending per beneficiary do not appear to have lower overall mortality rates than in states with lower spending (Figure 21).

Remember that these data are aggregated at the area level, while the decisions that determine both cost and quality are made by individual providers; they should not be taken as an indication that costs can be easily be reduced at an aggregate level without harming quality or access to care, or that even quality improvements that save money in the long run may not cost more in the short run. But they do indicate that there appear to be patterns in how health care decisions are made that are not necessarily driven by factors that improve quality, and that we should be able to figure out how to use our resources more effectively to provide higher quality care at the same or even lower costs than we currently face.

Do Efforts to Improve Quality Work?

One of the underlying problems with our health care financing mechanism is that we generally pay providers for providing more care and more intensive care, but not necessarily better care. This problem is particularly evident in the way that Medicare pays physicians—in fact, it is the real issue that confronts the Congress in discussing how to "fix" the SGR. What we need to be discussing is how to restructure the payment system so that we get what we want for the tremendous amount of money that we spend. Both private and public payers, purchasers, and providers have over the past several years been developing efforts to address this problem; the Leapfrog Group Incentive & Reward Compendium lists 97 programs around the country that are aimed at providing financial incentives to improve quality.[16] Several of these initiatives are already beginning to produce results, and they indicate that there is some promise to this approach.

In a pay-for-performance program run by the Integrated Healthcare Association in California—involving about 35,000 physicians in more than 200 physician organizations—participants reported that they screened about 60,000 more women for cervical cancer, tested nearly 12,000 more individuals for diabetes, and administered about 30,000 more childhood immunizations in 2005 than they had in 2004.[17] Earlier findings indicated that the use of information technology in various clinical applications also had increased substantially under the initiative (Figure 22).

In an analysis of a natural experiment in pay-for-performance, PacifiCare Health Systems paid its medical groups in California bonuses according to performance on a set of quality measures, while those in Washington and Oregon were not part of the program. Performance on cervical cancer screening improved significantly (Figure 23). There was no significant increase, however, in mammography screening or hemoglobin A1c testing.[18]

The National Committee for Quality Assurance (NCQA), with the American Diabetes Association, has developed a Diabetes Physician Recognition Program that awards recognition to physicians who demonstrate that they provide high quality care to patients with diabetes.[19] Although no financial incentive generally is provided under this program (in fact, there is a fee to participate), there have been several areas of improvement, including the proportion of patients with hemoglobin A1c counts below 7 percent—which rose from 25 to 46 percent between 1997 and 2003—and the proportion of patients with low-density Lipoprotein cholesterol levels below 100 milligrams per deciliter—which rose from 17 to 45 percent (Figure 24).

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[16] See The Leapfrog Group Compendium at ir.leapfroggroup.org/compendium/.

[17] IHA News Release, "Continued Quality Improvement in California Healthcare Announced by Integrated Healthcare Association" July 13, 2006.

[18] M.B. Rosenthal, R.G. Frank, Z. Li, and A.M. Epstein, "Early Experience with Pay-for-Performance: From Concept to Practice" *Journal of the American Medical Association* (294, 14) October 12, 2005, p. 1788-1793.

[19] See www.ncqa.org/dprp.

Can We Get Better Care at Lower Cost?

All of the pay-for-performance initiatives described above have focused primarily on quality improvement, which certainly is an area that needs improvement. The comparison of the cost and quality data, however, seem to indicate that we should be able to achieve a higher level of quality at lower cost. Some of the ongoing initiatives are producing data that support that hope.

The Hospital Quality Incentive demonstration is being conducted by the Centers for Medicare & Medicaid Services with Premier, Inc., including about 255 hospitals. Under this demonstration, hospitals are awarded bonus payments based on their performance on discharges in each of five clinical conditions, based on a total of 34 measures. In the first year, a total of almost $9 million in bonuses was paid, and quality improved in each of the five performance domains.[20] Premier, Inc. also found that better performance along several dimensions at least partially related to efficiency also seemed to be correlated with better performance on quality; for example, the readmission rates for pneumonia were 25 percent lower for the 10 percent of the hospitals in the top quality group than for the hospitals in the bottom quartile (Figure 25).

A study sponsored by the Commonwealth Fund has found that coordination across sites of care was correlated with factors that could indicate more appropriate use of health care providers: among patients who, when they left the hospital, said they had a good understanding of what they were responsible for in managing their health, the rates of subsequent emergency department use and hospital readmissions were significantly lower (Figure 26).

In another study sponsored by the Commonwealth Fund, the application of advanced practice nurse care for congestive heart failure patients reduced the total cost per patient from $9,618 to $6,152 (Figure 27). It's important to note that this decrease was composed of a 45 percent *increase* in the cost of ambulatory care and a 44 percent decrease in the cost of inpatient care—because inpatient care is much more expensive, the decrease in inpatient costs more than offset the increase in ambulatory care costs. However, with our current fragmented health care financing and delivery systems, it is difficult to implement programs that shift resources across providers, even if they could both improve the quality of care and save money overall.

Challenges in Aligning Financial Incentives with Better Performance

Although pay-for-performance mechanisms may be promising in encouraging improved health care, careful attention must be paid to the design of the payment systems intended to elicit these improvements; systems designed with even the best of intentions can have unintended consequences. For example, in the previously mentioned evaluation of the PacifiCare pay-for-performance initiative in California, it was found that, although cervical cancer screening rates improved, the greatest improvement was among the doctors who initially were in the lowest performing group (Figure 28). This could, in fact, be interpreted as an encouraging result, but the study also found that the vast majority of the bonus money went to the doctors who initially were in the highest performing group—but this group had the smallest improvement. As MedPAC has recommended, a balance needs to be struck between rewarding the level of performance and improvement in performance.[21]

It should also be noted that, despite the scores of pay-for-performance initiatives being implemented, the majority of physicians have not been involved in any sort of collaborative effort to improve the quality of care (Figure 29). Although these data are

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[20] Centers for Medicare & Medicaid Services Press Release, "Medicare Demonstration Shows Hospital Quality of Care Improves with Payments Tied to Quality" November 14, 2005.

[21] Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* March 2005.

several years old, they probably are not very different from the current situation. Perhaps these results are not surprising, given the small number of physicians who are financially affected by quality considerations—only 19 percent of physicians surveyed in 2003 indicated that quality bonuses or incentive payments were a major factor affecting their compensation (Figure 30). These data indicate that the involvement of Medicare on a nationwide basis is needed to draw physicians into coordinated efforts to improve quality—and efficiency.

Conclusions

As the Congress considers Medicare physician payments for the remainder of this session and beyond, several points must be kept in mind.

First, the current SGR mechanism for updating physician fees does not work—it produced inappropriately large increases in fees in its early years and untenable reductions for the past several years and the foreseeable future. Because the updates produced by the SGR formula are incorporated in the budget baseline, which is used to "score" the budgetary effects of new legislation, even freezing physician fees for the next ten years would be "scored" as "costing" the Medicare program billions of dollars, making it difficult for the Congress to appropriately address the problem without appearing to exacerbate the federal deficit. Moreover, it does not appear that the current mechanism has been effective in controlling the growth in Medicare spending—which is produced primarily by increased volume and intensity, rather than fees.

Second, it must be remembered that the Medicare program is more than a line item in the federal budget or a source of income for providers—it is a social program (one of the most popular in history!) that provides access to care for 43 million aged and disabled beneficiaries, who tend to be sicker and poorer than other Americans. As the Congress considers changes to Medicare physician payment, it must weigh the effects of those changes on the Part B premium that beneficiaries must pay; increases in physician payments proportionately raise the premium and put more financial pressure particularly on the most vulnerable groups of beneficiaries. At the same time, the sharp cuts in fees projected for the next several years are a potential threat to beneficiaries' access to care, and the potential for problems on that front must also be considered.

These issues, however, must be put in the context of a health care system that has the highest costs in the world, but fails to yield commensurate results in terms of the quality and appropriateness of care it provides. This failure cannot—and should not—be tolerated any longer. Fragmentation, lack of communication among physicians caring for a patient and between physicians and patients, medical errors and duplication of tests and other services, and the absence of a mechanism that encourages—or even, in some cases, allows—care coordination across sites of care are attributes of a health care system that is not a health care system at all.

There are many efforts in both the private and public sectors that are aimed at addressing at least some of these problems. Many of these initiatives are still in their early stages, but the evidence that is beginning to become available indicates the promise of some success. Both CMS and the Congress have expressed the desire to move toward pay-for-performance in Medicare, starting with hospitals and physicians, as well as nursing homes. Efforts to accomplish this should be maintained, with an eye toward ensuring that the systems that are put in place are appropriate and will actually encourage broadly improved care rather than narrowly focused activities to meet specific quality goals.

Progress in this direction is being enhanced by several CMS demonstration and pilot projects that are currently in operation, such as the Hospital Quality Incentive demonstration I mentioned earlier, the Physician Group Practice demonstration, and the Medicare Health Support pilot, as well as several that are being developed, such as the Medicare Care Management Performance demonstration, the Nursing Home Quality-

Based Purchasing demonstration, the Medicare Hospital Gain-Sharing demonstration—and particularly the Medicare Health Care Quality demonstration, which will test different approaches to broader system redesign.

Resources must be made available for continued efforts to develop appropriate measures of quality and the means to apply them. One hurdle that needs to be overcome in developing new approaches to improving quality is the possibility that some of these improvements may require high initial costs—this is particularly a problem in the context of Medicare, where demonstration projects that are intended to produce higher quality are required to meet a "budget neutrality" requirement that may be applied so strictly as to hinder the development of some potentially beneficial projects. To be sure, the projected spending impact of proposed demonstration projects is extremely important, but that issue needs to be considered more broadly. An especially difficult situation that needs to be addressed is accounting for the overall effects on Medicare and Medicaid—rather than the effects on each of the two programs separately—of projects that might enhance the quality—and overall efficiency—of care provided to the almost eight million beneficiaries who are eligible for both programs.

Pay-for-performance also must be considered in the context of other tools available to improve quality and efficiency. The primary objective of paying for performance should not be merely to reward good providers and punish bad ones, but to align the health care financing mechanism with what we'd like to see the health care system produce. Prices are messages to producers—and the message we are sending health care providers is that we want more services—and particularly more procedures—but that we don't care very much about how well those services are provided or how much they help patients achieve better health. There are several additional tools that can be used to achieve the desired objectives, and we should pursue all of them to get where we want to be:

Public information on quality and cost should be made available in a format that can be understood by patients and their advocates and acted upon by providers. This means that patients with a particular medical need should be able to identify providers that are best able to give them appropriate and efficient care, and that providers should be able to use that information to improve their quality and efficiency. Public reporting has been shown o be an effective tool in spurring quality improvement efforts.[22]

Ways need to be found to encourage more productive and beneficial interaction between patients and providers. This means that, in addition to rewarding physicians for producing units of care in an effective and efficient way, they must be encouraged to provide that care in a way that is effective and efficient in a broader sense. Examples of these types of incentives would be payments to specific providers for serving as the patient's "medical home"—that is, taking responsibility for obtaining and coordinating all the care needed by the patient across settings, including at home. Other ways to provide more coordination of care across sites—such as follow-up by hospitals for patients discharged with on-going conditions—should be developed.

Making extra payment available for achieving certain quality and efficiency goals helps to align the incentives of the financing and delivery systems, but some providers may face other barriers to achieving the goals that are established for them. Additional resources must be available to establish an infrastructure that enables providers to improve their performance. Medicare's Quality Improvement Organizations (QIOs) currently are tasked with that function, but relatively little is known about its priority in their list of requirements and their effectiveness in fulfilling that role.

All of these approaches hold promise in improving provider performance, not only for Medicare but for all patients.

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[22] See J.H. Hibbard, J. Stockard, and M. Tusler, "Does Publicizing Hospital Performance Stimulate Quality Improvement Efforts?" *Health Affairs* (22,2) March/April 2003, p. 84-94.

Finally, payment reform to reward excellence and efficiency would be greatly facilitated by a major enhancement of health services research funding that includes research on best practices, performance of different forms of health care delivery organization, diffusion of innovation, quality standards, evidence-based medicine, cost-effectiveness and comparative effectiveness, and the development and application of quality standards. This would require some effort and perhaps a substantial amount of resources, but it is the only way to avoid the seemingly endless spiral of spending that we face and improve the value of what we spend.

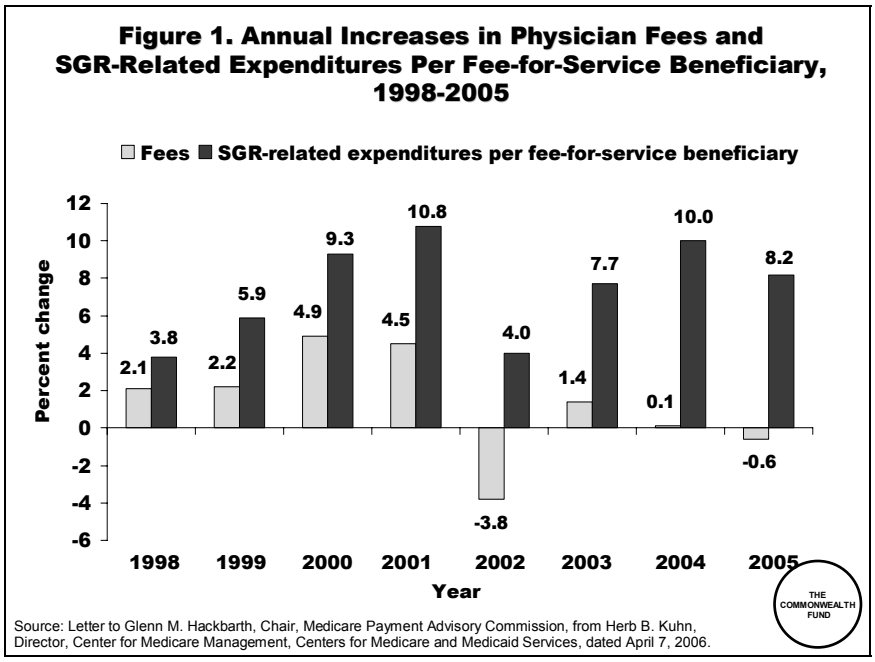
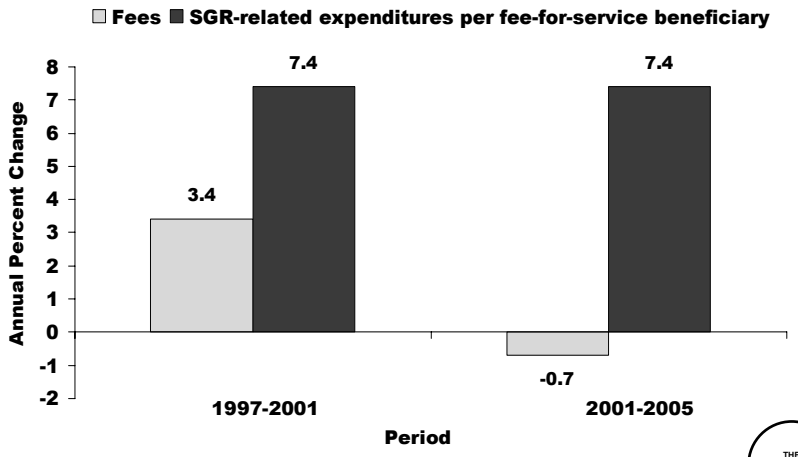


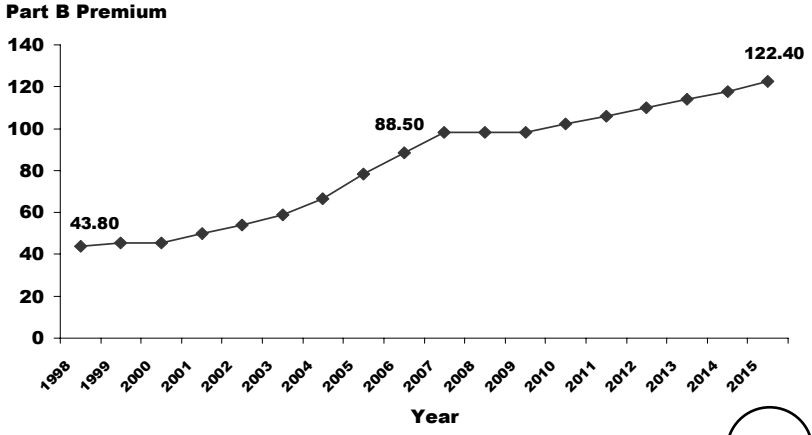
Figure 2. Annual Rates of Increase in Physician Fees and SGR-Related Expenditures Per Fee-for-Service Beneficiary, 1997-2001 and 2001-2005



Source: Letter to Glenn M. Hackbarth, Chair, Medicare Payment Advisory Commission, from Herb B. Kuhn, Director, Center for Medicare Management, Centers for Medicare and Medicaid Services, dated April 7, 2006.

THE COMMONWEALTH FUND

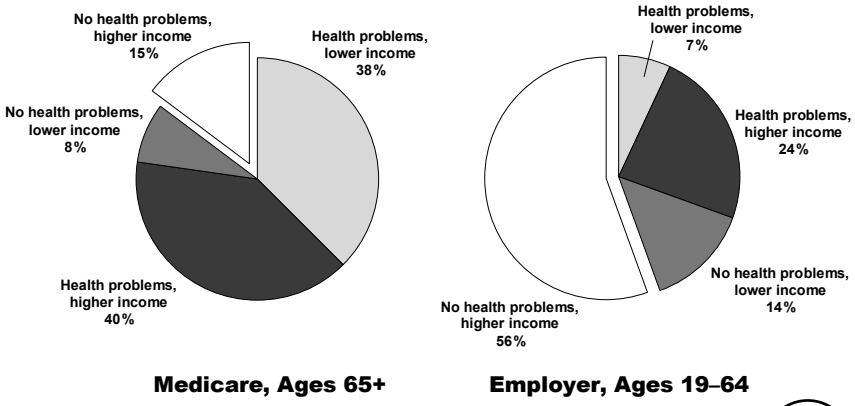
Figure 3. Medicare Part B Premium (Monthly), 1998-2006 (Actual) and 2007-2015 (Projected)



Source: Board of Trustees, Federal HI and Federal SMI Trust Funds, *2006 Annual Report.*

THE COMMONWEALTH FUND

Figure 4. Profile of Medicare Elderly Beneficiaries and Employer Coverage Nonelderly, by Poverty and Health Status, 2003



Note: Respondents with undesignated poverty were not included; lower income defined as ≤200% of poverty; health problems defined as fair or poor health, any chronic condition (cancer, diabetes, heart attack/disease, and arthritis), or disability .

Source: The Commonwealth Fund Biennial Health Insurance Survey (2003).

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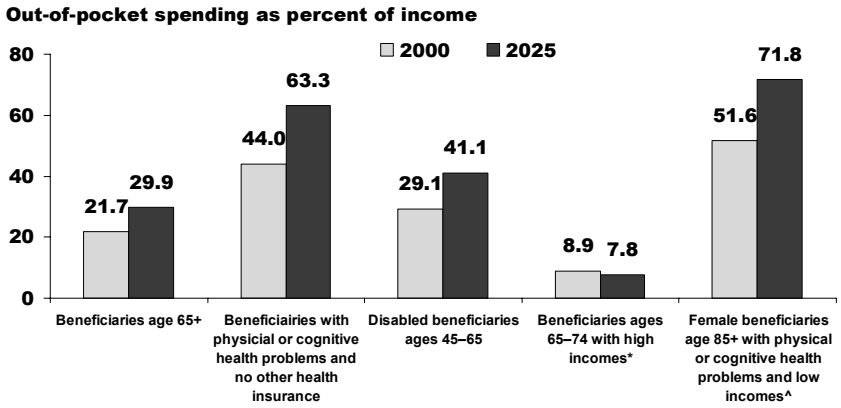
Figure 5. Projected Out-of-Pocket Spending As a Share of Income Among Groups of Medicare Beneficiaries, 2000 and 2005



* Annual household incomes of $50,000 or more.

^ Annual household incomes of $5,000 to $20,000.

Source: S. Maxwell, M. Moon, and M. Segal, *Growth in Medicare and Out-of-Pocket Spending: Impact on Vulnerable Beneficiaries,* The Commonwealth Fund, January 2001 as reported in R. Friedland and L. Summer, *Demography Is Not Destiny*, *Revisited*, The Commonwealth Fund, March 2005.

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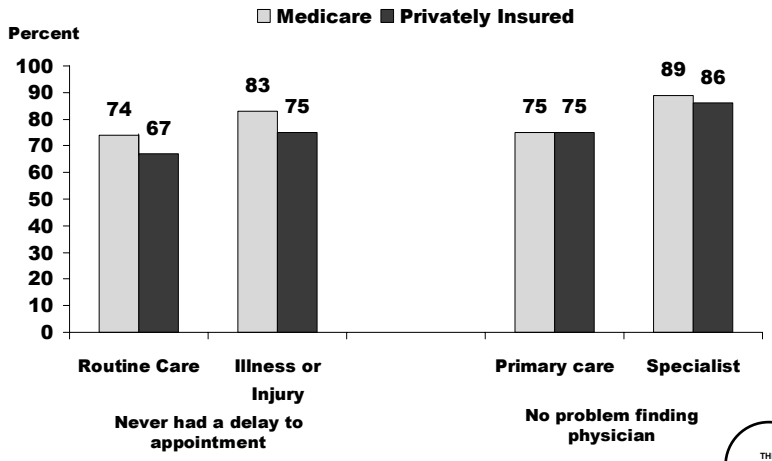
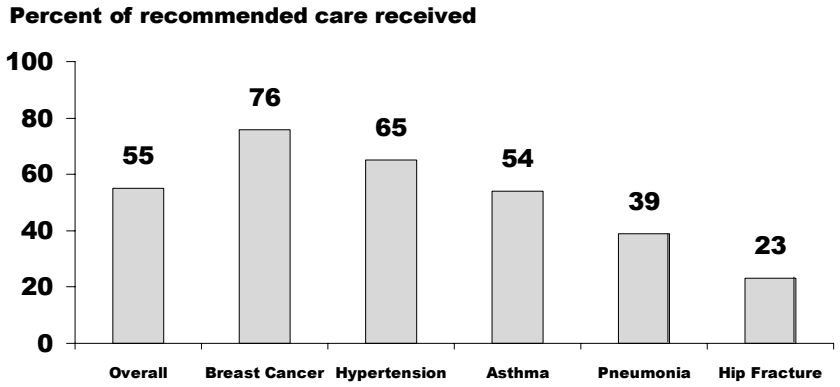
Figure 6. Access to Physicians for Medicare Beneficiaries and Privately Insured People, 2005



Source: MedPAC Report to the Congress: Medicare Payment Policy, March 2006, p. 85.

Figure 7. Proportion of Recommended Care Received by U.S. Adults, by Selected Conditions



Source: McGlynn et al., "The Quality of Health Care Delivered to Adults in the United States," *The New England Journal of Medicine* (June 26, 2003): 2635–2645.

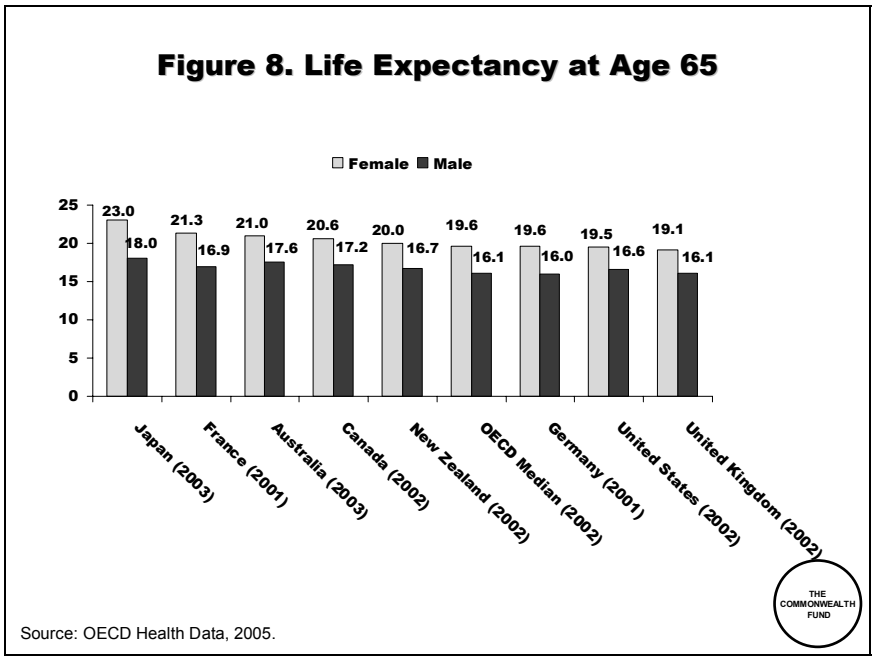


Figure 8. Life Expectancy at Age 65
Female
Male
25
20
15
10
5
0
23.0
18.0
21.3
16.9
21.0
17.6
20.6
17.2
20.0
16.7
19.6
16.1
19.6
16.0
19.5
16.6
19.1
16.1
Japan (2003)
France (2001)
Australia (2003)
Canada (2002)
New Zealand (2002)
OECD Median (2002)
Germany (2001)
United States (2002)
United Kingdom (2002)
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Source: OECD Health Data, 2005.

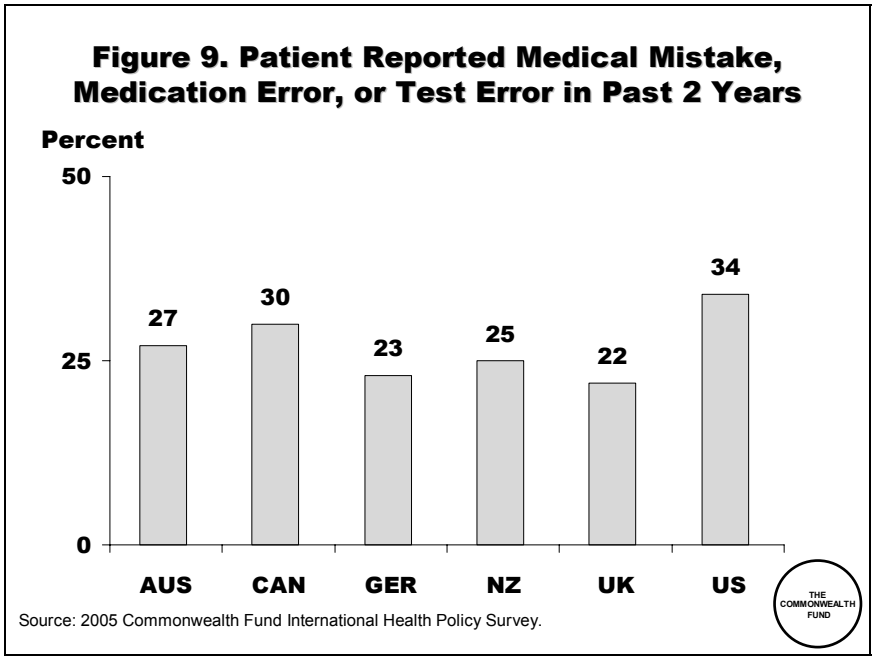
Figure 9. Patient Reported Medical Mistake, Medication Error, or Test Error in Past 2 Years
Percent
50
25
0
27
30
23
25
22
34
AUS
CAN
GER
NZ
UK
US
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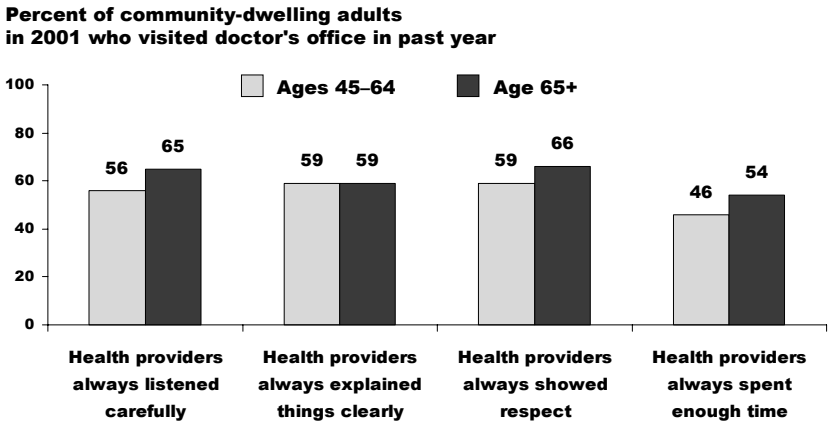
Source: 2005 Commonwealth Fund International Health Policy Survey.

Figure 10. Interpersonal Quality of Care Is Lacking



Source: S. Leatherman and D. McCarthy, *Quality of Health Care for Medicare Beneficiaries: A Chartbook, 2005*, The Commonwealth Fund. www.cmwf.org; Medical Expenditure Panel Survey (AHRQ 2005).

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Figure 11. Communication With Physicians
Views of Sicker Adults

In the past 2 years:	AUS	CAN	NZ	UK	US
Left a doctor's office without getting important questions answered	21	25	20	19	31
Did not follow a doctor's advice	31	31	27	21	39

Source: 2002 Commonwealth Fund International Health Policy Survey.

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Figure 12. Deficiencies in Care Coordination

Percent saying in the past 2 years:	AUS	CAN	GER	NZ	UK	US
Test results or records not available at time of appointment	12	19	11	16	16	23
Duplicate tests: doctor ordered test that had already been done	11	10	20	9	6	18
Percent who experienced either coordination problem	19	24	26	21	19	33

Source: 2005 Commonwealth Fund International Health Policy Survey. *Adults with Health Problems.*

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Figure 13. Continuity of Care with Same Physician

Percent:	AUS	CAN	GER	NZ	UK	US
Has regular doctor	92	92	97	94	96	84
--5 years or more	56	60	76	57	66	42
No regular doctor	8	8	3	6	4	16

Source: 2005 Commonwealth Fund International Health Policy Survey. *Adults with Health Problems.*

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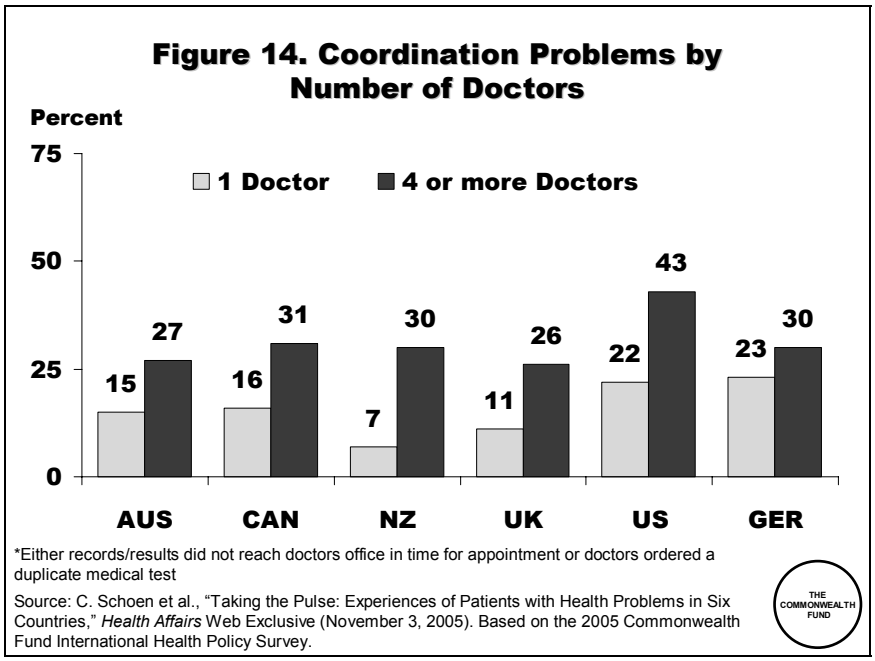
Figure 14. Coordination Problems by Number of Doctors
Percent
75
50
25
0
1 Doctor
4 or more Doctors
15
27
16
31
7
30
11
26
22
43
23
30
AUS
CAN
NZ
UK
US
GER
*Either records/results did not reach doctors office in time for appointment or doctors ordered a duplicate medical test
Source: C. Schoen et al., "Taking the Pulse: Experiences of Patients with Health Problems in Six Countries," Health Affairs Web Exclusive (November 3, 2005). Based on the 2005 Commonwealth Fund International Health Policy Survey.
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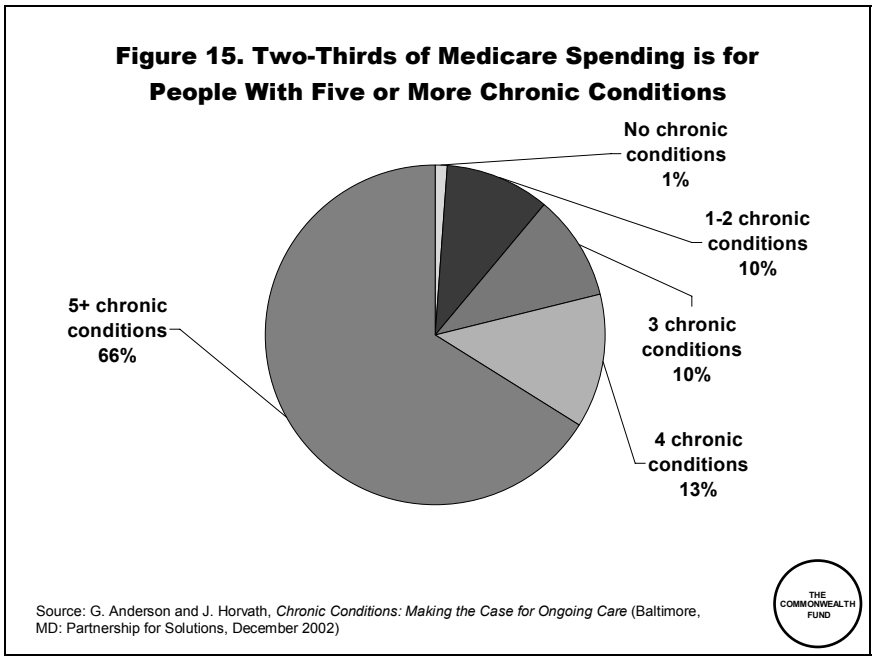
Figure 15. Two-Thirds of Medicare Spending is for People With Five or More Chronic Conditions
No chronic conditions 1%
1-2 chronic conditions 10%
3 chronic conditions 10%
4 chronic conditions 13%
5+ chronic conditions 66%
Source: G. Anderson and J. Horvath, Chronic Conditions: Making the Case for Ongoing Care (Baltimore, MD: Partnership for Solutions, December 2002)
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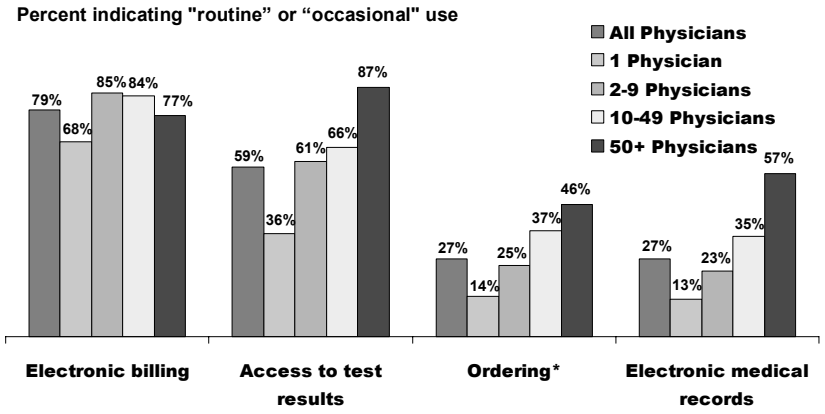
Figure 16. Physician Use of Electronic Technology Varies by Application



* Electronic ordering of tests, procedures, or drugs.

Source: Commonwealth Fund 2003 National Survey of Physicians and Quality of Care.

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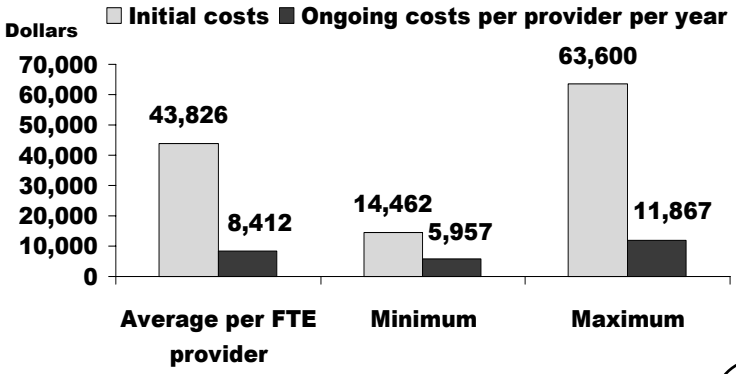
Figure 17. Electronic Health Records (EHR) in Solo or Small Group Practices: A Case Study

EHR Financial Costs Per FTE Provider For 14 Practices, 2004-2005



Source: R. Miller, et al. "The Value of Electronic Health Records in Solo or Small Group Practices. *Health Affairs*. 24(5). (September/October 2005): 1127.

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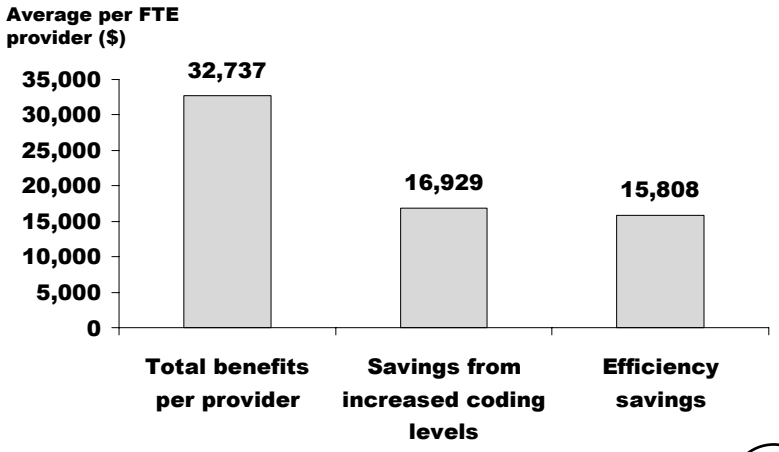
Figure 18. EHR Financial Benefits Per FTE Provider, For 14 Solo/Small Group Practices, 2004-2005



Source: R. Miller, et al. "The Value of Electronic Health Records in Solo or Small Group Practices. *Health Affairs*. 24(5). (September/October 2005): 1127.

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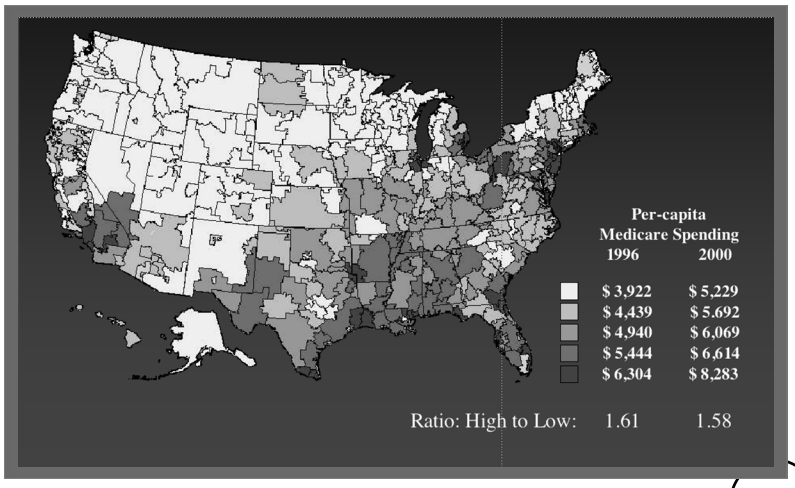
Figure 19. Variation in Per Capita Medicare Spending by Hospital Referral Region, 2000



Source: Eliot Fisher, presentation at AcademyHealth Annual Research Meeting, June 2006.

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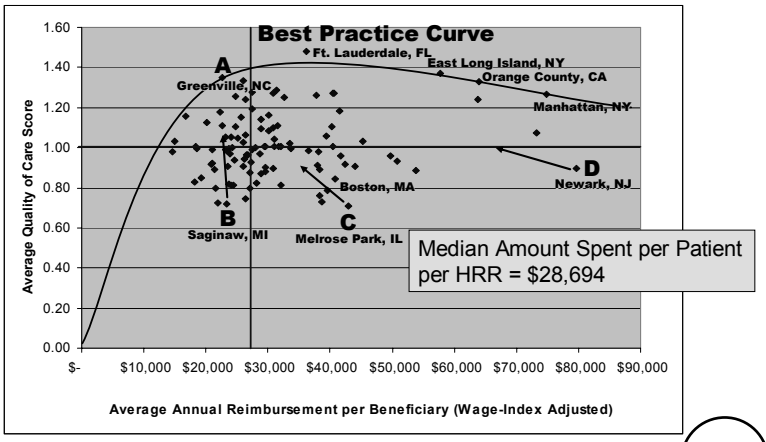
Figure 20. Variation in Annual Total Cost and Quality for Chronic Disease Patients

Quality of Care* and Medicare Spending for Beneficiaries with Three Chronic Conditions, by Hospital Referral Region



* Based on percent of beneficiaries with three conditions (diabetes, chronic obstructive pulmonary disease, and congestive heart failure) who had a doctor's visit four weeks after hospitalization, a doctor's visit every six months, annual cholesterol test, annual flu shot, annual eye exam, annual HbA1C test, and annual nephrology test.
Source: G. Anderson and R. Herbert for The Commonwealth Fund, Medicare Standard Analytical File 5% 2001 data.

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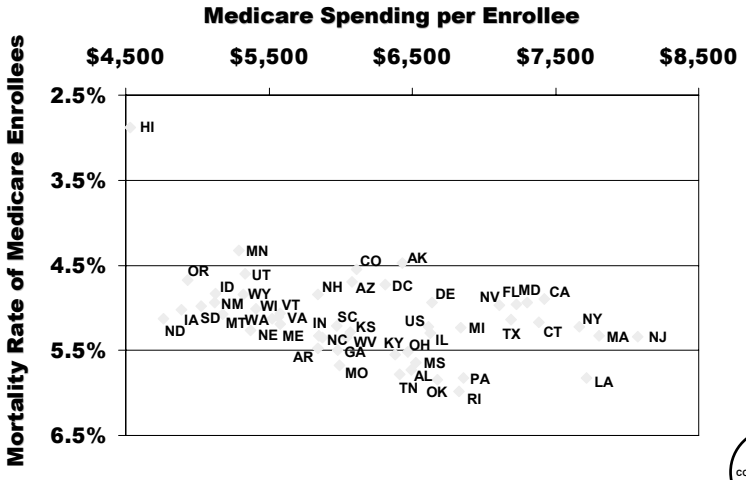
Figure 21. Medicare Spending Per Enrollee and Mortality Rate by State, 2003



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Source: Data from *The Dartmouth Atlas of Health Care*, www.dartmouthatlas.org

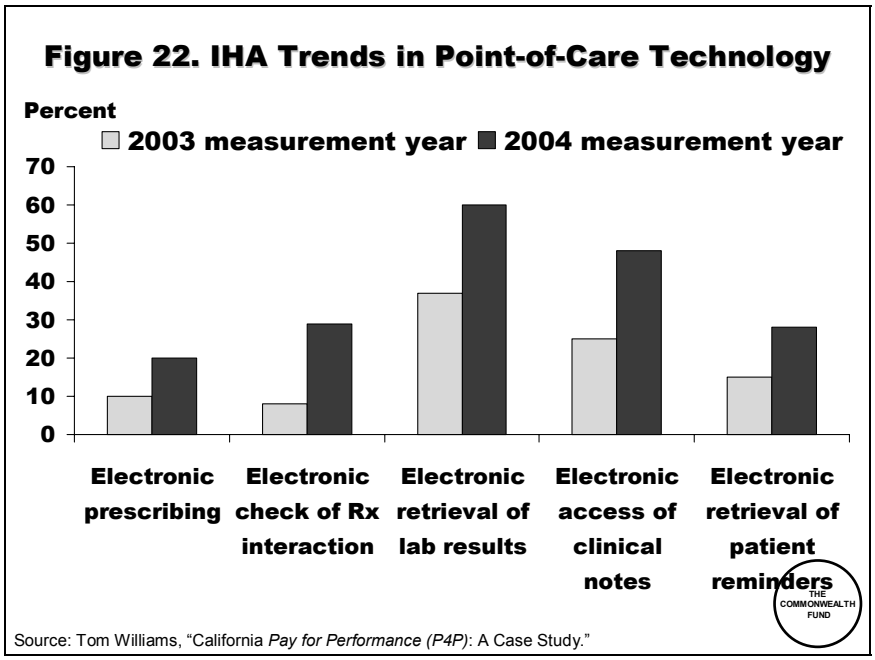
Figure 22. IHA Trends in Point-of-Care Technology
Percent
2003 measurement year
2004 measurement year
70
60
50
40
30
20
10
0
Electronic prescribing
Electronic check of Rx interaction
Electronic retrieval of lab results
Electronic access of clinical notes
Electronic retrieval of patient reminders
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Source: Tom Williams, "California *Pay for Performance (P4P)*: A Case Study."

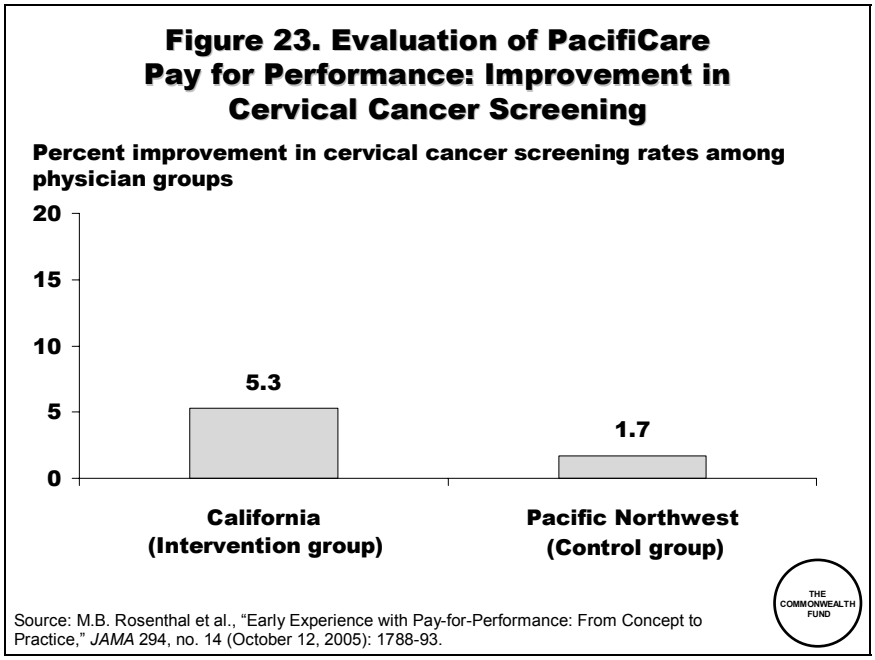
Figure 23. Evaluation of PacifiCare Pay for Performance: Improvement in Cervical Cancer Screening
Percent improvement in cervical cancer screening rates among physician groups
20
15
10
5
0
5.3
1.7
California (Intervention group)
Pacific Northwest (Control group)
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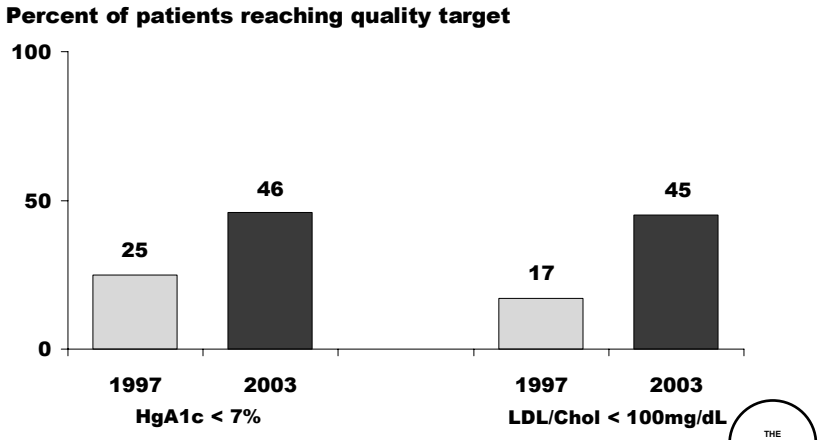
Source: M.B. Rosenthal et al., "Early Experience with Pay-for-Performance: From Concept to Practice," *JAMA* 294, no. 14 (October 12, 2005): 1788-93.

Figure 24. Physicians Participating in the Diabetic Care Program From 1997 to 2003 Showed Significant Improvement in Performance



Source: National Committee for Quality Assurance web site, www.ncqa.org/dprp.

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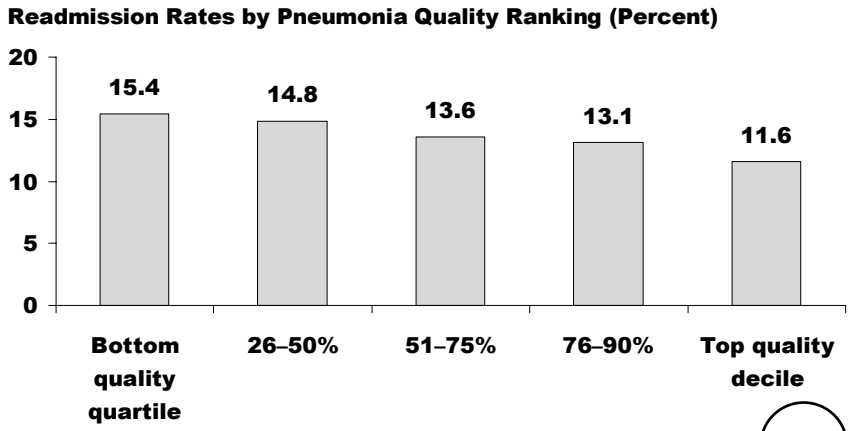
Figure 25. Medicare Premier Hospital Demonstration: Higher Quality Hospitals Have Fewer Readmissions



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Source: Stephanie Alexander, "CMS/Premier Hospital Quality Incentive Demonstration Project:1st Year Results," Presentation at IOM P4P Subcommittee Meeting, November 30, 2005

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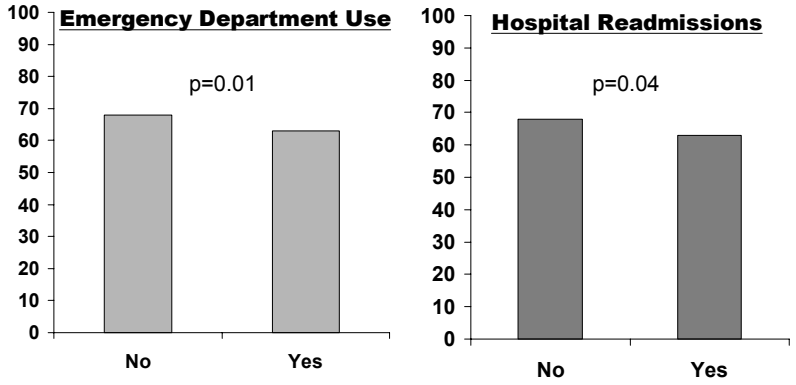
Figure 26. Coordination Across Sites of Care: Care Transition Measure Scores,* Emergency Department Use, and Hospital Readmissions



*** When I left the hospital, I had a good understanding of the things I was responsible for in managing my health; when I left the hospital, I clearly understood the purpose for taking each of my medications; The hospital staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left the hospital.**

Source: E.A. Coleman, "Windows of Opportunity for Improving Transitional Care," Presentation to The Commonwealth Fund Commission on a High Performance Health System, March 30, 2006.

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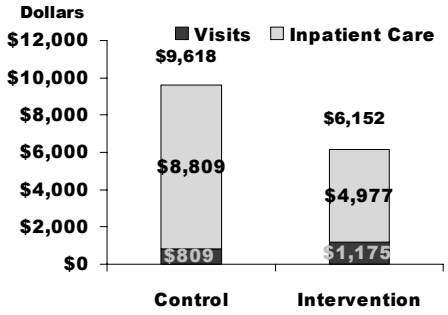
Figure 27. Improving Care Coordination and Reducing Cost

Effect of Advanced Practice Nurse Care on Congestive Heart Failure Patients' Average Per Capita Expenditures



- **Importance of improving transitions in care, doctor to doctor, and post-hospital**
- **Follow-up care following hospital discharge could reduce rehospitalization**
- **High cost care management could reduce errors and lower costs**
- **Will require restructuring Medicare benefits and incentives**

Source: M.D. Naylor, *Making the Bridge from Hospital to Home*, The Commonwealth Fund, Fall 2003.

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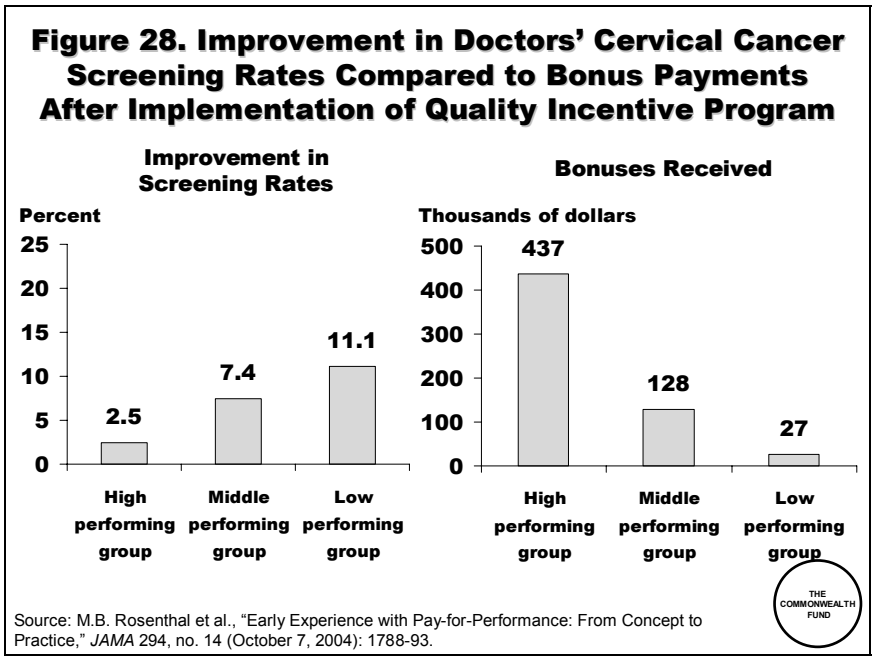
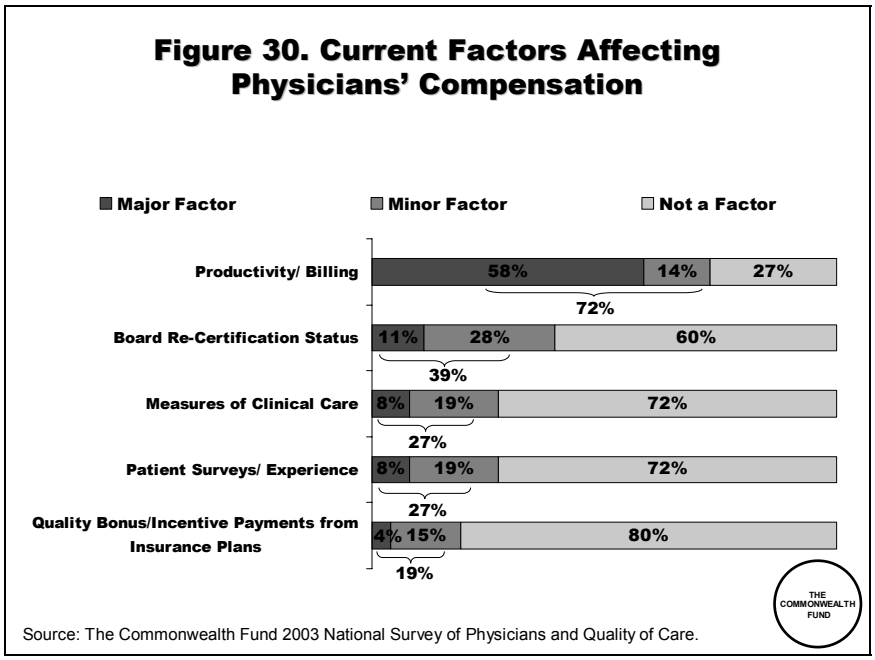




MR. DEAL. Thank you. Thank all of you. I will start out with the questions.

We are going to put you at a little bit of a disadvantage because we are probably going to be asking you to comment about testimony that is going to not be heard until later in the week. But in our effort to seek a better solution, I think we must do that.

I notice that virtually all of you made the point that quality of care is not really a factor that is rewarded under the current system. Mr. Miller, I think you said it very pointedly. I do like the term of value-based purchasing, or something as an alternative to pay-for-performance, because I think you are right, it does have the implication of grading somebody in a negative sort of way.

Is it possible, in a value-based purchasing system, to have adequate volume controls, because obviously, volume drives the cost? How do you incorporate, Mr. Miller, in a pay-for-performance model, still have cost containment measures that must, in some way, be directly related to both volume and intensity?

MR. MILLER. I think there are a couple of things to parse through here, in trying to answer this. I mean, there is a distinction that I think you have to draw between whether it is formulaic, much like an SGR volume containment, or whether you get more targeted approaches. So, I think the Commission's view on this is, and I think most people would say this, I mean, pay-for-performance or value-based purchasing, however you want to say it, won't necessarily restrain volume in and of itself, although I can give you some examples where, and I will in just a second, of where it could come about. But you may need, in addition to any kinds of programs like this, to have targeted approaches still aimed at restraining volume growth.

I know many members of this committee didn't want to hear some of this in the last hearing, but it may require still, for example, restraints on, for example, the coding edits that we have recommended on imaging, so that you are trying to restrain some obvious places where volume is growing very quickly. So, you might need some of the value-based purchasing, and then, some targeted approaches on volume.

And then, to give you an example of how things can come together, put yourself in a mind of one demonstration that is going on now at CMS, where groups of physicians are coming together, this is a group of physicians with say, a hospital, come together and say, we want to be evaluated both on the quality metrics related to our diabetics, say, and we want to be evaluated on how much we save, let us say, for example, we forestall an admission to a hospital. And in that instance, they are allowed to share in the savings. They come together, they try and target their efforts at quality, and reducing resources, avoiding an admission. And in that instance a circumstance like that could reduce volume. But

just to be clear, in and of itself, it doesn't necessarily restrain volume, and not in the way that people are looking at here.

MR. DEAL. That is a very good point, and I want to elaborate in the little bit of time we have.

One of the complaints that I have heard is that if we go to a performance-based system, it may very well increase the volume of services by the physician. Therefore, if he is isolated in the Part B, the savings may actually be realized in Part A, under the hospital portion of it, as you indicated about avoiding emergency room visits or other hospitalizations.

How do we adequately cross and bridge that barrier between the volume increase on the physician side that is actually saving money on the hospital side, with the two silos that we currently have?

MR. MILLER. That is a really good point, and let me give you at least two thoughts. I mean, there is obviously, it is a difficult problem. But let me first give you two thoughts.

Just as you heard some of the testimony here, I wouldn't completely abandon the thought that there aren't improvements that can be gained just on the physician side. There is a significant lack of coordination and handoff between physicians, physicians unable to track their patients and inform them that they need to get their blood sugars checked and that type of thing. So, I wouldn't abandon it entirely, but to your question, the idea is here, you want to look at these things in a much more episode-based basis, so that you are looking at the physician services, the hospital services, the post-acute care services together, and then, when you make a judgment about how the care was provided, you are looking at the entire episode, not just the physician's work themselves.

MR. DEAL. Thank you. My time has expired, but I do think that is the track we are going to have to follow in the future.

MR. MILLER. And I apologize for being long-winded.

MR. DEAL. No, I appreciate your answer. I think it is not one of those things that is easily answered quickly.

Mr. Pallone.

MR. PALLONE. Thank you, Mr. Chairman.

I wanted to start out with Mr. Guterman, and my questions relate to the concern about beneficiaries facing increased costs because of changes in the physician payment formula. And I was just going to ask you sort of yes or no questions initially, and then, we will get into some explanations.

I guess this is like, I will call this John Dingell style. Mr. Guterman, isn't it true that beneficiaries have faced record Part B premium increases under Medicare over the past few years?

MR. GUTERMAN. Yes.

MR. PALLONE. Okay. Isn't it true that in recent years, some beneficiaries have seen their entire cost-of-living adjustment in the Social Security check eaten up as a result of Medicare Part B premium increases?

MR. GUTERMAN. That is quite possible.

MR. PALLONE. Now, isn't it also true that today, the average Medicare beneficiary spends 9 percent of his Social Security check on the Part B premium?

MR. GUTERMAN. That is true.

MR. PALLONE. And isn't it correct that changes that adequately paid physicians will increase both the beneficiaries' Part B premium and the amount of the coinsurance beneficiaries pay?

MR. GUTERMAN. Yes.

MR. PALLONE. All right. Now, we get into explanations. If Congress is to fix the Medicare physician payment formula, is it your view that we should also protect beneficiaries from excessive increases in their Part B premiums?

MR. GUTERMAN. I think there are protections that are needed, particularly among vulnerable beneficiaries, the proportion of out-of-pocket spending even for Medicare-covered services, the proportion of their income that is spent on out-of-pocket spending is very high, and certainly Congress should take into account the needs of those groups that are most vulnerable.

MR. PALLONE. Okay. Now, I keep hearing from the physicians that we need formulas to reflect actual costs. I mean that is what they always say, of course, and of course, they are right. I mean, if you are going to keep the system going, you have to have the reimbursements reflect actual costs at some level.

So, my question is, if Congress were to adopt a payment formula for physicians that no longer had a global spending target like the current system, would beneficiary premiums be more or less susceptible to large increases than they are today, and if more, how would we address that?

MR. GUTERMAN. That is a good question, and it is very complicated. There is a very complicated answer, and I don't know that there is a definitive answer. Certainly, removing constraints on volume would make the beneficiary more susceptible to the results of increasing volume, but we have to keep in mind that the current system really isn't successful at all in controlling volume or total spending anyway.

So, I think we need to shift our emphasis to approaches that encourage more quality and efficiency, which will be not only cheaper for the beneficiary and the program, but also, better for the beneficiary and the program.

MR. PALLONE. Okay. Now, I am going to go to Mr. Miller, because I only have less than 2 minutes here. And again, my concern is that, to what extent cuts in physician payments jeopardize access to care.

The Sustainable Growth Rate is having some unintended consequences on a physician's ability to provide services. Physician payments are expected to take a 4.6 percent cut next year, as you know, and because Congress decided not to directly pay for the 2006 physician payment fix, and instead, recoup the cost from future payments, doctors will see further reductions in physician payments over the next 10 years, unless we do something. So, even though physician costs will go up, reimbursements over time will go down significantly, and that will likely jeopardize access to care, you would think.

So, while the current MedPAC report does not find significant problems with Medicare beneficiaries' access to care, do you think that we will see problems with access to care in the future if the anticipated cuts in Medicare payments to doctors take effect, as is currently projected over the next 10 years?

MR. MILLER. Yes. The Commission has said several times that if the cuts that are assumed in current law go into effect, you have negative 5 percent for 6, 9 years, depending on which estimate you look at, they are very concerned that access problems would result.

MR. PALLONE. Okay. Now, let me go back to Mr. Guterman. GAO recently released a report that says access to physician service is largely unchanged for Medicare beneficiaries in fee-for-service Medicare, and this is over a time when there was only one year of a negative update to doctors' reimbursement.

But do you believe that patients would still have the same degree of access if we were to allow the cuts in the Medicare physician fee schedule every year for the next 10 years to take place? And what effect do you think that would have on beneficiary access?

MR. GUTERMAN. I think it is difficult to believe that beneficiaries would be able to retain their current access under those kinds of cuts. Let me also say, in response to a statement you made before, there has been a lot of discussion about the level of physician payments matching the level of cost of the provision of care. I suggest that the level of value of physician care ought to be what is looked at, and how much it would cost to provide the care that patients need. Not just to provide the care that is currently provided.

MR. PALLONE. Okay. Thank you, gentlemen. Thank you, Mr. Chairman.

MR. DEAL. Thank you. Chairman Barton is recognized for questions.

CHAIRMAN BARTON. Thank you, Mr. Chairman. The gentleman that is representing CBO, I can't really read it, Mr. Marron?

MR. MARRON. Marron from CBO.

CHAIRMAN BARTON. Yes, CBO. Okay. Does CBO have a view of the MedPAC's proposed change for the SGR? I think the MEI is what they are calling it.

MR. MARRON. Sir, obviously, we don't have an opinion of--

CHAIRMAN BARTON. Push the button.

MR. MARRON. Yeah. Obviously, we don't have an opinion about whether that would be good or bad policy. We have cost estimates for various permutations of changes to the SGR. Let me just see if I have that one.

So, we have an estimate for a permanent change to the MEI, for which over the 10 year budget window, is the $218 billion number that I mentioned earlier.

CHAIRMAN BARTON. Okay. The gentleman who is representing MedPAC, Mr. Miller, does your group have a proposal on how to pay for your proposed fix?

MR. MILLER. No. We have, throughout all of our deliberations, we have identified savings in several areas. For example, we have put out a set of recommendations related to managed care payments. We also put out a set of recommendations related to some updates. We don't have something that amounts to $218 billion, but there is at least two points I would like to make about this.

The MedPAC idea is not MEI every year, and it gets characterized that way, and I tried to make this point in the opening statement. We look at a variety of factors, and if we think that there is a reason to justify less than that, we recommend less than that. The other point I would make about the $218 billion, and this is with all respect to CBO, and I understand how they go through their analysis, you also have to evaluate the cost of that proposal against what will actually happen. The $218 billion assumes that for the next 9 or 10 years, you get minus 4 updates, and so, relative to what will truly happen, it is not $218 billion. But we certainly understand how the scoring is done. I have been there. I understand it, and I agree with how they do it. I think it is just sort of the--

CHAIRMAN BARTON. So, we have got a real quandary here. It doesn't seem reasonable to have a system that we never use, and we are not using the SGR. It just doesn't seem, for lack of a better term, it doesn't seem fair to subject doctors to a cut, when we are giving increases to the other part of the healthcare system, in terms of what Medicare and Medicaid are reimbursing.

Yet, when we try to find a way to change the current system to something that could be sustained, there is absolutely nobody putting forward any proposals on how to pay for it. My friends on the Minority side, as the Minority is supposed to do, quite obviously point out the problems of the current system, and they want to be on the side of the angels in terms of providing more money for our physicians, but they don't have a solution on how to pay for it.

We get into this box at the end of every budget cycle, which we are in right now. If we let the current system go into place and have this cut, it is not right. Yet, if we try to change to a system that is sustainable, we can't pay for it. So, we end up scratching around trying to find $4 billion or $5 billion to just do the Band-Aid approach. I would like to get out of that box, but at some point in time, I need somebody to put some proposals forward on how to actually pay for the change.

I guess one question I will ask the gentleman with the Commonwealth Fund, Mr. Guterman, what about allowing for balanced billing? Would that be a part of a solution? Let physicians decide if their patients could afford to pay some out of their own pocket without violating Federal law?

MR. GUTERMAN. I have two responses to that. One is, again, as Mr. Miller said, you need to be more realistic about what the costs are and interpreting the meaning of the term costs from CBOs perspective. CBO rightly gives a baseline under current law, but if the performance of the last several years is to be taken into account, fixing physician payments, or at least avoiding cuts in physician payments year by year, may look like smaller pieces. If you look at it over time, it is going to add up to the same thing. So, you Members have to decide whether you are going to be constrained by the CBO baseline, which is indeed costs relative to what would be under current law, or whether you are going to take these piecemeal approaches to avoiding an untenable situation, and try to come up with a more comprehensive--

CHAIRMAN BARTON. Well, how about an answer to my question on balanced billing?

MR. GUTERMAN. The balanced billing approach, again, doesn't change the costs. It just changes who pays for it, and so, you would be shifting the payment onto the beneficiary, which I don't think would particularly change anything from the perspective of the healthcare system. It wouldn't necessarily encourage better care, either. I personally would tend to be against that kind of approach.

CHAIRMAN BARTON. Okay. My time has expired. Thank you, Mr. Chairman.

MR. DEAL. Thank you. Ms. Capps.

MS. CAPPS. Thank you, Mr. Chairman, and I want to thank the Chairman of the full committee for zeroing in on a real problem, and hope that we can work on it, and I think there is bipartisan interest in doing that. I am not sure if the last suggestion is necessarily, it sounds like means testing, but you know, the topic is how to build a payment system that provides quality, efficient care for Medicare beneficiaries. It is a great topic, Mr. Deal, for these two-part hearings.

But as I mentioned in my opening statement, the SGR is not the only formula that needs to be reexamined. Geographic adjustments are intended to compensate for the varied costs of living throughout the country, but unfortunately, the system whereby counties are grouped into localities whose geographic adjustments are averaged out, has led physicians, as I said earlier, in 175 counties in 32 States being underpaid by 5 or more percent for the cost of their services.

Mr. Steinwald, when GAO prepared for this hearing, did you look at discrepancies between the counties' geographic adjustments and those counties' locality adjustments, as to how they were being taken into account when you examined beneficiary access? Kind of a yes or no answer.

MR. STEINWALD. Not in preparation for this hearing, but we do have a study underway.

MS. CAPPS. It's underway, is it completed?

MR. STEINWALD. Not completed. We initiated it about a month ago at the request of the Chairman of the House Ways and Means Committee, and we have talked with the California Medical Association already, and understand their views. But to complete the study, we will need to do a fairly comprehensive analysis of Census data, and that will take us into next year.

MS. CAPPS. Well, Mr. Chairman, I would hope that that would be the topic for a conversation, and I know that California Medical Association representatives are here. I know that, based on my constituents' experiences in San Luis Obispo and Santa Barbara counties, there is a very strong and appropriate reason, a direct correlation between the two, the result that many of us see every day is that our district offices get calls that physicians are being forced to shut down their practices, because they can't afford to sustain it. They are not able to pay the rent. They are not able to send their kids to college. And then, that begs the question of being able to attract new physicians who will care for Medicare beneficiaries.

And so, I think we definitely need the study. We needed it several years ago, because this has been an ongoing thing, but I appreciate very much that it is underway, and look forward to getting a copy of it, and also would suggest that we have hearings on that.

But just with the remaining time that I have, every year, Mr. Miller, that the geographic issue is avoided, the problems become more costly to fix. I wish a representative from CMS was here today to discuss the reluctance to address it in a fair manner. Even without the study, I think there is enough evidence to know that we should be working on this.

But I want you to comment, if you would, on the determination that MedPAC has arrived at, that there needs to be a fix, counties and localities whose geographic adjustments are 5 or more percent less than those counties' own geographic adjustment factors. In other words, expand on your recommendations, if you would, please.

MR. MILLER. What we have done on this issue is, you know, this issue came to our attention, we analyzed it a couple of a different ways to look at it. But the short answer is, is in our agenda, we took it up, and the commissioners discussed it in either May or April at their public meeting, and did not come to consensus on what the solution should be. It is something that may come back around on our agenda, but at that particular meeting, did not come to a consensus.

MS. CAPPS. But you did arrive at the determination that there is, needs to be some adjustment.

MR. MILLER. What we arrived at is, as we went through and we did an analysis of the localities, and like you said, we are looking at the underlying cost of care, and how the geographic localities approximate that. What we found is, is that nationally, for the most part, it does approximate it, and then, there are some anomalies across the country. And then, when we got into, when the commissioners got into a discussion of what that meant, and how to resolve it, that is where they did not come to consensus.

MS. CAPPS. So, 175 counties, I guess not in a majority of the counties in the country, but a pretty substantial subset, where there are disparities in, there doesn't seem to be any fix. You would agree?

MR. MILLER. I am sorry. I am not--doesn't--

MS. CAPPS. You said that overall, in the country, it fits, but--

MR. MILLER. Right.

MS. CAPPS. But there are exceptions.

MR. MILLER. But there are exceptions, absolutely.

MS. CAPPS. And 32 States have this problem, 175 counties.

MR. MILLER. I am assuming those are CMA numbers. I don't recall what our numbers specifically came up with, but they did discuss this. They did not come to consensus on how to resolve it.

MS. CAPPS. So, the diagnosis is there, and I believe that fits in, then, with GAO's analysis also. That I am assuming, back to you, again, Mr. Steinwald, that you wouldn't be doing this study if you didn't have some indication that there is a problem.

MR. STEINWALD. Yes. It is something that we thought was worth looking at, and hasn't received a lot of attention in recent years. The system that is in place right now hasn't been adjusted in some time, so we thought it was worth a look. Although we are not coming to the conclusion in advance that there is a problem that needs to be fixed, but we are certainly looking at it.

MS. CAPPS. Thank you. I yield back.

MR. DEAL. Dr. Norwood is recognized for questions.

MR. NORWOOD. Thank you very much, Mr. Chairman.

Marron, is that how you say it?

MR. MARRON. Marron.

MR. NORWOOD. Marron. Good. I am sort of interested in some of the numbers you folks come up with. I have always, to date, been a little surprised how CBO scores its cost savings in pay-for-performance plans, because I will be honest with you, not anybody knows really what that is yet. Dr. McClellan can't explain to me in detail precisely the movement of a pay-for-performance plan. I know there are some demonstration projects going on under Part C, but really, the results are not in, and I think it is pretty interesting that you guys are pretty definite in your scoring model of oh, it will save this amount of money.

How do you do that when we really, truly don't understand exactly how pay-for-performance is going to work? Or what did we call it, value-based purchasing.

MR. MARRON. So, I am very sympathetic with where you are coming from as your general point, which is--

MR. NORWOOD. Which means you don't know if your score is right or not?

MR. MARRON. No, I am going to come back to our score. In essence, yes. Pay-for-performance is still, in essence, in an R&D stage. A lot remains to be seen about how it will actually operate in practice. We will learn a lot in the hearing on Thursday.

I was going to say the one case in which we were able to score it cleanly is that one of the pay-for-performance measures that has been implemented by Congress has the feature that what it does is it delays payments to doctors and, in essence, says we are going to take some money away from you, and then we are going to pay it back when you file some information with us to get it. And in our scoring model, we are able to score that precisely because it is a timing shift.

MR. NORWOOD. So, you are going to be a slow payer, we are.

MR. MARRON. Exactly.

MR. NORWOOD. Yeah, well, we have been through that. That is a great plan. Mr. Steinwald, I will just ask you very briefly, if you were

told that perhaps you had lung cancer, would you rather have a CAT scan or a chest film?

MR. STEINWALD. I take your point. You are relating to the intensity increases.

MR. NORWOOD. I am indeed.

MR. STEINWALD. Well, you are the doctor, and I am--the implication of the question is I would probably rather have a CAT scan, so I will go with that.

MR. NORWOOD. Well, there is not any implication. Are you crazy or not? Would you rather have a chest film or a CAT scan, and the answer is, you know, I think it is a good idea to have a CAT scan, because they actually can diagnose exactly, maybe, where the cancer is, versus a chest film. You look like a smart man. I know what you would choose. That increases intensity, does it not?

MR. STEINWALD. Yes.

MR. NORWOOD. That you were talking about earlier, but it also increases the cost to you a little bit, doesn't it?

MR. STEINWALD. Yes. It does, and I would gladly pay it. My point in raising it--

MR. NORWOOD. Of course.

MR. STEINWALD. --is that it also increases spending per beneficiary, and much of that increased spending per beneficiary goes to physicians. So, the fee--

MR. NORWOOD. Okay. Time out. Time out. Correctly, if I may.

MR. STEINWALD. Yes, sir.

MR. NORWOOD. I take your point, too, and what you say is there has been a great increase in intensity and volume, and of course there has. There has been great improvement in medicine and healthcare. There have been a lot more seniors on Medicare than before. So, I am not sure that that tells us anything by you saying that.

All of you are economists or statisticians? None of you are healthcare providers, are you?

MR. STEINWALD. No.

MR. NORWOOD. Okay. I find that very interesting. If each of you would, then, give--because you have used this word a lot--healthcare quality and healthcare efficiency, could you define that for me? What the hell is healthcare quality? Excuse me, what is healthcare quality?

MR. MARRON. Certainly. I think I managed to avoid mentioning that in my opening statement. You know, its real challenge--to a geeky economist, it would be some story about appropriately balancing the value of the healthcare you receive against the cost of it, quality determined basically in the quality of your healthcare outcomes, and how the person values those.

MR. NORWOOD. Okay, what about efficiency? You have missed quality. What about efficiency? How do you define healthcare efficiency?

MR. MARRON. So efficiency would essentially be, if you could define a unit of healthcare delivered or a unit of quality healthcare delivered, the cost of delivering that, and the efficiency, the lower that is, the more efficient it is.

MR. NORWOOD. It is no wonder you guys got it wrong. Mr. Steinwald, you define healthcare quality for me.

MR. STEINWALD. Given your response to Dr. Marron, I think I will pass, but efficiency--so I do think it relates to what we are now trying to call value-based purchasing, getting the most for the dollars we spend, and there is a lot of evidence that we are not getting the most for the dollars we spend right now in the Medicare program.

MR. NORWOOD. Is it quality when, if the doctor does everything humanly possible to treat you, and you die, is that healthcare quality?

MR. STEINWALD. It certainly could be.

MR. NORWOOD. That is right. Now you got it. Now, let us go on down the line quickly, Mr. Chairman. Mr. Miller, healthcare quality and efficiency. What do you think it is?

MR. MILLER. The Commission views efficiency as the highest quality, the best quality outcome, with the lowest resources.

MR. NORWOOD. What is a quality outcome?

MR. MILLER. It would depend on the clinical situation that you are talking about. So, for example, with diabetes, it might be avoiding a hospitalization, because you control the blood sugars.

MR. NORWOOD. Yeah, but maybe you don't. Is that lack of quality?

MR. MILLER. It depends on whether that result--if the physician has done everything that they thought they need to do, and that still resulted, it may be. If a physician failed to get a beneficiary back in to get their blood sugars checked, that might be poor quality.

MR. NORWOOD. What if the physician tried and the patient wouldn't come?

MR. MILLER. There are definitely issues of compliance, but--

MR. NORWOOD. So, we have got these boxes we checked to determine the quality, which is based on many things.

Mr. Guterman, quality and efficiency please.

MR. GUTERMAN. All right. Let me try to address that by saying that I think quality is what the doctor thinks, on a clinical basis, is good for my health if I am his or her patient. What I would like to see is, since we are talking a lot about economists telling doctors what to do, I would like to see the doctor be able to make those decisions based on purely clinical

considerations instead of economic considerations, which the current payment system encourages.

MR. NORWOOD. I know my time is up. I agree with that. But Mr. Chairman, this is so important to point out, that if these men actually are going to define what is quality in pay-for-performance, we are in trouble. No offense, gentleman, it is just you are not--

MR. DEAL. That is all right. Dr. Burgess is going to set their fee next Thursday, I believe. Thank you.

Mr. Allen, you are recognized for questions.

MR. ALLEN. Thank you, Mr. Chairman, and thank you all for being here.

A couple of my colleagues earlier on said we had the best healthcare system in the world, and I want to play off that a little bit. It seems to me that is probably true in most areas that I know about, and I am not a doctor, for someone. But the challenge is when you look at the healthcare system as a whole, you look at it as a system, and you look at the cross-national comparisons, there are lots of ways in which we don't have the best healthcare system, even if we would choose, for a particular condition, if we had access to the best person and the best healthcare somewhere in this country, we would choose to be here rather than other countries.

The point I am trying to make is I think we need to deal with this as a system, and you know, Mr. Guterman at one point said the cost and quality need to be considered together. I want to list that a little bit higher. I think that Dr. Norwood is right about intensity. All the people I know who talk about the healthcare system would say that technology is a major factor in driving up costs, and we do want to pay, it is fair for the society to pay more for better results, but let me start with you, Dr. Miller.

I am concerned that we are paying too much for Medicare Advantage plans, and this gets back a little bit, Chairman Barton was saying well, we don't have any proposals to pay for this. Well, I am going to make one. In the past, MedPAC has issued reports detailing the overpayments to Medicare HMOs. The June 2006 MedPAC report states that you believe Medicare should be financially neutral with respect to Medicare Advantage and fee-for-service, unlike the current payment system. CBO estimates from March of this year show we can save $63 billion over the next 10 years if we were to eliminate the overpayments to Medicare Advantage plans. That doesn't get us all the way to a permanent fix, but even in D.C., $63 billion is not chump change.

So, my question is, Mr. Miller, has MedPAC quantified the current amount of overpayments to Medicare HMOs?

MR. MILLER. Yeah. And just to take one qualification before I say it, what we quantified is how much more managed care plans are paid above fee-for-service. Whether it is an overpayment is sort of a judgment for the Congress to make. We quantified that. It is 11 percent.

MR. ALLEN. I understood that your calculation was based on an adjustment for treating the same kind of patient, same kind of condition, in Medicare fee-for-service versus Medicare Advantage. Is that right?

MR. MILLER. Yeah. I think I understand what you are driving at, 11 percent is sort of a product of two things: how the payment system is structured, for example, certain benchmarks are set well above fee-for-service in certain areas of the country, and the fact that managed care organizations at the present time appear to enroll people who are more healthy, which presumably means you would spend less on them. But they are, under the current--although this is changing, because DRA changed the law, but currently, those payments, which would come down, stay with the plans, although that is beginning to phase out, based on a law change in DRA.

MR. ALLEN. At least, based on the current estimates--

MR. MILLER. Eleven percent.

MR. ALLEN. Eleven percent.

MR. MILLER. Absolutely.

MR. ALLEN. CBO says that is $63 billion. That goes over 10 years. If you made that change now, immediately, it seems to me that you have paid for a significant portion of a long-term fix, not the only portion. Now, I would agree that we need to do something on the cost side, and I guess beyond just finding additional money.

And are there other suggestions, I would guess I would say, for places where we can have systemic cost containment, in a way that just doesn't sort of make a blanket reduction in payments? And that would be for anyone.

MR. MILLER. I mean, I will just say this. I don't think this is the systemic thing you are looking for. We have made other recommendations that look at specific Medicare payment systems, and would result in savings, but I don't think it is the systemic idea that you are looking for.

MR. ALLEN. Very quickly, Mr. Miller. Have you considered pay-for-performance for HMOs?

MR. MILLER. Absolutely. We made a recommendation on that, I think, 2 years ago, at this point, maybe a year and a half ago.

MR. ALLEN. And what has the response been to that recommendation?

MR. MILLER. It has not been picked up by the Congress or administratively.

MR. ALLEN. Okay. I would love to explore it, but my time is up, and I yield back.

MR. NORWOOD. [Presiding] Dr. Burgess, you are recognized for questions.

MR. BURGESS. Thank you, Dr. Norwood, and Mr. Miller, if we could, let us just pursue Mr. Allen's line of questioning for a moment, under the systemic cost containment. I referenced a bill, H.R. 5866, which was recently introduced, to introduce an MEI minus 1, replacing the SGR. There are certain pay-fors written into that bill. One of them is elimination of the HMO stabilization fund in the Medicare Modernization Act. I hope Mr. Allen hasn't left, because I am sure he is now going to rush to cosponsor this legislation, and I look forward to him joining us on that.

But I wonder, I know you haven't had a chance to look at that, but I wonder if, Mr. Chairman, if it wouldn't be out of order to ask the MedPAC folks to take a look at this legislation, and to give us your thoughts as to what other systemic cost containment we might look for in that bill.

MR. MILLER. We can do that. Everything that we have ever said about what would save money is a matter of public record. It is in our reports, and I mean, even without looking at the bill, we can extract that and send it to you.

MR. BURGESS. Very good. I would appreciate that very much.

MR. MILLER. We are also obviously happy to look at a bill.

MR. BURGESS. Mr. Miller, you also referenced the episodic basis on, sometimes, in which care is rendered, and I know this was asked earlier by another member, but under the pay-for-performance parameters, it is very difficult to know when someone is managing a group of diabetics, if they are doing everything correctly. Who avoided a hospitalization and who didn't, and how much money was saved by those hospitalizations that were avoided?

And then, for Mr. Marron on the other hand, when he is trying to figure out the actuarial basis as the bottom line, how is he going to be able to figure in the cost of that saved hospitalization when it didn't occur?

MR. MILLER. When it didn't occur.

MR. BURGESS. Well, the doctor who is doing everything according to the book on his pay-for-performance guidelines managing a cadre of, a panel of diabetics, doing all the hemoglobin A1cs, doing all the visual field checks, everything that is supposed to happen, if he avoids a hospitalization in that panel of patients, how is Mr. Marron going to know that? How is he going to find that savings to extrapolate it down to the bottom line?

MR. MILLER. Well, let me, first of all, I am sure Mr. Marron has views on how he would do this, but let me just make a couple of points. Before we talk about the episode, I also think it is a step forward, even just in the physician world, to say things to give performance metrics or value metrics, whichever our label is for today, that says you know, do you have a tracking system, simple things like this, that allow you to track your diabetics, and inform them that they need to have their blood sugar levels. I mean, that is just a step forward that doesn't exist now. Now, to your question--

MR. BURGESS. It doesn't uniformly exist. It does exist in some--

MR. MILLER. It does, I am sorry, but certainly, not uniformly, and certainly, the Medicare payment system doesn't do anything to encourage it. If anything, it probably discourages it. So, I am sorry, I overspoke, but that is what the thought was.

To the point, I mean, I think, for example, and again, you will want to comment on this, I mean, if, in the demonstration that I was referring to--

MR. BURGESS. And let me ask you to submit that answer for the record in writing.

MR. MILLER. All right. Sure.

MR. BURGESS. I do need to get on to a couple of other things. Mr. Guterman, we also heard some comments about the cost-of-living adjustment for seniors is consumed by the increase in the Part B premium. Isn't that essentially what the SGR was designed to do, since it goes up every year by the amount of the, set to the GDP figure? Is that--I mean, wouldn't that be the intended consequence?

MR. GUTERMAN. To control spending?

MR. BURGESS. Yes.

MR. GUTERMAN. Yes. Yeah, that was. It just hasn't worked.

MR. BURGESS. Wouldn't it--the activity to income related to Part B premium on the Medicare Modernization Act of--I am sorry, in 2003. Did that modify that loss of the COLA every year for low-income individuals? If we fully implemented the income relating to Part B program, would that modify the loss of the COLA for low-income individuals?

MR. GUTERMAN. That would tend to spread the cost more toward the high end of the income distribution, that is true. If I may add two quick points in response to one of your previous questions: prior to coming to the Commonwealth Fund, I was at CMS and was involved in the development of demonstration programs. One of the problems we faced was justifying demonstration programs, because we had to show that they promised savings, or at least budget neutrality, and the argument we used to give was that that was why we were doing

demonstration programs. We tried to generate the kind of information that Mr. Marron would need to make better estimates of cost savings resulting from these kinds of programs.

We are starting to get some of that information. In the Premier Hospital Quality Incentive demonstration, for instance, it was found that hospitals that were the highest performers also had a lower percentage of readmissions among their patients, which is a direct reduction in cost to Medicare for their patients, because Medicare pays for every admission. The National Committee for Quality Assurance has found that physicians that participate in their diabetic care program have achieved improvements in crucial measures of diabetic care, which also could be probably traced to cost.

MR. BURGESS. Well, let me interrupt you, because the Chairman is going to tell me I am out of time here in just a moment. Chairman Barton referenced we need to be able to get out of the box that SGR has placed us into. Let me just ask that question from a different perspective. Maybe we ought to assume that SGR is a good formula, and it is one that everyone ought to live by. Should we incorporate SGR to Part A, Part C, and Part D the same as we have done to Part B? That is, should hospitals, drug plans, and Medicare Advantage plans live under a cost reduction every year, or reimbursement reduction every year, in order to control the growth? And I will leave that question for anyone who cares to try to answer it.

MR. STEINWALD. I think there are some reasons, and I tried to portray the history of spending that led to SGR, that Part B really is different from other parts. If you take the Inpatient Prospective Payment System, for example, which is still the largest part of Medicare, we are now, as you know, paying by DRG, and in essence, the update is being set by Congress every year as part of the budget process. So, you have got--

MR. BURGESS. But that is a market basket update based on the cost of inputs. Physicians have no such update that is related to the cost of delivering the car.

MR. STEINWALD. Yeah, but it is a much larger bundle of services included in the--

MR. BURGESS. So, the savings could be much greater.

MR. STEINWALD. Sure. I mean, if part of the implication is should we have value-based purchasing that goes beyond Part B, absolutely.

MR. NORWOOD. Thank you very much, Dr. Burgess. Your time has expired. Mr. Green, you are recognized for questions.

MR. GREEN. Thank you, Mr. Chairman. Mr. Miller, in your testimony, you mentioned pay-for-performance proposals, and the use of

health information technologies. You allude to the notion that such, just any old piece of IT equipment won't work.

Would you elaborate on the importance of widespread health IT adoption models, and the success of pay-for-performance models? And given the financial pressures currently faced by physicians, does MedPAC believe that participation in a pay-for-performance model is enough incentive for physicians to invest in the health IT equipment, or would a Medicare add-on payment help further increase efficiency through a speedier adoption of health IT invest to pay-for-performance? And again, the health IT that really will be beneficial to Medicare.

MR. MILLER. You have got a couple of questions in there, and let me go at it this way. The Commission has discussed in detail in going through its pay-for-performance or value-based purchasing recommendations, and at the time that they considered this, there was great concern that simply reimbursing or paying additionally for the adoption of IT would not necessarily result in improvements in the quality of care. There are a lot of examples out in the private sector where people have purchased IT systems, but not necessarily changed their delivery mechanisms of care, and that the purchase of the IT was an expenditure, and basically, a failure where quality was concerned.

And so, the way the Commission ended up going at this is we said, make these the functionality of IT. Do you have a tracking system for your diabetics? Can you identify every patient that has taken this drug? Make those functionalities part of the way physicians get performance payments, and then allow the market to come in and say here are the systems that will help you reach those metrics. And then, you change the business proposition of saying, I am not paying for IT, but I know I will get more payments if my functionality improves, so I will purchase IT. That was the line of reasoning.

MR. GREEN. Okay. But in the IT, is there, and I know MedPAC doesn't want to say this plan is good, this process is good, is bad, but again, you want one that actually does track the success, for example, in tracking diabetics.

MR. MILLER. Absolutely. We wouldn't have the expertise to say this package versus that package, but we wrote up in the report efforts that are currently underway in the private sector and in the public sector, defining operational standards and languages, and all that type of stuff, but we wouldn't make a specific recommendation. But the answer, yes, that is what we are looking for.

MR. GREEN. Okay. This question is for, frankly, anyone on the panel. The U.S. system--on Thursday, we will hear from Dr. McClellan and a panel of physician representatives out implementing a pay-for-performance system in Medicare.

First, I would like to get the opinions of Dr. Miller and Mr. Steinwald and Mr. Guterman on whether we know exactly what pay-for-performance is for physicians in Medicare, such as it could begin in January of next year. Do we know enough now to be able to do something?

MR. GUTERMAN. Let me take that one. I think the answer is probably no, not completely. I think we need to be prepared to take some interim steps, like requiring, if we are going to avoid the decreases in physician payments that are in line for the next several years, to focus on getting something for that extra money. In particular, to improve the ability to collect quality measures and provide a financial incentive for submission of quality measures, similar to Section 501 of the Medicare Modernization Act for hospitals.

MR. MILLER. This follows right off of what you were asking me before. The Commission's view of it was for physicians to start with this IT functionality, is something that could be within reach. Now, for January of '07, which is essentially a couple of weeks away at this point, it is probably, it would be hard to get to that point, and harder still to get to a full array of performance measures. And what the Commission talked about is bringing together clinicians, people who study quality, the private sector, who is already into this, and medical societies, and ask them to put forward, which in some respects, they are doing now, put forward the metrics that they thought should be part of this.

MR. GREEN. Mr. Steinwald.

MR. STEINWALD. For GAO, I think it is wonderful to hear about all of these demonstrations and other initiatives taking place, but in terms of something systemic that could be put into place on January 1, obviously, it would be interesting to hear what Dr. McClellan has to say on Thursday, but I would be very doubtful that there would be such a system that would be implementable in that short a timeframe.

MR. GREEN. Thank you, Mr. Chairman. In fact, if I have--oh, I am over time. Okay. I was going to yield some time to my colleague from Texas, because I knew he didn't have enough.

MR. NORWOOD. Thank you very much Mr. Green. I would like to recognize Chairman Bilirakis now for 5 minutes for questioning.

MR. BILIRAKIS. Thank you, Mr. Chairman. Gentleman, others have gone into the pay-for-performance, value-based purchasing, I guess it has been called, whatnot. Echocardiograms, that is, I guess you might say, well, if it is done by a primary care physician in his office, to use basically as a screening device for every patient, is that good quality medicine? Is that value-based purchasing?

MR. MILLER. Did you say on every patient?

MR. BILIRAKIS. I said on every patient.

MR. MILLER. Well, without knowing exactly every patient, but I would assume every patient, that might raise some questions.

MR. BILIRAKIS. But there is a history of this physician having picked up problems early on, which all of them, may of course save money, and that sort of thing. Would that be considered good quality medicine, or is that taking advantage of the system, so to speak?

MR. MILLER. I mean, if you were involved in a pay-for-performance system, and let us just pick an example. So, let us say we are in that situation.

MR. BILIRAKIS. Yes.

MR. MILLER. We are in the group of physicians that have come together, like the example that I was talking about, and this physician's practice style resulted in avoided hospitalizations, and savings resulted from that, and obviously, the outcomes of the patients were all positive, then that practice style would be rewarded, but if they were just really imaging, or whatever the case may be, every person that walked in, literally, I am not sure that many clinicians, I think, would look at that and raise questions about whether that makes sense or not.

MR. BILIRAKIS. All right. Well, let us say it wasn't every patient. Let us say maybe it was patients that reached a certain age, possibly maybe had a family history, that sort of thing.

MR. MILLER. And you see there, I think now, that is what we are talking about. I mean, I think there are things that, standards that have been put together by associations and societies of physicians who say you know, when somebody walks in with lower back pain, you don't necessarily load them up and put them on the MRI right there. There are steps that you take before you go ahead and take the imaging.

And I think that is the kind of thing that we are talking about, and those kinds of, if we could create incentives for physicians to be judicious in how they use this, and to focus it on the people who are actually in need, as opposed to, well, anybody who walks in here, I am going to run this imaging, we think that would be a positive step. Right now, the system rewards the physician, literally, who runs the echo or the image on anybody that walks in.

MR. BILIRAKIS. Right. Yeah. Well, I certainly don't want to be the person having to sit down and draft up the definition of value-based purchasing. I mean, how would you be able to possibly cover virtually every occurrence that might possibly take place.

Well, that is another thing. Let me ask, does the SGR accurately reflect the costs that physicians incur for providing Medicare services? Dr. Guterman. No or yes.

MR. GUTERMAN. No.

MR. BILIRAKIS. No.

MR. GUTERMAN. It is not intended to do that.

MR. BILIRAKIS. It does not. Dr. Miller.

MR. MILLER. Same.

MR. BILIRAKIS. And Mr. Steinwald.

MR. STEINWALD. No.

MR. BILIRAKIS. And Mr. Marron. No.

MR. MARRON. No.

MR. BILIRAKIS. All right. Now, you started to explain, Dr. Guterman.

MR. GUTERMAN. Well, the SGR is intended to adjust physician fees for the amount of resources that, overall, should be devoted to physician care based on the growth in the economy as a whole. So it actually is explicitly severing the total amount, the setting of physician fees from the, or at least removing the setting of physician fees from totally being driven by resource costs.

MR. BILIRAKIS. And well, don't you think that the intent, when it was created, was that it would cover adequately the actual physician fees, the practically expected, anticipated physician fees?

MR. STEINWALD. I will give that a try. One of the elements of SGR is MEI, inflation in the cost of running a medical practice, the Medicare Economic Index. That is one of four elements. But the other important element is real growth in the economy, and at the time it was enacted, it was the sense of the Congress that that would be an allowance for volume and intensity or technology growth, that this was what was affordable, and that was why it was put into the formula, I believe.

And the other two elements are the growth in the fee-for-service population, or the change in that, and the change in law and regulations that could affect Medicare spending per beneficiary.

MR. BILIRAKIS. Well, would we say that it was intended more to serve as an incentive to control the overutilization of services provided by physicians to Medicare beneficiaries, or to serve as a formula, if you will, to determine the actual cost improvements to those physicians?

MR. STEINWALD. Well, as I said earlier, remember, when it was put in place, there were enormous increases in the '80s in spending per beneficiary, under the old physician fee schedule system. Congress froze fees and did other things during that period that were unsuccessful, and therefore--

MR. BILIRAKIS. Your insurance.

MR. STEINWALD. Therefore, the combination of the national fee schedule and the spending targets that went into place in 1992 led to a period where spending increases were moderate over the 1990s.

MR. BILIRAKIS. Well, all right. My time is up. That 5 minutes really flies. But apparently, it hasn't worked. I think you all would agree it is not working. Thank you.

Thank you, Mr. Chairman.

MR. NORWOOD. Thank you very much, Mr. Chairman. And I think your question, one specifically, was outstanding, and Mr. Miller points out the problem. You say that well, that physician should not take that MRI unless, for example, there are some standards which might be age, might be family history, and that is great. That really saves money and that works, except that one 48 year old patient who doesn't fit any of those standards, who you have misdiagnosed because you didn't take the MRI. What do you do with that? I don't need an answer. I am just throwing that out.

Dr. Burgess, I would recognize you for a last question, if you have one. If not, hand it back.

MR. BURGESS. Actually, I had a last page of questions.

Let me then, if I could, Mr. Miller, I know you said this earlier, but in your testimony, you said a full, if we were to change from the SGR to a more MEI-based formula, the full MEI was not necessary on a year over year basis. Did I understand that correctly?

MR. MILLER. You did.

MR. BURGESS. And the cost of inputs that the MEI addresses, that could be adjusted over time as was necessary, if we were to go to an MEI formula?

MR. MILLER. Yeah. If I understand your question, what I was saying is, is that MedPAC looks that--and let us say the MEI is some percentage increase. Actually, let me give you a different example. For the last several years, the hospital's market basket, which is the hospital's version of the MEI, has been going up 3, 3.5, 4 percent. There were a couple of years there where hospital costs were growing at 6, 7, 8 percent, and the Commission went through an analysis, and looked at those costs, and said we don't think that the Medicare program should recognize all of that cost growth, and so, the point I was making is that just because the MEI says 2.5, 3.5, whatever percent, the Commission wouldn't necessarily look at that and say physicians get 2.5 or 3.5 percent. They would look at other factors, and they may lower that MEI. That is what I was trying to say.

MR. BURGESS. And indirectly, you have alluded to the problem, in that there is very little in the cost of doing business today that is a whole lot less than what it was 5 years ago. That is, electricity rates are higher, rates for employees are higher, rates for malpractice insurance are higher, so the physicians have seen that, have seen their market basket increase in what they are having, the checks they are having to write to keep their

doors open, and at the time, the SGR is pounding on them on the other end by saying we are going to cut you 4.5, 5.4, whatever percentage that is.

There is also the perverse activity of, some insurance companies do peg their rates to Medicare rates, so every time we put a 4.4 percent whack onto our friends in the physician community, the other insurances will follow suit, and we have the unintended consequence of making it even harder for that practice--I think Ms. Capps referenced this--making it even harder for that practice to stay open, because we are reducing their rates in the private sector as well. We never intended these rates to be Federal price controls, but in reality, that unfortunately is many times what happens.

Mr. Chairman, you have been very kind, and I will yield.

MR. NORWOOD. Thank you very much.

I think it is important for the record. I started this hearing out by saying that I am lucky enough to be on Medicare by the end of the week, and Ms. Eshoo pointed out to me that well, I didn't have to be on Medicare. I could simply pay for my own healthcare, but I want the record to reflect that isn't true. You can't find a doctor, frankly, and any doctor who would treat me for me paying them gets kicked off Medicare plus fines, et cetera, so it isn't exactly like I could go out into the marketplace and pay for my own healthcare after 65.

I think the conclusion to this hearing, from my mind, is that probably we have the finest healthcare in the entire world in the United States, yet Congress is busy trying to set the prices for physicians, trying to tell them how to practice medicine, trying to take over the administration of their office with IT, and I just wonder, are we going to continue to have the finest healthcare in the world once Congress, through you gentlemen, and I mean no offense to you earlier, through you gentlemen doing what we ask you to do, is healthcare in this country going to stay like it is today, in terms of the great quality and outcomes that we have?

This hearing will now recess.

MR. BURGESS. Mr. Chairman. Mr. Chairman, can I ask unanimous consent that you posed a hypothetical situation where if you went to a physician off of Medicare, or on Medicare, and you wrote him a check for reimbursement, can we just have in the record what the penalties would be for that Medicare physician, or that physician who accepted an assignment under Medicare, what the penalties would be for that physician if he accepted payment from you?

MR. NORWOOD. So ordered.

[The information follows:]

Should a doctor in Medicare opt out of assignment and then bill Medicare:

(The enforcement provision for the use of Medicare private pay contracts may be found at Section 1803(b)(3)(C), 42 U.S.C. 1395a(b)(3)(C) applies☺

(a) Basic freedom of choice
Any individual entitled to insurance benefits under this subchapter may obtain health services from any institution, agency, or person qualified to participate under this subchapter if such institution, agency, or person undertakes to provide him such services.
(b) Use of private contracts by medicare beneficiaries
(1) In general
Subject to the provisions of this subsection, nothing in this subchapter shall prohibit a physician or practitioner from entering into a private contract with a medicare beneficiary for any item or service—
(A) for which no claim for payment is to be submitted under this subchapter, and
(B) for which the physician or practitioner receives—
(i) no reimbursement under this subchapter directly or on a capitated basis, and
(ii) receives no amount for such item or service from an organization which receives reimbursement for such item or service under this subchapter directly or on a capitated basis.
(2) Beneficiary protections
(A) In general
Paragraph (1) shall not apply to any contract unless—
(i) the contract is in writing and is signed by the medicare beneficiary before any item or service is provided pursuant to the contract;
(ii) the contract contains the items described in subparagraph (B); and
(iii) the contract is not entered into at a time when the medicare beneficiary is facing an emergency or urgent health care situation.
(B) Items required to be included in contract
Any contract to provide items and services to which paragraph (1) applies shall clearly indicate to the medicare beneficiary that by signing such contract the beneficiary—
(i) agrees not to submit a claim (or to request that the physician or practitioner submit a claim) under this subchapter for such items or services even if such items or services are otherwise covered by this subchapter;
(ii) agrees to be responsible, whether through insurance or otherwise, for payment of such items or services and understands that no reimbursement will be provided under this subchapter for such items or services;
(iii) acknowledges that no limits under this subchapter (including the limits under section 1395w–4 (g) of this title) apply to amounts that may be charged for such items or services;
(iv) acknowledges that Medigap plans under section 1395ss of this title do not, and other supplemental insurance plans may elect not to, make payments for such items and services because payment is not made under this subchapter; and
(v) acknowledges that the medicare beneficiary has the right to have such items or services provided by other physicians or practitioners for whom payment would be made under this subchapter.
Such contract shall also clearly indicate whether the physician or practitioner is excluded from participation under the medicare program under section 1320a–7 of this title.

(3) Physician or practitioner requirements
(A) In general
Paragraph (1) shall not apply to any contract entered into by a physician or practitioner unless an affidavit described in subparagraph (B) is in effect during the period any item or service is to be provided pursuant to the contract.
(B) Affidavit
An affidavit is described in this subparagraph if—
(i) the affidavit identifies the physician or practitioner and is in writing and is signed by the physician or practitioner;
(ii) the affidavit provides that the physician or practitioner will not submit any claim under this subchapter for any item or service provided to any medicare beneficiary (and will not receive any reimbursement or amount described in paragraph (1)(B) for any such item or service) during the 2-year period beginning on the date the affidavit is signed; and
(iii) a copy of the affidavit is filed with the Secretary no later than 10 days after the first contract to which such affidavit applies is entered into.
(C) Enforcement
If a physician or practitioner signing an affidavit under subparagraph (B) knowingly and willfully submits a claim under this subchapter for any item or service provided during the 2-year period described in subparagraph (B)(ii) (or receives any reimbursement or amount described in paragraph (1)(B) for any such item or service) with respect to such affidavit—
(i) this subsection shall not apply with respect to any items and services provided by the physician or practitioner pursuant to any contract on and after the date of such submission and before the end of such period; and
(ii) no payment shall be made under this subchapter for any item or service furnished by the physician or practitioner during the period described in clause (i) (and no reimbursement or payment of any amount described in paragraph (1)(B) shall be made for any such item or service).
(4) Limitation on actual charge and claim submission requirement not applicable
Section 1395w–4 (g) of this title shall not apply with respect to any item or service provided to a medicare beneficiary under a contract described in paragraph (1).
(5) Definitions
In this subsection:
(A) Medicare beneficiary
The term "medicare beneficiary" means an individual who is entitled to benefits under part A of this subchapter or enrolled under part B of this subchapter.
(B) Physician
The term "physician" has the meaning given such term by paragraphs (1), (2), (3), and (4) of section 1395x (r) of this title.
(C) Practitioner
The term "practitioner" has the meaning given such term by section 1395u (b)(18)(C) of this title.

Should a doctor not opt out of assignment but violates the law by accepting payment from seniors while also billing Medicare for other patients the general fraud provisions apply: The general fraud provisions for federal health care programs, including Medicare, may be found at Sections 1128 (42 U.S.C. 1320a-7), 1128A (42 U.S.C. 1320a-7a) and 1128B (42 U.S.C. 1320a-7b.

a) Mandatory exclusion
The Secretary shall exclude the following individuals and entities from participation in any Federal health care program (as defined in section 1320a–7b (f) of this title):
(1) Conviction of program-related crimes
Any individual or entity that has been convicted of a criminal offense related to the delivery of an item or service under subchapter XVIII of this chapter or under any State health care program.
(2) Conviction relating to patient abuse
Any individual or entity that has been convicted, under Federal or State law, of a criminal offense relating to neglect or abuse of patients in connection with the delivery of a health care item or service.
(3) Felony conviction relating to health care fraud
Any individual or entity that has been convicted for an offense which occurred after August 21, 1996, under Federal or State law, in connection with the delivery of a health care item or service or with respect to any act or omission in a health care program (other than those specifically described in paragraph (1)) operated by or financed in whole or in part by any Federal, State, or local government agency, of a criminal offense consisting of a felony relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct.
(4) Felony conviction relating to controlled substance
Any individual or entity that has been convicted for an offense which occurred after August 21, 1996, under Federal or State law, of a criminal offense consisting of a felony relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.
(b) Permissive exclusion
The Secretary may exclude the following individuals and entities from participation in any Federal health care program (as defined in section 1320a–7b (f) of this title):
(1) Conviction relating to fraud
Any individual or entity that has been convicted for an offense which occurred after August 21, 1996, under Federal or State law—
(A) of a criminal offense consisting of a misdemeanor relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct—
(i) in connection with the delivery of a health care item or service, or
(ii) with respect to any act or omission in a health care program (other than those specifically described in subsection (a)(1) of this section) operated by or financed in whole or in part by any Federal, State, or local government agency; or
(B) of a criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct with respect to any act or omission in a program (other than a health care program) operated by or financed in whole or in part by any Federal, State, or local government agency.
(2) Conviction relating to obstruction of an investigation
Any individual or entity that has been convicted, under Federal or State law, in connection with the interference with or obstruction of any investigation into any criminal offense described in paragraph (1) or in subsection (a) of this section.
(3) Misdemeanor conviction relating to controlled substance
Any individual or entity that has been convicted, under Federal or State law, of a criminal offense consisting of a misdemeanor relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.
(4) License revocation or suspension
Any individual or entity—
(A) whose license to provide health care has been revoked or suspended by any State licensing authority, or who otherwise lost such a license or the right to apply

for or renew such a license, for reasons bearing on the individual's or entity's professional competence, professional performance, or financial integrity, or
(B) who surrendered such a license while a formal disciplinary proceeding was pending before such an authority and the proceeding concerned the individual's or entity's professional competence, professional performance, or financial integrity.
(5) Exclusion or suspension under Federal or State health care program
Any individual or entity which has been suspended or excluded from participation, or otherwise sanctioned, under—
(A) any Federal program, including programs of the Department of Defense or the Department of Veterans Affairs, involving the provision of health care, or
(B) a State health care program,
for reasons bearing on the individual's or entity's professional competence, professional performance, or financial integrity.
(6) Claims for excessive charges or unnecessary services and failure of certain organizations to furnish medically necessary services
Any individual or entity that the Secretary determines—
(A) has submitted or caused to be submitted bills or requests for payment (where such bills or requests are based on charges or cost) under subchapter XVIII of this chapter or a State health care program containing charges (or, in applicable cases, requests for payment of costs) for items or services furnished substantially in excess of such individual's or entity's usual charges (or, in applicable cases, substantially in excess of such individual's or entity's costs) for such items or services, unless the Secretary finds there is good cause for such bills or requests containing such charges or costs;
(B) has furnished or caused to be furnished items or services to patients (whether or not eligible for benefits under subchapter XVIII of this chapter or under a State health care program) substantially in excess of the needs of such patients or of a quality which fails to meet professionally recognized standards of health care;
(C) is—
(i) a health maintenance organization (as defined in section 1396b (m) of this title) providing items and services under a State plan approved under subchapter XIX of this chapter, or
(ii) an entity furnishing services under a waiver approved under section 1396n (b)(1) of this title,
and has failed substantially to provide medically necessary items and services that are required (under law or the contract with the State under subchapter XIX of this chapter) to be provided to individuals covered under that plan or waiver, if the failure has adversely affected (or has a substantial likelihood of adversely affecting) these individuals; or
(D) is an entity providing items and services as an eligible organization under a risk-sharing contract under section 1395mm of this title and has failed substantially to provide medically necessary items and services that are required (under law or such contract) to be provided to individuals covered under the risk-sharing contract, if the failure has adversely affected (or has a substantial likelihood of adversely affecting) these individuals.
(7) Fraud, kickbacks, and other prohibited activities
Any individual or entity that the Secretary determines has committed an act which is described in section 1320a–7a, 1320a–7b, or 1320a–8 of this title.
(8) Entities controlled by a sanctioned individual
Any entity with respect to which the Secretary determines that a person—
(A)

(i) who has a direct or indirect ownership or control interest of 5 percent or more in the entity or with an ownership or control interest (as defined in section 1320a-3 (a)(3) of this title) in that entity,
(ii) who is an officer, director, agent, or managing employee (as defined in section 1320a-5 (b) of this title) of that entity; or
(iii) who was described in clause (i) but is no longer so described because of a transfer of ownership or control interest, in anticipation of (or following) a conviction, assessment, or exclusion described in subparagraph (B) against the person, to an immediate family member (as defined in subsection (j)(1) of this section) or a member of the household of the person (as defined in subsection (j)(2) of this section) who continues to maintain an interest described in such clause—
is a person—
(B)
(i) who has been convicted of any offense described in subsection (a) of this section or in paragraph (1), (2), or (3) of this subsection;
(ii) against whom a civil monetary penalty has been assessed under section 1320a-7a or 1320a-8 of this title; or
(iii) who has been excluded from participation under a program under subchapter XVIII of this chapter or under a State health care program.
(9) Failure to disclose required information
Any entity that did not fully and accurately make any disclosure required by section 1320a-3 of this title, section 1320a-3a of this title, or section 1320a-5 of this title.
(10) Failure to supply requested information on subcontractors and suppliers
Any disclosing entity (as defined in section 1320a-3 (a)(2) of this title) that fails to supply (within such period as may be specified by the Secretary in regulations) upon request specifically addressed to the entity by the Secretary or by the State agency administering or supervising the administration of a State health care program—
(A) full and complete information as to the ownership of a subcontractor (as defined by the Secretary in regulations) with whom the entity has had, during the previous 12 months, business transactions in an aggregate amount in excess of $25,000, or
(B) full and complete information as to any significant business transactions (as defined by the Secretary in regulations), occurring during the five-year period ending on the date of such request, between the entity and any wholly owned supplier or between the entity and any subcontractor.
(11) Failure to supply payment information
Any individual or entity furnishing items or services for which payment may be made under subchapter XVIII of this chapter or a State health care program that fails to provide such information as the Secretary or the appropriate State agency finds necessary to determine whether such payments are or were due and the amounts thereof, or has refused to permit such examination of its records by or on behalf of the Secretary or that agency as may be necessary to verify such information.
(12) Failure to grant immediate access
Any individual or entity that fails to grant immediate access, upon reasonable request (as defined by the Secretary in regulations) to any of the following:
(A) To the Secretary, or to the agency used by the Secretary, for the purpose specified in the first sentence of section 1395aa (a) of this title (relating to compliance with conditions of participation or payment).
(B) To the Secretary or the State agency, to perform the reviews and surveys required under State plans under paragraphs (26), (31), and (33) of section 1396a (a) of this title and under section 1396b (g) of this title.

(C) To the Inspector General of the Department of Health and Human Services, for the purpose of reviewing records, documents, and other data necessary to the performance of the statutory functions of the Inspector General.
(D) To a State medicaid fraud control unit (as defined in section 1396b (q) of this title), for the purpose of conducting activities described in that section.
(13) Failure to take corrective action
Any hospital that fails to comply substantially with a corrective action required under section 1395ww (f)(2)(B) of this title.
(14) Default on health education loan or scholarship obligations
Any individual who the Secretary determines is in default on repayments of scholarship obligations or loans in connection with health professions education made or secured, in whole or in part, by the Secretary and with respect to whom the Secretary has taken all reasonable steps available to the Secretary to secure repayment of such obligations or loans, except that
(A) the Secretary shall not exclude pursuant to this paragraph a physician who is the sole community physician or sole source of essential specialized services in a community if a State requests that the physician not be excluded, and
(B) the Secretary shall take into account, in determining whether to exclude any other physician pursuant to this paragraph, access of beneficiaries to physician services for which payment may be made under subchapter XVIII or XIX of this chapter.
(15) Individuals controlling a sanctioned entity
(A) Any individual—
(i) who has a direct or indirect ownership or control interest in a sanctioned entity and who knows or should know (as defined in section 1320a–7a (i)(6) [1] of this title) of the action constituting the basis for the conviction or exclusion described in subparagraph (B); or
(ii) who is an officer or managing employee (as defined in section 1320a–5 (b) of this title) of such an entity.
(B) For purposes of subparagraph (A), the term "sanctioned entity" means an entity—
(i) that has been convicted of any offense described in subsection (a) of this section or in paragraph (1), (2), or (3) of this subsection; or
(ii) that has been excluded from participation under a program under subchapter XVIII of this chapter or under a State health care program.
(c) Notice, effective date, and period of exclusion
(1) An exclusion under this section or under section 1320a–7a of this title shall be effective at such time and upon such reasonable notice to the public and to the individual or entity excluded as may be specified in regulations consistent with paragraph (2).
(2)
(A) Except as provided in subparagraph (B), such an exclusion shall be effective with respect to services furnished to an individual on or after the effective date of the exclusion.
(B) Unless the Secretary determines that the health and safety of individuals receiving services warrants the exclusion taking effect earlier, an exclusion shall not apply to payments made under subchapter XVIII of this chapter or under a State health care program for—
(i) inpatient institutional services furnished to an individual who was admitted to such institution before the date of the exclusion, or
(ii) home health services and hospice care furnished to an individual under a plan of care established before the date of the exclusion,
until the passage of 30 days after the effective date of the exclusion.

(3)
(A) The Secretary shall specify, in the notice of exclusion under paragraph (1) and the written notice under section 1320a–7a of this title, the minimum period (or, in the case of an exclusion of an individual under subsection (b)(12) of this section or in the case described in subparagraph (G), the period) of the exclusion.
(B) Subject to subparagraph (G), in the case of an exclusion under subsection (a) of this section, the minimum period of exclusion shall be not less than five years, except that, upon the request of the administrator of a Federal health care program (as defined in section 1320a–7b (f) of this title) who determines that the exclusion would impose a hardship on individuals entitled to benefits under part A of subchapter XVIII of this chapter or enrolled under part B of such subchapter, or both, the Secretary may, after consulting with the Inspector General of the Department of Health and Human Services, waive the exclusion under subsection (a)(1), (a)(3), or (a)(4) of this section with respect to that program in the case of an individual or entity that is the sole community physician or sole source of essential specialized services in a community. The Secretary's decision whether to waive the exclusion shall not be reviewable.
(C) In the case of an exclusion of an individual under subsection (b)(12) of this section, the period of the exclusion shall be equal to the sum of—
(i) the length of the period in which the individual failed to grant the immediate access described in that subsection, and
(ii) an additional period, not to exceed 90 days, set by the Secretary.
(D) Subject to subparagraph (G), in the case of an exclusion of an individual or entity under paragraph (1), (2), or (3) of subsection (b) of this section, the period of the exclusion shall be 3 years, unless the Secretary determines in accordance with published regulations that a shorter period is appropriate because of mitigating circumstances or that a longer period is appropriate because of aggravating circumstances.
(E) In the case of an exclusion of an individual or entity under subsection (b)(4) or (b)(5) of this section, the period of the exclusion shall not be less than the period during which the individual's or entity's license to provide health care is revoked, suspended, or surrendered, or the individual or the entity is excluded or suspended from a Federal or State health care program.
(F) In the case of an exclusion of an individual or entity under subsection (b)(6)(B) of this section, the period of the exclusion shall be not less than 1 year.
(G) In the case of an exclusion of an individual under subsection (a) of this section based on a conviction occurring on or after August 5, 1997, if the individual has (before, on, or after August 5, 1997) been convicted—
(i) on one previous occasion of one or more offenses for which an exclusion may be effected under such subsection, the period of the exclusion shall be not less than 10 years, or
(ii) on 2 or more previous occasions of one or more offenses for which an exclusion may be effected under such subsection, the period of the exclusion shall be permanent.
(d) Notice to State agencies and exclusion under State health care programs
(1) Subject to paragraph (3), the Secretary shall exercise the authority under this section and section 1320a–7a of this title in a manner that results in an individual's or entity's exclusion from all the programs under subchapter XVIII of this chapter and all the State health care programs in which the individual or entity may otherwise participate.
(2) The Secretary shall promptly notify each appropriate State agency administering or supervising the administration of each State health care program (and, in the case

of an exclusion effected pursuant to subsection (a) of this section and to which section 824 (a)(5) of title 21 may apply, the Attorney General)—
(A) of the fact and circumstances of each exclusion effected against an individual or entity under this section or section 1320a–7a of this title, and
(B) of the period (described in paragraph (3)) for which the State agency is directed to exclude the individual or entity from participation in the State health care program.
(3)
(A) Except as provided in subparagraph (B), the period of the exclusion under a State health care program under paragraph (2) shall be the same as any period of exclusion under subchapter XVIII of this chapter.
(B)
(i) The Secretary may waive an individual's or entity's exclusion under a State health care program under paragraph (2) if the Secretary receives and approves a request for the waiver with respect to the individual or entity from the State agency administering or supervising the administration of the program.
(ii) A State health care program may provide for a period of exclusion which is longer than the period of exclusion under subchapter XVIII of this chapter.
(e) Notice to State licensing agencies
The Secretary shall—
(1) promptly notify the appropriate State or local agency or authority having responsibility for the licensing or certification of an individual or entity excluded (or directed to be excluded) from participation under this section or section 1320a–7a of this title, of the fact and circumstances of the exclusion,
(2) request that appropriate investigations be made and sanctions invoked in accordance with applicable State law and policy, and
(3) request that the State or local agency or authority keep the Secretary and the Inspector General of the Department of Health and Human Services fully and currently informed with respect to any actions taken in response to the request.
(f) Notice, hearing, and judicial review
(1) Subject to paragraph (2), any individual or entity that is excluded (or directed to be excluded) from participation under this section is entitled to reasonable notice and opportunity for a hearing thereon by the Secretary to the same extent as is provided in section 405 (b) of this title, and to judicial review of the Secretary's final decision after such hearing as is provided in section 405 (g) of this title, except that, in so applying such sections and section 405 (l) of this title, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively.
(2) Unless the Secretary determines that the health or safety of individuals receiving services warrants the exclusion taking effect earlier, any individual or entity that is the subject of an adverse determination under subsection (b)(7) of this section shall be entitled to a hearing by an administrative law judge (as provided under section 405 (b) of this title) on the determination under subsection (b)(7) of this section before any exclusion based upon the determination takes effect.
(3) The provisions of section 405 (h) of this title shall apply with respect to this section and sections 1320a–7a, 1320a–8, and 1320c–5 of this title to the same extent as it is applicable with respect to subchapter II of this chapter, except that, in so applying such section and section 405 (l) of this title, any reference therein to the Commissioner of Social Security shall be considered a reference to the Secretary.
(g) Application for termination of exclusion
(1) An individual or entity excluded (or directed to be excluded) from participation under this section or section 1320a–7a of this title may apply to the Secretary, in the manner specified by the Secretary in regulations and at the end of the minimum

period of exclusion provided under subsection (c)(3) of this section and at such other times as the Secretary may provide, for termination of the exclusion effected under this section or section 1320a–7a of this title.
(2) The Secretary may terminate the exclusion if the Secretary determines, on the basis of the conduct of the applicant which occurred after the date of the notice of exclusion or which was unknown to the Secretary at the time of the exclusion, that—
(A) there is no basis under subsection (a) or (b) of this section or section 1320a–7a (a) of this title for a continuation of the exclusion, and
(B) there are reasonable assurances that the types of actions which formed the basis for the original exclusion have not recurred and will not recur.
(3) The Secretary shall promptly notify each appropriate State agency administering or supervising the administration of each State health care program (and, in the case of an exclusion effected pursuant to subsection (a) of this section and to which section 824 (a)(5) of title 21 may apply, the Attorney General) of the fact and circumstances of each termination of exclusion made under this subsection.
(h) "State health care program" defined
For purposes of this section and sections 1320a–7a and 1320a–7b of this title, the term "State health care program" means—
(1) a State plan approved under subchapter XIX of this chapter,
(2) any program receiving funds under subchapter V of this chapter or from an allotment to a State under such subchapter,
(3) any program receiving funds under subchapter XX of this chapter or from an allotment to a State under such subchapter, or
(4) a State child health plan approved under subchapter XXI of this chapter.
(i) "Convicted" defined
For purposes of subsections (a) and (b) of this section, an individual or entity is considered to have been "convicted" of a criminal offense—
(1) when a judgment of conviction has been entered against the individual or entity by a Federal, State, or local court, regardless of whether there is an appeal pending or whether the judgment of conviction or other record relating to criminal conduct has been expunged;
(2) when there has been a finding of guilt against the individual or entity by a Federal, State, or local court;
(3) when a plea of guilty or nolo contendere by the individual or entity has been accepted by a Federal, State, or local court; or
(4) when the individual or entity has entered into participation in a first offender, deferred adjudication, or other arrangement or program where judgment of conviction has been withheld.
(j) Definition of immediate family member and member of household
For purposes of subsection (b)(8)(A)(iii) of this section:
(1) The term "immediate family member" means, with respect to a person—
(A) the husband or wife of the person;
(B) the natural or adoptive parent, child, or sibling of the person;
(C) the stepparent, stepchild, stepbrother, or stepsister of the person;
(D) the father-, mother-, daughter-, son-, brother-, or sister-in-law of the person;
(E) the grandparent or grandchild of the person; and
(F) the spouse of a grandparent or grandchild of the person.
(2) The term "member of the household" means, with respect to any person, any individual sharing a common abode as part of a single family unit with the person, including domestic employees and others who live together as a family unit, but not including a roomer or boarder.

[1] So in original. Probably should be section "1320a–7a(i)(7)".

MR. NORWOOD. Mr. Pallone pointed out what is the point? I couldn't pay for it anyway.

We will recess until Thursday morning at 10:00 a.m. Thank you very much, gentlemen, for your time and cooperation.

[Whereupon, at 12:20 p.m., the subcommittee recessed, to reconvene Thursday, July 27, 2006, at 10:00 a.m.]

MEDICARE PHYSICIAN PAYMENT: HOW TO BUILD A PAYMENT SYSTEM THAT PROVIDES QUALITY, EFFICIENT CARE FOR MEDICARE BENEFICIARIES

THURSDAY, JULY 27, 2006

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:05 a.m., in Room 2125 of the Rayburn House Office Building, Hon. Mike Ferguson presiding.

Members present: Representatives Gillmor, Norwood, Shimkus, Buyer, Ferguson, Burgess, Barton (ex officio), Brown, Gordon, Rush, Eshoo, Green, Capps, and Allen.

Staff Present: Melissa Bartlett, Counsel; Brandon Clark, Policy Coordinator; Chad Grant, Legislative Clerk; Bridgett Taylor, Minority Professional Staff Member; Amy Hall, Minority Professional Staff Member; and Jessica McNiece, Minority Research Assistant.

MR. FERGUSON. Good morning. We will reconvene our hearing, entitled "Medicare Physician Payment: How to Build a Payment System that Provides Quality, Efficient Care for Medicare Beneficiaries."

I will begin by saying that I will be chairing the hearing today in place of Chairman Deal, who is tending to his 99 year old mother in Georgia, who is in failing health. I know you join me in offering our thoughts and prayers to the Chairman and his family and his mom.

Secondly, I will alert the committee that members will be acknowledged today in the order that was established in the first part of our hearing, and we will obviously, because this is a continuation of a hearing, we will not have opening statements from members.

I now would like to acknowledge Dr. Mark McClellan. Dr. McClellan, thank you for being here with us today. Dr. McClellan is Administrator of the Centers for Medicare & Medicaid Services. Dr. McClellan has asked for 10 minutes to present his opening statement, and we will offer him the 10 minutes.

Dr. McClellan, welcome. You are recognized.

STATEMENT OF DR. MARK MCCLELLAN, ADMINISTRATOR, CENTERS FOR MEDICARE & MEDICAID SERVICES

DR. MCCLELLAN. Thank you very much Mr. Chairman, and Representative Green.

MR. FERGUSON. Would you just turn on your microphone?

DR. MCCLELLAN. Turn on my microphone. All the distinguished members of the committee. I want to thank you for inviting me to discuss this very important issue of how Medicare reimburses physicians to provide care for people with Medicare.

As this committee and others have recognized, the current method for determining Medicare's payments to physicians is not sustainable. From the standpoint of access to quality care, it is not sustainable to significantly reduce payment rates year after year, but it is also not sustainable to simply keep adding more money into the current system to head off scheduled payment reductions due to rapidly rising costs.

In the recently released mid-session review of the budget, Medicare Part B expenditures are again projected to be significantly higher than previously estimated, $30 billion higher over 5 years, reflecting rapid growth in the use of both physician-related services and hospital outpatient services.

The main reason for the 10 percent growth in expenditures for physician services in 2005 is growth in the volume and intensity of services by over 7 percent. The volume and intensity of physician services has been going up by between 5 and 7 percent per year in recent years. The volume and intensity of outpatient services rose by more than 8 percent in 2005, and this has resulted in a projected increase in next year's Part B premium, to $98.40. That is an increase projected of 11 percent, that would go up even more if physician payment rates are increased.

So, we are in an unsustainable situation that is the direct result of paying more for more services regardless of their quality or impact on patient health. In fact, if physicians take steps to improve quality and keep overall healthcare costs down, we pay them less. If a primary care physician invests in a health IT system that enables her to share information with colleagues and track patients better, resulting in fewer lab tests and fewer visits to the doctor, and maybe fewer hospital admissions and complications, Medicare pays her less. So, the physician can't take these steps and make ends meet in her office practice.

But on the other hand, if she performs duplicative lab tests because she can't easily get the results of tests done already, or if her patients have more visits for complications, because the care is poorly

coordinated, Medicare pays more. If a surgeon takes steps to prevent infections, for example, by taking a little more time to work with the surgical team to improve postoperative care, we pay her less. But if the surgical team doesn't take steps to prevent post-op complications, so the patient needs further procedures, and spends more time in the hospital, we pay more. We can't afford to pay this way any more. That is why the President's budget has proposed budget neutral payment reforms to redirect the dollars we are spending, to help physicians deliver the kind of care they want to provide.

I am pleased to report that the physician community, supported by CMS and by broad-based, privately led quality alliances, has been making great strides in developing the sorts of quality measures that will help us in supporting the kind of care we want. These measures are being developed and implemented by practicing healthcare professionals, working with health plans and employers and consumer representatives. These initiatives are focused on promoting care that the evidence shows improves patient health and avoids unnecessary medical costs.

For example, diabetes is one of the leading causes of death and impairment among Medicare beneficiaries, and accounts for a significant portion of Medicare spending. Physicians involved in diabetes care have identified measures of quality, including measures of the control of blood sugar and cholesterol and blood pressure. The medical evidence indicates that improvements in these measures can lead to fewer hospitalizations by avoiding complications from diabetes, such as amputation and kidney failure, and heart disease. We also now know that public reports on these quality measures can help patients with diabetes learn more about how they can get the best care for their condition, and that paying at least a little more to help physicians to improve results, rather than simply provide more treatments to diabetic patients, can lead to better outcomes.

With even a small portion of payments tied to better results, physicians can spend more time doing what is best for the patient. Maybe it is spending extra effort on patient education about nutrition and monitoring for a patient who is having a hard time with compliance with their diet and medication. Maybe it is regular phone calls from a specially trained nurse to identify problems early in a patient with brittle diabetes. By helping patients use medications or implement diet and lifestyle changes effectively, we can avoid emergency room visits and surgeries that result when a diabetic patient doesn't have good control over their blood sugar or blood pressure or cholesterol.

The American Medical Association and many medical societies have been very active this year in developing a range of new quality measures. Currently, there are 57 unique measures that can be used by one or more

of 34 medical specialties. Among those specialties, 26 have at least 3 measures they can use, and 8 more have 1 or 2 measures. Many measures apply to many specialties, such as those related to preventing infections and blood clots after surgery, and those related to preventive services and preventing complications of common conditions like diabetes. And we are expecting that physician groups, in collaboration with the quality alliances, will develop more measures in the near future.

There is growing evidence that quality measures like these help patients choose better care, and help reduce overall healthcare costs. We are seeing this with public reporting on hospital quality, where Medicare hospital payments are now tied to quality reporting, and hospitals nationwide are reporting on an increasing range of quality measures. These measures will expand to include patient satisfaction and risk-adjusted outcomes for common health problems next year.

And we are also seeing that paying for better quality can make a difference. In our Premier Hospital Quality Incentive Demonstration project, we are using quality measures in five clinical areas, including heart attacks, heart failure, pneumonia, coronary artery bypass surgery, and hip and knee replacements. Providers that fall into the top 20 percent in these reported measures receive higher payments. In this demonstration program, we have seen across the board improvements in quality in the five clinical areas over the past 2 years. Readmission rates for pneumonia, for example, were 25 percent lower for the top 10 percent of hospitals. That translates into substantial cost savings, not to mention better patient outcomes.

While reporting and payment based on physician quality measures isn't as far along yet, we are also seeing promising results for physicians. This year, CMS started the Physician Voluntary Reporting program, in which thousands of physicians are now reporting on evidence-based measures of quality of care relevant to their practice. With physician support and feedback, this voluntary pilot is helping us identify feasible and effective ways for physicians to report on quality of care and improve their care.

We are also starting to see some promising results when we pay more for better physician care. Our Physician Group Practice Demonstration program involves reporting on 32 quality measures on performance by 10 large physician groups, with a total of over 5,000 physicians. The goals are to encourage better coordination of Part A and Part B services, and to support physicians for achieving better health outcomes and overall reductions in healthcare costs. Participating groups have told us that the quality reporting and payment bonuses for quality and efficiency have made it possible for the groups to make quality

improvement, particularly moves to invest in health IT and moves to improve coordination of care.

Early results show reduced hospitalizations, especially for heart failure patients. The private sector has also been very active in implementing innovative payment systems that recognize and reward high quality care. For example, the Integrated Healthcare Association, a collaboration of many large health plans, employers, and physician groups in California, now involves reporting by some 35,000 physicians on various aspects of clinical quality, patient satisfaction, and the use of health IT effectively.

The IHA recently announced that in 2005, they saw across the board improvements in clinical measures, including 60,000 more screening services for cervical cancer than in 2004, 12,000 more screenings for diabetes, and 30,000 more childhood immunizations. In addition, physicians increased their adoption of health IT.

There are many other examples around the country right now where preventable health problems are actually being prevented, and costs are being reduced for common chronic diseases like heart failure and diabetes, and where patients undergoing thoracic surgery and other surgical procedures are experiencing better results and fewer costly postoperative complications.

The fact is, physicians want to provide the best care possible, but we are making it difficult for them, and more expensive for all of us, by paying more for more complications and poor coordination of care, rather than paying more for what we really want, better care and lower overall costs. There is more and more evidence that it doesn't have to be this way when we involve patients and doctors in measuring and improving care.

This is the direction that we want to go in Medicare, and for the sake of our health and the sustainability of the Medicare program, it is the only direction that we can afford.

We look forward to continuing to work with the Congress on that goal. Mr. Chairman, I would be happy to answer any questions that you and the other committee members may have.

Thank you.

[The prepared statement of Hon. Mark McClellan follows:]

PREPARED STATEMENT OF THE HON. MARK MCCLELLAN, ADMINISTRATION, CENTERS FOR MEDICARE & MEDICAID SERVICES

Introduction

Chairman Deal, Representative Brown, distinguished members of the Subcommittee, thank you for inviting me here today to discuss our efforts to promote high-quality physicians' services for our Medicare beneficiaries. The Centers for Medicare & Medicaid Services (CMS) is actively engaged with both the Congress and

physician community on this important topic. This is a very significant time. It is a moment when, with your leadership, we can make real progress in identifying ways to align Medicare's physician payment system with the goals of health professionals for high-quality care, without increasing overall Medicare costs. If we are able to design a payment system that aligns reimbursement with quality and efficiency, we can better encourage physicians to provide the type of care that is best suited for our beneficiaries -- care focused on prevention and treating complications; care focused on the most effective, proven treatments available. This is far preferable to the current physician payment system, which simply increases payment rates as the volume of services continues to grow rapidly.

In order to move toward this vision, CMS has supported and worked collaboratively with the physician community to develop measures that capture the quality of care being provided to our Medicare beneficiaries. We continue to support efforts to expand the available measures of physician quality, including measures of the overall cost or efficiency of care. Through the Physician Voluntary Reporting Program (PVRP), CMS is also working with the physician community to develop and gain experience with the infrastructure and methods needed to collect data on several quality measures and provide confidential feedback to physicians based on those reports. CMS is also conducting demonstration programs designed to test a pay-for-performance system in the physician office setting that we hope will yield information helpful to the agency and the Congress as we consider options for revising the Medicare physician payment system. Throughout all of these efforts, CMS will continuously work with physicians and their leadership in an open and transparent way in order to support the best approaches to provide high quality health care services without creating additional costs for taxpayers and Medicare beneficiaries.

Physician Payment Update

Currently, updates to Medicare physician payments are made each year based on a statutory formula established in section 1848(d) of the Social Security Act. The calculation of the Medicare physician fee schedule update utilizes a comparison between target spending for Medicare physicians' services and actual spending. The update is based on comparison of cumulative targets for each year and actual spending from 1996 to the current year. If actual spending exceeds the targets, updates in subsequent years are negative until such time as spending comes into line with the targets and vice versa. The use of targets is intended to control the growth in aggregate Medicare expenditures for physicians' services.

Actual spending on physicians' services has been growing at a faster rate than target spending. For several years now, in response to this rise in spending, the statutory update formula would have operated to impose payment cuts. However, to stave off the cuts, in the Medicare Modernization Act (MMA) and Deficit Reduction Act (DRA), Congress temporarily suspended the requirements of the formula in favor of a specific, statutorily dictated update in 2004, 2005, and 2006. In passing these measures, Congress did not include a long-term modification to the underlying update formula. This resulted in actual spending that, rather than being held back, actually advanced, furthering the gap between actual spending and the targets, exacerbating the already difficult situation.

When, in 2007 and beyond, the statutory formula is reactivated under current law, it is expected to impose cuts in payments to physicians over a number of years, to bring actual spending back in line with the targets. Sustained reductions in payment rates raise real concerns about the current system's ability to ensure access to care for Medicare beneficiaries. In addition, it does not create incentives for physicians to provide the highest quality care at the lowest overall cost. For these reasons, finding better approaches for payment that do not increase overall costs remains an urgent priority.

The existing system is designed to control spending in the aggregate, but in recent years it has not been successful in limiting spending growth by influencing the behavior of individual physicians. We recently released the Mid-Session Review of the Budget. Medicare Part B expenditures are now projected to be significantly higher than budgeted, as a result of rapid growth in the use of both physician-related services and hospital outpatient services. The main reason for the 10 percent growth in expenditures for physicians' services in 2005 is an increase in the volume and intensity of services. Increases in the volume and intensity of physicians' services are estimated to be 7 percent for 2005, and are projected to be 6 percent for 2006. The continuing rapid growth in utilization and thus in Part B spending has two important consequences: it will lead to substantial increases in Part B premiums, and will increase the difference between actual and target expenditures with the existing update formula.

Furthermore, the increases in volume and intensity do not appear to be driven primarily by evidence-based changes in clinical practices. And with reductions in payment rates when volume rises, some health care providers may feel more pressure to increase volume in order to sustain revenues. This sort of behavior is precisely what we do not want. There is already substantial evidence of overuse, misuse, and underuse of medical treatments that results in potentially preventable complications and higher costs. Yet by paying more for more treatments, regardless of their quality or impact on patient health, our current system does little to address these quality problems and in certain respects could support and encourage less than optimal care. Instead, we should be paying for care in a way that encourages improved quality and keeps overall costs down. Fully addressing this situation will require legislative action by the Congress. The Administration looks forward to working with the Congress as it explores a budget-neutral legislative resolution to this challenge, but CMS believes that any new payment system must emphasize quality and appropriateness of care, as opposed to paying more for higher volume and intensity.

Developing Quality Measures

The physician community understands the urgency of revising Medicare's payment system, and for some time now, supported by CMS, has been engaged in efforts to develop useful, agreed upon measures of quality care. Quality measures are the basic foundation and pre-requisite for a payment system that encourages physicians in their efforts to provide the most clinically appropriate care, rather than the most volume.

For several years, CMS has been collaborating with a variety of stakeholders to develop and implement uniform, standardized sets of performance measures for various health care settings. In the past year, thanks to the leadership of many physician organizations, these efforts have accelerated even further.

Our work on the quality measures has been guided by the following widely-accepted principles. Quality measures should be evidence-based. They should be valid and reliable. They should be relevant to a significant part of medical practice. And to assure these features, quality measures should be developed in conjunction with open and transparent processes that promote consensus from a broad range of health care stakeholders. It also is important that quality measures do not discourage physicians from treating high-risk or difficult cases, for example, by incorporating a risk adjustment mechanism when needed. In addition, quality measures should be implemented in a realistic manner that is most relevant for quality improvement in all types of practices and patient populations, while being least burdensome for physicians and other stakeholders.

There are several distinct steps pertaining to the implementation of physician quality measures, including: 1) development through a standardized process; 2) consensus endorsement of measures as valid, usable, important, and feasible; and 3) consensus endorsement of measures for use in the healthcare market.

Development through a standardized process. There are a limited number of experienced physician quality measure developers. These include the American Medical Association's Physician Consortium for Performance Improvement (AMA-PCPI), the National Committee for Quality Assurance (NCQA), and some physician specialty societies. Most of the physician measurement development work prior to 2006 pertained to primary care specialties.

Consensus measure endorsement. Once measures are developed, it is still necessary to achieve a broader consensus on their validity, usability, and importance as a measure of healthcare quality. The National Quality Forum plays a significant role in this process. Most of the NQF endorsed measures as of 2006 relate to ambulatory care and therefore primary care specialties.

Consensus for use in healthcare marketplace. There is an additional need for consensus on measures for practical use in the marketplace. This is to promote uniformity by payers and purchasers in implementing quality reporting programs for physicians that have the maximum impact on improving quality and avoiding unnecessary costs. Without this consensus, physicians could not only be burdened by dealing with numerous sets of measures for numerous payers, but also the results themselves would suffer by the small number of patients that any individual payer would represent for a particular physician practice. This consensus-building role is fulfilled by the Ambulatory Care Quality Alliance (AQA). The AQA in April, 2005 endorsed a 26 measure starter set of measures pertaining to primary care specialties. In 2006, the AQA is focusing on adding non-primary care specialties to its consensus measures.

Implementation for reporting. Implementation of measures requires additional considerations, particularly the method of clinical data reporting. Generally, physician claims do not include all the clinical data required for physician quality measurement. Physicians and payers do not necessarily have interoperable electronic health records that have potential for automating the process of data gathering either. As a result, any method of quality measure reporting should build on existing claims reporting systems if it is to be successful in the near future. The AQA has a specific workgroup that focuses on developing consensus in reporting, and CMS is supporting efforts by the AQA, AHIC, and others to assure that interoperable electronic health records systems will support more automated collection and reporting of consensus measures as they become available.

Examples of Quality Measures

Examples of three ambulatory quality measures are based on the results of the hemoglobin A1C and LDL and blood pressure tests for diabetic patients. The clinical evidence suggests that patients who have a hemoglobin A1C test below 9 percent, an LDL less than or equal to 100 mg/dl, and blood pressures less than or equal to 140/80 mmHg have better outcomes. These measures are evidence-based, reliable and valid, widely accepted and supported, and were developed in an open and transparent manner. Evidence indicates that reaching these goals can lead to fewer hospitalizations by avoiding complications from diabetes such as amputation, renal failure, and heart disease.

Two quality measures endorsed by the National Quality Forum (NQF) for heart failure patients include placing the patient on blood pressure medications and beta blocker therapy. Here too, these therapies have been shown to lead to better health outcomes and reduce preventable complications. Together, diabetes and heart failure account for a large share of potentially preventable complications.

In addition to primary care quality measures, other specialties are developing measures. For example, measures of effectiveness and safety of some surgical care at the hospital level have been developed through collaborative programs like the Surgical Care Improvement Program (SCIP), which includes the American College of Surgeons. Preventing or decreasing surgical complications can result in a decrease in avoidable

hospital expenditures and use of resources, and more important, avoiding complications improves the health, functioning, and quality of life of Medicare beneficiaries. For example, use of antibiotic prophylaxis has been shown to have a significant effect in reducing post-operative complications at the hospital level. This particular measure is well developed and there is considerable evidence that its use could not only result in better health but also avoid unnecessary costs. This post-operative complication measure, which is in use in our Hospital Quality Initiative, is being adapted for use as a physician quality measure. Application of this type of post-operative complication measure at the physician level has the potential to help avoid unnecessary costs as well as improve quality.

We also are collaborating with other specialty societies, such as the Society of Thoracic Surgeons (STS), to implement quality measures that reflect important aspects of the care of specialists and sub-specialists. The STS has already developed a set of 21 measures at the hospital level that are risk adjusted and track many common complications as outcome measures. STS is also conducting a national pilot program to measure cost and quality simultaneously, while communicating quality and efficiency methods across regional hubs with the objective of reducing unnecessary complications and their associated cost. The STS measures have been adapted to a set of five quality measures for physicians, such as for a patient who receives by-pass surgery with use of internal mammary artery. Many other specialties have also taken steps to develop evidence-based quality measures.

The Physician Voluntary Reporting Program

As a first step toward aligning Medicare's physician payment system with the goals of quality improvement, CMS launched the PVRP in January 2006. The goals of the PVRP include: 1) developing methods for collecting data submitted by physicians' offices on the quality measures; and 2) providing physicians' offices with confidential feedback reports detailing their performance rate and reporting rates on applicable measures. CMS anticipates that this effort will provide the agency and the physician community with experience in gathering data on quality and help us better understand what may be required in moving toward a system that rewards quality care, not simply volume of care.

PVRP Quality Measures

When CMS conceived of the PVRP the agency decided to draw on measures of quality previously developed in collaboration with the physician community, including efforts by the American Medical Association's Physician Consortium for Performance Improvement (AMA-PCPI), the National Committee for Quality Assurance (NCQA), and other physician specialty societies. Where there were no measures to address specialty services, the PVRP incorporated adaptable measures endorsed by the NQF. We are working closely with various parties, including the Ambulatory Quality Alliance (AQA), to expand the initial set. We anticipate that this cooperative effort, culminating in endorsement by the AQA of an expanded set of measures, will continue to expand the scope of covered services. CMS expects that physicians will continue to be the leaders in the development of performance measures for the various specialties. They are in the best position to understand which measures will represent high quality care and have a significant impact if made available and used within their profession. As they do so, we will be able to incorporate them into the PVRP.

There are currently 16 quality measures in the PVRP. When selecting the 16 measures, preference was given to measures that were endorsed by both the NQF and AQA and that collectively covered a broad range of medical specialties and did not add undue burden to physicians. CMS is working to expand the PVRP measure set beyond the 16 to cover medical specialties that account for the majority of Medicare payments.

We anticipate an expanded set of PVRP measures this fall that physicians can report during the first quarter of 2007. In that effort we are continuing to work with the physician community. The Alliance of Specialty Medicine, for example, has provided CMS with feedback on the implementation of the PVRP pilot program, and has been working closely with its members to develop additional quality improvement and performance measures for the future expansion of the PVRP program. In that effort to expand available measures, CMS focused on those measures subject to the standardized measure development process, and consensus endorsement through AQA and NQF. In addition, CMS entered a contract with Mathematica in September, 2005 to develop physician specialty measures. Mathematica chose the AMA and the NCQA as sub-contractors for this work that is being carried out through the AMA-PCPI process.

PVRP Data Collection

The usual source of clinical data for quality measures is retrospective chart abstraction but this process is costly and burdensome to physicians' offices. As a result, the PVRP was designed to enable physicians' offices to submit quality measures data through the pre-existing administrative claims submission process. Specifically, physicians can submit a predefined set of Healthcare Common Procedure Coding System (HCPCS) codes, commonly referred to as the G-codes, to report data on the PVRP measures. When a physician determines that a particular measure is applicable to the work he or she does, the PVRP is designed to allow use of a single G-code to report on that measure, thus minimizing the burden on the physician.

We anticipate that the use of G-codes to report on the PVRP quality measures will be reasonably straightforward while avoiding the burden of chart abstraction. For example, the HCFA-1500 form currently used by all physicians for Medicare billing purposes (and by many private payers as well) is being used to report the PVRP G-codes, paralleling the process physicians have been using for years to report and bill for the medical services they provide.

The AMA has designed CPT Category II codes based upon this same principle of utilizing the pre-existing administrative claims process. These codes are supplementary tracking codes used for measurement of clinical performance measures, rather than for reporting specific procedures performed in the treatment of a patient. Where available, CMS has incorporated CPT Category II codes for use in the PVRP.

The use of G-codes on the pre-existing administrative claims form is an interim reporting mechanism until electronic submission of clinical data through electronic health records (EHR) is more widely available. EHR will greatly facilitate clinical data reporting by physicians' offices in the future but its adoption is not widespread. CMS is currently able to accept the electronic submission of data for primary care physicians and we are working with EHR vendors to expand acceptance of electronic data beyond primary care. CMS is also exploring the possibility of leveraging pre-existing data base registries. One such registry that CMS is actively exploring is the one developed by the Society of Thoracic Surgeons.

PVRP Feedback to Physicians

One of the purposes of the PVRP is to assist physicians with their own quality improvement goals. Therefore, CMS will be providing physicians' offices the opportunity to receive confidential feedback reports. These reports will be first available in December 2006 and will contain the performance and reporting rates for the PVRP quality measures for which that office submitted data. CMS hopes that such information will provide physicians' offices with the guidance they need to implement their own internal quality improvement programs.

CMS will also be working collaboratively with the physician community in order to gauge the utility and relevance of the information provided to them in the confidential

feedback report. CMS anticipates working with physicians to ensure that the confidential feedback report provides information that is deemed useful, complete, and accurate.

In addition to the provider feedback report, CMS is reaching out to physician communities on many other levels to ensure that they receive needed information and support. A few of the activities that CMS has undertaken include:

1) Local level support through the CMS Regional Offices
2) PVRP email address for questions at PVRP@cms.hhs.gov
3) Informational website support, including Frequently Asked Questions (FAQs), at www.cms.hhs.gov/PVRP
4) PVRP Community collaborative website, to be released in early August 2006. The PVRP Collaborative website will allow participants the opportunity to utilize discussion threads to provide input or seek answers from other participants, including sharing of best practices or lessons learned.
5) Help Desk support for the registration process and PVRP Community collaborative website. The Help Desk is available for support from 7 am – 7 pm (CST) at (866) 288-8912

CMS finds the information provided by the physician community to be very valuable and will continue to explore other venues to offer the physician community the information and support that they need.

Quality Based Payment System

CMS does not have the statutory authority to implement a quality-based payment system. However, the PVRP initiative will give us an opportunity to educate ourselves and our physician partners about what is needed to set up a quality data gathering and reporting system that works best for our patients and that is least burdensome to the participating physicians. We also hope to provide useful information to physicians' offices that will assist them with their professional quality improvement goals. We will continue working with the physician community to increase the number of available measures so that physicians of all specialties will have a set of measures applicable to the work that they do. We are pleased that at this point we have almost 6,400 physicians who have indicated a willingness to participate in the PVRP. Though we would like to see this number continue to increase, the current number of participants is adequate for testing our quality measures reporting infrastructure

Demonstration Projects Focused on Quality

In addition to the PVRP, demonstration projects being undertaken by the Agency are designed to help us understand how to use our payment systems to encourage quality care by our physician partners.

The Physician Group Practice Demonstration

In early 2005, CMS announced the Physician Group Practice (PGP) demonstration. This demonstration is designed to encourage physician groups to coordinate their care to chronically ill beneficiaries, give incentives to groups that provide efficient patient services, and promote active use of utilization and clinical data to improve efficiency and patient outcomes.

Many physician practices and other supportive practices can lead to better patient outcomes and lower overall health care costs. For example, there is good evidence that by anticipating patient needs, especially in those patients with chronic diseases, health care teams that partner with patients and coordinate across physician practices can help implement physicians' plans of care more effectively, reducing the need for expensive procedures, hospitalizations for preventable complications and perhaps even some office visits. Medicare's current payment system reimburses physicians based on the number

and complexity of specified services and procedures that they provide, not how physicians work together to avoid problems in the first place.

Medicare is now testing whether performance-based payments for physicians under the demonstration result in better care. The PGP demonstration is the first value-based purchasing initiative for physicians under Medicare. The PGP demonstration rewards physicians for improving the quality and efficiency of health care services delivered to Medicare fee-for-service beneficiaries. Mandated by Section 412 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, the PGP Demonstration seeks to:

- encourage coordination of Part A and Part B services,
- promote efficiency through investment in administrative structure and process, and
- reward physicians for improving health outcomes.

The demonstration is allowing CMS to test physician groups' responses to financial incentives for improving care coordination, delivery processes and patient outcomes, and the effect on access, cost, and quality of care to Medicare beneficiaries.

Physician groups participating in the demonstration are paid on a fee-for-service basis. However, they will implement care management strategies designed to anticipate patient needs, prevent chronic disease complications and avoidable hospitalizations, and improve quality of care. To the extent they implement these strategies effectively to improve care, physician groups will be eligible for additional performance payments derived from any savings that are achieved through improved care coordination for an assigned beneficiary population.

Performance targets will be set annually for each group based on the growth rate of Medicare spending in the local market. Performance payments may be earned if actual Medicare spending for the population assigned to the physician group is below the annual target. Performance payments will be allocated between efficiency and quality, with an increasing emphasis placed on quality during the demonstration. The demonstration is required by law to be budget neutral.

CMS selected ten physician groups on a competitive basis, representing some 5,000 physicians with over 200,000 Medicare fee-for-service beneficiaries, to participate in the demonstration. The groups were selected based on a variety of factors including technical review panel findings, organizational structure, operational feasibility, geographic location, and demonstration implementation strategy. The groups will be implementing a variety of methods for improving quality and CMS will measure and evaluate the results of each.

Below are preliminary examples of quality and efficiency innovations being put into place by two of the groups participating in CMS' PGP demonstration. Please note that references to results in these examples are based on the organizations' information and not official CMS demonstration results. Therefore, the references should be considered with caution and not interpreted as conclusive.

1. Disease Management Strategies

Park Nicollet Health Services (PNHS) is redesigning its care processes for patients with congestive heart failure and diabetes. Through the use of nurse case managers and information technology, over 600 congestive heart failure patients are monitored daily in order to identify patients at-risk of de-compensating so case managers can follow-up with the patients and/or their physicians regarding next steps, including getting the patients to see their physician that same day. According to PNHS, preliminary results suggest that as a result of this activity, the estimated number of averted hospitalizations for heart failure patients has increased steadily over time.

In addition, clinical care processes have been redesigned for diabetes patients so physicians can treat patients based on today's test results, nurse case managers identify patients overdue for tests or who are not meeting their health goals and work with their physicians on next steps, and certified diabetes educators are available at the clinic via immediate referral to teach patients on how to administer insulin, read meters, use new medications, and coordinate follow-up care. According to PNHS, preliminary results are suggesting that nurse visits with diabetes patients have increased over time and more patients are receiving their required insulin treatments.

2. Transition Management

The Everett Clinic's (TEC's) primary goal is to improve care delivery for seniors through their senior care model that improves post-discharge and emergency room visit follow-up and promotes palliative care for qualifying seniors. Hospital patient coaches focus on improving follow-up care while the patient is hospitalized and an automatic encounter request system reminds primary care physicians to follow-up with recently hospitalized patients within five days of discharge. Palliative care is promoted through the presence of hospice nurses within primary care offices who also provide intense case management and end-of-life planning education. According to TEC's preliminary results, the implementation of the automatic encounter request system could show promise in improveing patient follow-up and decreasing the hospital readmission rate for its patients aged 65 and older. TEC has also indicated a favorable trend in inpatient admissions and believes that both proper follow-up and improved care coordination and palliative care have all contributed to these positive results.

2006 Oncology Demonstration Project

CMS worked closely with the American Society for Clinical Oncology, the National Comprehensive Cancer Network and the National Coalition for Cancer Survivorship to develop a demonstration project that would assess oncologists' adherence to evidence based standards as part of routine care. The categories of data collected include:

- the primary focus of the evaluation and management (E&M) visit;
- whether current management adheres to clinical guidelines; and
- the current disease state.

Participating oncologists and hematologists qualify for additional payments if they submit data from each of the three categories when they bill for an evaluation and management (E&M) visit of level 2, 3, 4, or 5 for established patients. Physicians reporting data on all three categories qualify for an additional payment of $23 in addition to the E&M visit. The results will be closely analyzed by CMS.

The evaluation will use a combination of quantitative and qualitative methods to examine the impact of the demonstration on:

- Medicare spending;
- beneficiary outcomes;
- physician practice adherence to clinical guidelines; and
- financial status of physicians' practice.

In addition, through field assessments and physician surveys, the evaluation will examine how the demonstration impacted the way physicians delivered care to beneficiaries, and the types of modifications they needed to make in order to be able to report the data. The evaluation will include a validation study of physician-reported adherence to guidelines (American Society of Clinical Oncology guidelines and National Comprehensive Cancer Network guidelines).

The evaluation of the 2006 demonstration is being managed jointly by CMS' Office of Research, Development and Information (ORDI) and the National Cancer Institute (NCI). Contractor bids have been submitted for the evaluation and an award is expected to be made by fall 2006. The demonstration is scheduled to be completed at the end of 2006.

Value-Based Purchasing (VBP) and the Private Sector

Ambulatory Quality Alliance (AQA) and Hospital Quality Alliance (HQA) Efforts

Part of an effective value-based purchasing system is provision of information to the public and healthcare purchasers so that patients can make informed decisions about which providers they seek care from. The AQA and the HQA are both organizations made up of a broad cross section of stakeholders (including CMS) that have focused their efforts on improving care by collecting data on agreed upon quality measures in their respective settings, and then making that information available to consumers, payers and health care professionals. The AQA recently announced a number of pilot programs charged with the responsibility of identifying, collecting and reporting data on the quality of physician performance across care settings. The HQA has been reporting meaningful and useful information on the quality of heart attack, heart failure and pneumonia care to patients in more than 4,000 of the nation's hospitals since April 2005 and recently expanded that data set to include information on surgical site infections.

The two organizations recently announced a joint committee to help coordinate some of their efforts. As a first step, they will coordinate and expand several ongoing pilot projects that are designed to combine public and private information to measure and report on performance in a way that is fully transparent and meaningful to all stakeholders. These sorts of efforts are the kind of thing we need to move us to an environment where physicians and other providers are acclimated to the idea that quality measures are important, that they can help them provide the best care to their patients and at the same time, reward them for doing so. That is a fundamental shift away from the way Medicare currently pays physicians.

Integrated Healthcare Association

Value-based purchasing is a concept being tested in the private market as well. For example, the Integrated Healthcare Association (IHA), an organization made up of health plans, physician groups, and healthcare systems, plus academic, consumer, purchaser, and pharmaceutical representatives all in California have been working for several years now to promote the use and reporting of quality measures in physician practices in that state.

California's value-based purchasing program involves approximately 35,000 physicians in 211 physician organizations, who care for over 6 million individuals enrolled in seven major health plans (Aetna, Blue Shield, Blue Cross, CIGNA, Health Net, PacifiCare, and Western Health Advantage). Physicians are rewarded by the plans based on their physician group's performance in relation to clinical quality and patient satisfaction measures, and for investment in information technology.

Earlier this month, IHA announced that compared to 2004, physician groups participating in IHA's VBP program in 2005 reported that they screened about 60,000 more women for cervical cancer, tested nearly 12,000 more individuals for diabetes, and administered approximately 30,000 more childhood immunizations for their patients enrolled in HMO plans.

In addition to the across-the-board improvements on the evidence-based clinical measures, physician groups participating in the program increased their use of IT for such activities as prescribing, monitoring lab results, preventive and chronic care reminders, and electronic messaging. The percentage of physician groups achieving the maximum score for IT use increased by 11 percent in 2005. Prior year results showed that

physician groups that received full credit on IT measures had average clinical scores that were significantly higher than those that showed little or no evidence of IT adoption.

Bridges to Excellence

The Bridges to Excellence program, a multi-state, multi-employer coalition developed by employers, physicians, plans, healthcare services researchers and other industry experts, and supported by the Robert Wood Johnson Foundation's Rewarding Results program is working to encourage significant leaps in the quality of care by recognizing and rewarding health care providers who demonstrate that they deliver safe, timely, effective, efficient and patient-centered care.

This organization is offering participating physicians up to $50 per year for each patient covered by a participating employer or plan based on their implementation of specific processes to reduce errors and increase quality. In addition, a report card for each physicians' office describes its performance on the program measures and is made available to the public.

Physicians treating diabetics who meet certain high performance goals can receive up to $80 for each diabetic patient covered by a participating employer and plan. In addition, the program offers a suite of products and tools to help diabetic patients get engaged in their care, achieve better outcomes, and identify local physicians that meet the high performance measures. The cost to employers is no more than $175 per diabetic patient per year with savings of $350 per patient per year.

Physicians treating cardiac patients who meet established performance goals can receive up to $160 for each cardiac patient covered by a participating employer and plan. As with the diabetes program, cardiac Bridges to Excellence makes available a suite of products and tools to help cardiac patients get engaged in their care, achieve better outcomes, and identify local physicians who meet the high performance measures. The cost to employers is no more than $200 per cardiac patient per year with savings up to $390 per patient per year.

Rochester Individual Practice Association

Health plans are not the only organizations pushing VBP. Physicians have embraced this approach as well, because they recognize that it will reward them for what they want to do, which is provide the best care possible. The Rochester Individual Practice Association (RIPA), a physician-led IPA with over 3,000 participating physicians, 900 of whom are in primary care specialties, has been using VBP principles for several years now. The organization provides physicians' services to more than 300,000 Blue Cross HMO members in upstate New York and its physicians are paid on a capitated basis by the plan.

Physicians in this organization pool a portion of the capitated payments they receive from the HMO. These funds are then reallocated based on the physicians' performance. A busy internist my contribute $15,000 and, depending on his/her performance, receive back between $7,500 and $22,500. RIPA measures patient satisfaction and compliance with a range of clinical standards. Physicians are sent an individualized report three times per year, comparing them to their colleagues. Their year end report includes payment based on how they performed and they are told at that time, how much more they would have earned, had they increased their performance by a given amount.

This approach has produced results. Just for example, RIPA reports that physicians succeeded in reducing the inappropriate use of antibiotics, which resulted in a yearly savings of over $1 million to the HMO. These savings were used to increase bonuses to the physicians. In addition, RIPA identified diabetes management and coronary artery disease patients in 2002 and trended their costs forward. They then compared these projected trends with their actual costs with a VBP program in place. It is notable that pharmacy costs increased due to more intense treatment, but in a very short time, costs for hospitalizations went down, which resulted in a multi-million dollar savings.

Conclusion

Mr. Chairman, thank you again for this opportunity to testify on physician payments within the Medicare program. We look forward to working with Congress and the medical community to develop a system that ensures appropriate payments for providers while also promoting the highest quality of care, without increasing overall Medicare costs. As a growing number of stakeholders now agree, we must increase our emphasis on payment based on improving quality and avoiding unnecessary costs. I would be happy to answer any of your questions.

MR. FERGUSON. Thank you, Dr. McClellan. The Chair recognizes himself for questions.

We are going to have 5 minutes for questions with the committee members this morning, and I will try and set a good example. I am going to ask committee members to try and be good at keeping to their 5 minutes.

Dr. McClellan, just very briefly, you and I had talked about a separate issue recently, and just if you could very briefly address this gain sharing issue from the Deficit Reduction Act. Specifically, when the RFP may be going out for this. We are already a little bit overdue on that, and also, the discrepancy between the interpretation of the gain sharing demonstration project between six States, as was my understanding, or, as some have said, for the demonstration project to include six hospitals. If you could just very briefly touch on that.

DR. MCCLELLAN. Well, let me start by saying that gain sharing, properly implemented, is an important step. It actually does fit in very closely with the topic of this hearing, the idea that we need to help doctors work together with hospitals to improve care, prevent avoidable healthcare costs and complications, is something that gain sharing done right is exactly designed to support.

So, we are looking at the best way to implement the demonstration program, as you said, different Members of Congress have had different interpretations, and we are going to reflect that when we go forward with the RFP and our other related initiatives in this broad area of helping doctors and hospitals work together. We do have other authorities that enable us to promote the same goals of gain sharing, which is supporting payments, increased payments to physicians, when quality improves in overall costs of care, including hospital care go down.

I know how important this is to you, and it is very important to me, because it does fit in with these overall goals of helping healthcare providers work together to improve quality and costs.

MR. FERGUSON. We can expect that RFP.

DR. MCCLELLAN. You can expect it very soon, I think within a matter of a few weeks.

MR. FERGUSON. Okay. Can you please take me through the quality measurement process, from the creation of a clinical quality measurement all the way through the reporting on that measure.

DR. MCCLELLAN. Well, it starts with, the best measures start with physician involvement. Physicians who are practicing have the best on the ground grasp of where there are opportunities to support better care by measuring what we are trying to do, and providing better financial or public reporting support for it. So, most of the measures that have been developed began with medical groups. The American Medical Association has a Physician Consortium that works together to develop consistent measures across specialties. Many medical specialties have also developed their own areas of focus for clinical quality measurement, and the principles that I think are important here, besides physician leadership, are the use of identifying an important clinical area, where a valid measure, a clinically valid measure can be developed, and there is a real meaningful opportunity to improve care.

MR. FERGUSON. How many clinical quality measures should we expect to be reported by any one physician? I mean, is it the goal that every physician, every service that a physician provides be measured?

DR. MCCLELLAN. Physicians provide a very broad range of service, and the programs that have been most successful have identified key areas, common conditions like diabetes or heart failure, where there are clear opportunities for improving care and keeping costs down, and focusing on measures in those areas. Such areas exist in just about every specialty, and that is why I think just about every specialty is developing one or more measures now.

MR. FERGUSON. Some have suggested that we may be jumping the gun a little bit here, that with a focus on clinical quality measurements if data collection can be better with health IT, should we wait a little bit to see how that works before we move to this new phase?

DR. MCCLELLAN. Health IT adoption would definitely help with automatic reporting on quality of care, and that could reduce some burdens for physicians. The problem is, as you know, that most physician offices don't have electronic record systems in place now. So if we want to move forward on providing better support for doctors, to improve care, to do what they think is best, and keep costs down, we really can't wait for broad adoption.

And it is also a chicken and an egg problem. Right now, if we pay for more lab tests and more volume of services, the money is going to pay for these potentially duplicative procedures and less efficient care, rather than giving physicians the financial support they need for investing in health IT. I think when we start moving in this direction, we

can actually encourage the adoption of health IT, and as quickly as possible, reduce any reporting burdens.

MR. FERGUSON. Well, how do efficiency measures differ from quality measurements, and how do they work together? How can they work together?

DR. MCCLELLAN. Well, I think they should work together, and the kind of efficiency that we want to improve is, when I think about efficiency, I think about getting down unnecessary costs, duplicative lab procedures, preventable hospitalizations, and that involves starting with the quality measures. So, you can't look at efficiency in isolation from quality, but if you start looking at episodes of care for common conditions, like heart failure or an elective surgical admission, you can identify ways where you can improve quality and keep costs down.

I mentioned in my opening statement the case of diabetes, where we see lots of examples of patients having difficulty complying with their medicines, and as a result, ending up with kidney failure or emergency room admissions or other problems. The same thing is true in surgical conditions. Surgeons have identified ways to prevent postoperative infections and other complications.

If we can provide more support for that, we can get better quality, and reduce costs at the same time. So, efficiency, properly considered, should go right along with the quality measures.

MR. FERGUSON. I am only 36 seconds over time. Mr. Green. The gentleman from Texas, Mr. Green, is recognized for 5 minutes for questions.

MR. GREEN. Thank you, Mr. Chairman. I would like to again welcome Dr. McClellan.

DR. MCCLELLAN. Thank you.

MR. GREEN. I appreciate working with you in lots of different capacities over the last few years, whether it is the FDA or CMS.

Like a lot of my colleagues, I am concerned that moving too quickly into requiring reporting quality measures would result in more bureaucracy, not necessarily more quality care. And in looking at the 2007 expected physician measures, it strikes me that these quality measures are fairly basic to start with, like checking for cataracts in the ophthalmology specialty, and it seemed like the real measurement of quality improvement would be patient outcomes, yet outcome measures are more difficult to develop, in the sense that they require adjustments for patient complications and other factors.

Now, I know you start with asking doctors to report the basic quality measures. Is there a way, as we move along, to merge both quality and outcome into that quality measure?

DR. MCCLELLAN. There is. That is what we have done with our hospital quality reporting. In 2004, when reporting began, it was mainly on evidence-based clinical practices that we know, if followed, will lead to better outcomes for patients. The hospital quality measure is next year going to expand to include patient satisfaction, which is a really important outcome, and also, some risk-adjusted outcomes for common causes of admissions, like heart attacks. So, there is a gradual progression there.

Thanks to the leadership of some of the physician groups, particularly the American College of Physicians, the American Academy of Family Practice, we actually do have some outcome-related quality measures that physicians feel confident, physician groups feel confident we could start reporting soon.

For example, for diabetes, measures of hemoglobin A1c level. This is a good overall measure of how well controlled diabetes is, and thanks to the physician groups, we can start with that one. But I would expect, gradually and with careful development and leadership from the physician groups, we will see more of those outcome types of measures developed over the next few years.

MR. GREEN. Thank you. Obviously, I have some other questions, Mr. Chairman. I would like to ask one that has been an issue. A lot of my colleagues are quite concerned with the CMS proposed rule relating to documentation for citizenship under Medicaid beneficiaries. And being from Texas, you know our situation. No practicing in California. We are particularly concerned that the rule would cause millions unnecessarily to lose their health coverage. Current law is very clear, stating that a child born in our country is a U.S. citizen. In cases where Medicaid has paid for the child's birth in the U.S. hospital, can you explain why the CMS rule would fail to allow the State to use that claim for payment as proof that the child was a U.S. citizen? It seems pretty standard.

DR. MCCLELLAN. Well, I do want to make sure that this law is implemented effectively. It matters a great deal to members of this committee who, on the one hand, want to make sure that Medicaid benefits are targeted where they need to go, but on the other hand, don't want to impose undue burdens on citizens and Medicaid beneficiaries.

For new births, there are a number of ways that we identified in our regulation, and we are seeking comment on this regulation, too, so we can add to it further, such as using the automatic vital statistics. Texas and other States have told us hey, we do get automatic records, as you are saying, when a birth occurs. Let us just link to that data that we already have, rather than require someone to go through a pay per base process, and that is definitely a process that States can set up.

We are monitoring this very closely, Congressman, and if there are specific suggestions for how we can improve implementation, we would be glad to do it, but using existing State data, like data on vital statistics of birth, is something that can be part, can be provided for documentation.

MR. GREEN. That seems like an easy one. Again, if a child is born in Texas, they are a citizen, no matter what the citizenship of their parents are. And according to the Administration of Child Welfare Policy Manual, States are currently required to verify the citizenship and immigration status of all children receiving Federal foster care. I have no problem with that, but this verification mandate, it seems like CMS has failed to exempt children in foster care from those with citizenship requirements, the same way SSI beneficiaries and Medicare beneficiaries are exempt.

Is there a way we could make those regulations apply to both--again, we are talking about some obvious cases, a child who is born in our country would have the same documentation requirements as maybe an SSI beneficiary.

DR. MCCLELLAN. Well, interpreting the law as written, and working with Members of Congress to make sure we got that right, it did appear to us that SSI beneficiary seniors were, dual eligible beneficiaries were not subject to the same restrictions. For foster care beneficiaries, again, there are a lot of steps that States can use. States often have records in other parts of their databases since the foster children will be eligible for a number of services, they have vital statistics records, and so forth that can be used, and the rules build in a lot of opportunities for States to take the time needed to gather the information. It doesn't require immediate provision of proof of citizenship in order for services to continue.

So far, we have seen States moving forward on implementing this effectively. We will keep watching closely to make sure that foster children and every Medicaid beneficiary who is entitled to services continues to get them.

MR. GREEN. Okay. Mr. Chairman, let me just have one followup, and we will work with you on this.

DR. MCCLELLAN. Be glad to do that.

MR. GREEN. Like in a lot of other cases.

MR. FERGUSON. I would just ask that it be very brief.

MR. GREEN. Okay. The CMS requires the original documents for proof of citizenship, and I know it may be difficult, but for parents, for example, to mail in their driver's license or their original birth certificate to the State for the eligibility process, it can take weeks. I know you can get a certified copy of your birth certificate, but again, that takes weeks.

But for an adult to mail in their, I don't want to give up my Texas driver's license, except to a law enforcement officer--

DR. MCCLELLAN. I don't either.

MR. GREEN. --who asks for it. So, I think there might be some effort that we can do to look at that on verification.

DR. MCCLELLAN. There is, and States like Texas that have set up good verification systems for their driver's license can actually provide that data automatically. The State can do it. They can link to their driver's license databases, so that nobody has to mail anything.

MR. GREEN. Okay. Thank you, Mr. Chairman.

MR. FERGUSON. Speaking of Texas, the distinguished Chairman of the full committee, Mr. Barton, is recognized for questions.

CHAIRMAN BARTON. Thank you, Mr. Chairman. It is good to see somebody from New Jersey in the chair. That is a good thing.

Dr. McClellan, thank you for being here, and thank you for trying to implement that requirement in our reform act from last year that tries to funnel as many possible Medicaid benefits to U.S. citizens. I know that is a radical idea, but I think it is important. We don't want to make the burden too hard on the States to prove citizenship, but prior to that, the States couldn't even ask a citizenship question. Given the skyrocketing costs, I think it is fair to the taxpayers and to the people that to the largest extent possible, those benefits go to our citizens. So I appreciate your efforts in that regard.

On the subject of today's hearing, could you explain, in layman's terms, what a quality measure is? What does that really mean? We are having all this debate about pay-for-performance and physician quality measures. I don't really understand what a quality measure is.

DR. MCCLELLAN. Mr. Chairman, done right, it is what we want our healthcare system to provide, and it is what doctors want to do in delivering medical care. Right now, we measure a lot of things in how we pay for Medicare benefits. We measure the number of lab tests you do, the number of visits you have. There is a whole lot of paperwork around that. That is not what healthcare is really all about. Healthcare is about keeping people well, preventing complications from their chronic diseases, helping them deal with the consequences of serious illnesses.

And quality measures are indicators or ways of making sure that we are supporting what we really want in healthcare. When they are developed by physicians, and developed in the private sector, so they can be implemented feasibly, they can help us do a better job of providing support to physicians who want to deliver the best care possible, and they can help patients make better decisions about their care. When you are choosing where to get a car, where to get any other product in our

economy, you like to get good information on the quality of the product and the cost of the product.

CHAIRMAN BARTON. Does a quality measure, to be valid in a medical sense, have to be replicable and developed by methods that are standard? I mean, that is provable, testable, verifiable?

DR. MCCLELLAN. That is right. Those are all parts of measures that are valid, and unless those steps are taken, I doubt that any physician would regard this as a worthwhile indicator of how they are doing in providing care.

CHAIRMAN BARTON. So, it is supposed to be something that is a fact, that is accepted, that if you meet that standard it is almost certain or certain that something good is going to happen, or nothing bad will happen.

DR. MCCLELLAN. That is the idea.

CHAIRMAN BARTON. Okay. Now, you have some demonstration programs that are underway trying to develop these quality measures. Isn't that correct?

DR. MCCLELLAN. Yes, sir.

CHAIRMAN BARTON. All right. Are there any results, or are there any results that have been developed in these demonstration projects? If there are, what does the evidence that has been developed to date show?

DR. MCCLELLAN. Well, let me give you a couple of examples from our Physician Group Practice Demonstration. This is where we are paying physician groups more when they do what they are trying to do, which is get better outcomes for their patients and lower the overall cost of care. The measures that we are using in this demonstration include measures like best practices for caring for patients with diabetes and heart failure, and promoting the use of preventive care, screening for cancer, screening for heart disease and diabetes.

What we have seen in the early results from these demonstrations is reports from each of the physician groups that they are taking steps like investing in health IT systems, or using nurse practitioners to help do better on these quality measures, to help their healthcare system improve. They are making investments that didn't make financial sense under Medicare's old payment systems. You know, when we paid more for more lab tests, they wouldn't get the money they needed to invest in health IT.

Now, when we are paying more for better results for diabetes patients, health IT systems make financial sense. They can make ends meet in the practice, and do more with it. So, they are starting to see better results in patient care, particularly for diabetes and heart failure, and they are changing the way that they practice in ways that are good for patients, according to these physician groups.

CHAIRMAN BARTON. Okay. Well, I have 10 seconds, so I need to get to the $64,000 question, which shows how old I am, that I would remember that phrase.

What would happen if we do away with the SGR system that we currently have for physician reimbursement, that we are not using, for all intents and purposes. We substitute something for it every year, and it is that time of the year to do that. We went to this MEI index that has been proposed by MedPAC, but for this year, just increased payments from last--switched to MEI, maybe give a 1 percent increase, and then allow balanced billing.

DR. MCCLELLAN. I don't think there are formal estimates of the impact of balanced billing. If all we did was switch to MEI or MEI minus 1, that would lead to much higher projected costs, because we wouldn't be doing anything about the rapid increases in volume of services that we are seeing. We wouldn't be taking steps directly to promote better quality care, which again, according to many of the physician groups, we really need to do.

CHAIRMAN BARTON. Do you have enough confidence in MEI as a system, just as a system, that if we just scrapped SGR? It is not working, it is not going to work, we can't fix it, so let us just do away with it. Is there enough confidence in MEI that we could use that as the base, and then play with it plus or minus?

DR. MCCLELLAN. Well, it would need to be combined with some other important steps to promote better quality and to keep costs down. You mentioned balanced billing. That is one idea that could potentially have an impact on how people use services. Quality reporting, so that people can make more informed decisions about their care, could make a difference. I know Congressman Burgess, Congressman Norwood, and others have ideas for promoting quality improvement efforts in other ways at the same time.

We very much want to work with this committee to take steps in the direction of not just paying more for the same physician payment system, or just going to MEI, but making sure we are paying better, by promoting--again, doctors have some great ideas for keeping overall costs down and improving quality of care, and that is what we really want to support.

CHAIRMAN BARTON. Well, does the Administration support us doing something structurally reforming the system this Congress?

DR. MCCLELLAN. We do. We want to be careful, though, that we are promoting quality, and keeping overall costs down at the same time. If all we do is add in more money to the physician payment system, premiums are going to up. Getting rid of the MEI system alone would increase costs over 10 years for Medicare by more than $240 billion,

according to our estimates, and that means probably $80 billion in additional costs for beneficiaries. We have got to do better than that.

CHAIRMAN BARTON. Okay. Well, I thank you, Doctor, and as you know, Ways and Means also has jurisdiction, but I think Chairman Thomas shares my frustration with the current system, and we will make a serious effort to work with you and the Administration and his committee to try to structurally change the system this year.

DR. MCCLELLAN. Thank you very much. We look forward to working closely with you.

CHAIRMAN BARTON. Thank you, Mr. Chairman.

MR. FERGUSON. Ms. Eshoo is recognized for questions.

MS. ESHOO. Thank you, Mr. Chairman. Nice to see you in the chair. Good morning, Dr. McClellan.

DR. MCCLELLAN. Good morning.

MS. ESHOO. There was some mention of, on your part, and I think some of the members about HIT. There is a bill from this committee that is going to be on the floor today, and I want to link HIT and what really isn't in the bill, relative to interoperability, to the whole issue of this pay-for-performance issue.

My observation of where you all are on this is that there really isn't any meat on the bones. I think you have to kind of pull up the emergency brake on this thing, and really work it through, and I don't think it is ready for primetime, and most frankly, if you are going to rely on HIT to implement it, you know what the bill has in it that is on the floor today? Three years.

So, it is not forthcoming. I tried to amend the bill, but the Rules Committee rejected the amendment to speed this up. I believe in HIT, but if there is not interoperability, it simply is not going to work. Hospitals and our entire healthcare system have to be able to be connected to one another in order to receive information and talk to each other. I mean, it is as simple as that.

So, the two are not meshing, and I think that there has to be a lot more work done on that. Having said that, I want to turn to an issue that you and I have gone round and round on, and that is the whole issue of the geographical locality payment system. You, I think, have an appreciation, even though nothing has happened, that it is more than 30 years overdue. You, I believe, have the ability to implement an administrative solution to the problem. I think you are aware of the proposal that has been forwarded by the bipartisan California delegation which allows counties whose individual county geographic adjustment factor exceeds its locality geographic adjustment factor by 5 percent, to move to a new payment locality, and be reimbursed at their own

appropriate levels. The plan also provides for automatic updates every 3 years, and establishes a hold harmless provision for rural counties.

So, my question is have you considered this proposal? Can CMS support it, and implement the change effective in 2007? Again, I believe you have the ability and the authority to implement an administrative solution. I am told that CMS will not mandate locality changes nationally until it receives the approval of every State medical association. Is this the case?

DR. MCCLELLAN. Well, as you know, we can only implement reforms administratively that are budget neutral, so that means that if we take steps to increase payments in certain counties, there are going to be doctors in other counties who will face payment reductions, and so, that is why it is helpful for us to implement these changes successfully with having support from the physicians who are going to be affected by the changes, and the State medical societies is one group--

MS. ESHOO. Right. Now, if the medical association supports it, what does that say to you?

DR. MCCLELLAN. That the physicians who might be adversely affected agree--

MS. ESHOO. Yeah, CMA has endorsed this.

DR. MCCLELLAN. --this is an appropriate step. Well, as I understand it, the proposal that CMA has endorsed is a legislative proposal. It is not one that would be--

MS. ESHOO. Well, would you support it?

DR. MCCLELLAN. Well, it would have additional costs. We would want to look at ways that those costs would be paid for. We are absolutely for, as you know, I have spent a lot of time on this with you, steps to make payments more accurate for physicians. As far as I know, though, the CMA or anyone else has not identified where these additional costs would come from.

MS. ESHOO. The last time we had a conversation about this, Dr. McClellan, was last year, late last fall. I spoke to you before we went home for our Thanksgiving vacation. You were going to talk to and meet with Chairman Thomas, and get back to me. And it is wonderful to see you today, but--

DR. MCCLELLAN. It is good to be back.

MS. ESHOO. I haven't heard back from you. So, what was the upshot of your conversation with Chairman Thomas at that time? That was last November.

DR. MCCLELLAN. Congresswoman, we received a letter from Chairman Thomas suggesting that we collect some additional data on this problem this year, and we are working on this, as well as GAO, and I believe MedPAC, and then report on that--

MS. ESHOO. How close are you to--

DR. MCCLELLAN. They wanted a report on that--

MS. ESHOO. --completing the report?

DR. MCCLELLAN. --in 2007, with proposals that could be implemented in 2008. So, that is one of the steps that we are taking. We have also--I also sent a letter to Jack Lewin, the head of the CMA, earlier this year, and met with him earlier this year, asking him if they had any administrative proposals that they wanted us to consider or put out for public comment with our physician rule this year, and the answer was no. There is this legislative proposal that you mentioned, which is part of the process that we are doing in this study, and I know the CBO and MedPAC--

MS. ESHOO. So, your answer to this--

DR. MCCLELLAN. --are looking--

MS. ESHOO. --entire issue is, is that hopefully, by the end of this Administration, something might be done. That is--

DR. MCCLELLAN. Well--and I would like to spend more time, I would like to get something done sooner.

MS. ESHOO. Can you?

DR. MCCLELLAN. We have talked about--well, we talked before about leadership on this issue. Leadership only works when there are other people who are following in the same direction, and at this point, many of the physician groups in California have objected to this change. CMA has specifically said they do not want an administrative solution. They only want the legislative solution, which would come with, I think, something like $10 billion in additional costs. So, that is higher Medicare costs, higher premiums for beneficiaries. We really need to look at that carefully. I will keep working as closely as I can with you. I think this is--many of my physician friends, my colleagues, are affected by this in Northern California. As you know well--

MS. ESHOO. Only when you leave are they going to lynch you.

DR. MCCLELLAN. Well, they are--

MR. FERGUSON. The gentlewoman's time--

DR. MCCLELLAN. They are letting me know now.

MS. ESHOO. Yeah, right.

MR. FERGUSON. The gentlewoman's time has expired.

MS. ESHOO. Thank you.

DR. MCCLELLAN. Thank you.

MR. FERGUSON. Dr. Norwood is recognized for questions.

MR. NORWOOD. Thank you very much, Mr. Chairman.

Dr. McClellan, we have had our ups and downs over the years, but when you do good, you do good, and I want to congratulate you and CMS on the fine job I think that you all have done in working out this

problem of non-citizens receiving Medicaid in this country. The law of the land says that only citizens of the country should receive it, and I get a little discouraged when people come here and nitpick about it. I think you have done a great job. Next year, we should have an oversight hearing, and perhaps make some changes in it, but you are doing the right thing, and you handled it beautifully, and I do appreciate that.

DR. MCCLELLAN. Thank you.

MR. NORWOOD. Now, having said that, tell me which country in the world you think has the best healthcare.

DR. MCCLELLAN. Our country, without question.

MR. NORWOOD. I think so too. Does that imply we have quality healthcare in this country?

DR. MCCLELLAN. We have very high quality healthcare. We also have a lot of opportunities to do even better at a lower cost.

MR. NORWOOD. Well, that is the implication here. That is what the bureaucrats are saying, the people outside of healthcare, and I know you all love to bring in oh, this practicing doctor's group says, this specialist group says. I would like for everybody here not to get confused. Why they are cooperating with you is because you won't pay them costs for what they do now, and they don't have any choice but to cooperate with you, because they are facing a large cut coming up. So, try not to trick yourself into thinking everybody that is practicing medicine out there today agrees that bureaucrats stuck away in Baltimore and in Washington, D.C. actually know how to improve healthcare in this country.

I frankly think a lot of what is said about pay-for-performance, Dr. McClellan, is a slap in the face to our physician community, who does, indeed, have the best healthcare in the world. Now, everybody would agree you can improve on it. You can start by paying for preventive procedures. You know, how dumb is that? How long has it taken us to figure that out, that we ought to be paying for prevention? But we don't do it. You might even consider paying some of these folks' costs for what they do. You would be absolutely surprised, maybe, what they can do if they just don't have to figure out how to stay in business, because you pay them less than it costs to do the procedures.

And I am not telling you something you don't know. You know that is true.

DR. MCCLELLAN. And you know very well the law that we are implementing that pays at these rates that are just, like I said, it is not sustainable.

MR. NORWOOD. What you are doing is paying them for what they already do. If you don't believe me, let Dr. Burgess get the microphone in just a minute, or I can line up doctors from here to Baltimore. They do

all this stuff you are talking about. Who is filling out these forms that you say we have increased quality over the last 5 years? Who filled those forms out?

DR. MCCLELLAN. That information comes from the physicians and the group practices and the hospitals and their practices.

MR. NORWOOD. They don't put a notation at the bottom, we've already been doing this, because they want you to finally start paying them something. I mean, we just need to be honest with ourselves about this. I wasn't very happy with your definition to the Chairman about what really is healthcare quality. Now, do that again for me. Explain to me, at the end of the day, what we are testing here. And maybe start by telling me, does healthcare quality mean outcomes? Does it mean whether the patient lived or died? What does healthcare quality mean?

DR. MCCLELLAN. Healthcare quality has many aspects, because as you know, from talking to many practicing physicians, different patients have different needs. Healthcare quality is about getting the right care to the right patient at the right time, that often will result in better outcomes. There certainly are a lot of preventable complications that happen today when people don't get good quality care, but it depends a lot on the circumstance of the individual patient.

MR. NORWOOD. Excuse me to interrupt. Let us stop right there for a second now. That is true, but that doesn't necessarily mean you can make that happen from Baltimore, nor does it mean you can make that happen from a physician's office. That, in itself, is complex, because a lot of that has to do with the person being treated. But it is pretty hard to figure that out on forms sometimes. But excuse me for interrupting. Go ahead and finish this definition of quality. I am trying to understand it.

DR. MCCLELLAN. Well, I agree with your point about we can't make this happen from Baltimore. My concern is that the way that we pay now actually gets in the way of this happening. I have talked to doctors, I was in practice myself. I filled out those forms. It can be very frustrating to go through a lot of paperwork, and then hardly get any money to be able to make your practice ends meet, and not get paid for what you really know can make a difference in preventing complications and keeping a patient well.

Now, our current system doesn't do that. It is a lot of paperwork, as you said. It is not sufficient payment, even though the costs have been going up at double digit rates, even though Medicare premiums for beneficiaries have been going up at double digit rates, we are working on trying to find a way to do this better with a lot of leadership from the physicians, including some of those practicing physicians. It is not easy, but I can tell you our current system isn't getting the job done.

MR. NORWOOD. Well, that is the system that you set up in Baltimore. I mean, you have been telling doctors how to practice. You have been setting their fees for a long time, and you tell them how to practice through their fees. Now, we are fixing to do the administrative part for the physician's office, so let us understand what has caused this problem to start with.

I see it, Mr. Chairman. Thank you very much.

MR. FERGUSON. Mr. Brown is recognized for questions.

MR. BROWN. Thank you, Mr. Chairman, and thank you, Mr. Green. Dr. McClellan, nice you see you again.

DR. MCCLELLAN. Nice to see you.

MR. BROWN. I understand the Administration wants--and it is a bit of a followup on Dr. Norwood's questions, is sort of the general area--wants to link physician payments to the quality of care they provide, but my understanding is that Medicare doesn't have, yet, consensus measures, validated by the National Quality Forum and the Ambulatory care Quality Alliance, that could be reported by each physician specialty. Is that right?

DR. MCCLELLAN. There are a number of measures that have been validated by the NQF and AQA for many specialties, not all, and many specialties are in the process of getting measures through that consensus process. The measures start with the physician groups, and then get consensus from other stakeholders, insurers, businesses, consumer groups. That process is ongoing now.

MR. BROWN. But I assume we are a long way away from having them across the board for all physician specialties.

DR. MCCLELLAN. Well, when we started with hospital quality measurement, we didn't have measures of hospital quality for everything. You may remember in the Medicare Modernization Act, hospitals got paid a little bit more for reporting on 10 measures of quality. Over time, that has grown, and next year, we are going to see a much broader range of quality measures, including patient satisfaction and some important outcomes of care. This is a gradual process, and we are not trying to rush into anything. On the other hand, if we don't do something to help physicians deliver better quality care at a lower cost, we are going to continue to see rising Part B spending and rising Part B premiums for beneficiaries.

So, that is why there is some urgency. At the same time that we want to be careful in supporting physician groups and moving this effort forward.

MR. BROWN. The Medicare carriers that process Medicare physician claims are undergoing, my understanding is, a massive consolidation, though, and will be hard pressed to provide both training and education

for doctors to make the necessary systems changes needed to implement any new physician reporting systems in January. Is that generally right?

DR. MCCLELLAN. The reason for the reforms in how we are paying our contractors that process claims is because we want to do a better job of getting claims processors, that gives physicians what they need: high quality service, accurate payments, timely payments. The contractors that are going to be rewarded, and they are going to expand in these processes, are the ones that are doing the best job. We are taking a performance-based approach to supporting doctors and hospitals in the program, really for the first time. So, I think it could actually help the doctors and the hospitals get better service. That is certainly the goal.

MR. BROWN. So, how does--I am a bit confused how this adds up in enabling us to gauge or measure pay-for-performance. We have got a lot of physician specialties where the work is not yet done. You compared it to hospitals. There are a few thousand hospitals. There are 800,000 doctors, so it is a more complicated process. We have the consolidation of the Medicare carriers. How does this add up so that we can measure pay-for-performance?

DR. MCCLELLAN. It adds up that we are giving doctors better service in claims processing and the administrative support they need to get paid for their service. Right now, there are some very divergent error rates and times for processing among the contractors that pay for physician services and hospital services. At the same time, physician groups are helping to lead this effort towards paying better for better care. If you put those two together, what I am aiming for is better service for the physicians and hospitals in Medicare, and better payments for what it is that they think is really important to improve quality and keep overall cost down.

MR. BROWN. Okay. Let me shift in my last minute to Medicaid real quickly. And on Wednesday, a letter was sent to Secretary Levitt, signed by all 205 House Democrats and Bernie Sanders, opposing the regulatory cuts the Administration has proposed on Medicaid. I have copies of all these letters that I am going to mention, if you would like a second copy.

These cuts, as is pointed out in the letter, can harm children's access to services needed to learn in schools, harming hospitals, nursing homes, and facilities that care for the indigent. There was a letter May 8 signed by 83 House Republicans opposing the $12 billion. I have that letter, too. Two other House Republicans wrote separate letters, bringing the total to 85. That is 291 House Members opposing these cuts. I have a letter dated July 20, signed by 50 Senators of both parties opposing any action by the Administration to move forward with these administrative cuts. The National Governors Association also wrote a letter opposing these cuts as well.

There are not too many examples of that kind of broad-based support, majority of the House, half the Senate, and the Governors Association so united in opposition to an Administration's potential administrative action. Given this Congressional concern and the concern of so many others, can you assure this subcommittee that your Administration won't move forward to implement the regulatory cuts to Medicaid outlined in the President's budget?

DR. MCCLELLAN. Well, Congressman, I can assure you that as we move forward, we will do it taking account of any concerns that are raised about potential harms. There are many examples, as you know, in Medicaid spending not going for the intended purposes of improving care for people who the most vulnerable members of our society. We have seen that we can work with States to redirect spending, and in some cases, save money while delivering better care.

I was very pleased that Secretary Levitt and Governor Romney yesterday were able to announce the approval of a waiver in Massachusetts that has the potential to expand coverage to everyone in the State, because we were taking dollars that were going in some potentially concerning directions, towards high payments for institutions, excessive emergency room care, and we are redirecting that to where it really needs to go, delivering better benefits for people with Medicaid, giving them control over getting preventive services, getting care in the community.

That is the purpose of all of our steps in improving the Medicaid program. I am very pleased we have been able to expand coverage by taking these steps and make the program more sustainable at the same time, and we are going to bring that same care and caution, and close analysis, to moving forward on any of the Medicaid regulatory reforms.

So, you will hear more from us about this, and I will look forward to discussing these steps with you further.

MR. BROWN. Mr. Chairman, my guess is that the people that signed those letters aren't convinced that they won't do significant damage when they make these cuts--

MR. BURGESS. [Presiding] Right. I would remind the gentleman this is a hearing about Medicare reimbursement rates, and we are under some time constraints.

I will recognize Mr. Shimkus for 5 minutes for questions.

MR. SHIMKUS. Thank you, Mr. Chairman. Dr. McClellan, it is great to have you here, and why would you volunteer to have this job? Sometimes, I don't know.

DR. MCCLELLAN. Thank you.

MR. SHIMKUS. But I know your heart is in the right place, and these are always difficult challenges. What happens when doctors decide not to treat Medicare patients because of the reimbursement schedule?

DR. MCCLELLAN. Well, when that happens, that is clearly a quality of care problem. If patients in Medicare don't have access to the physicians they need, primary care practitioners, specialists, their healthcare will suffer, and that really puts their health in jeopardy. That would be a real concern.

MR. SHIMKUS. Yeah, I have always, and a lot of the folks in the audience, know that I am really blessed to be on this committee, but it is one of the most frustrating ones, because you really have providers who, you know, they love their job, they love providing healthcare to individuals, and the reimbursements are always out of whack, and one of the reasons are we are a big provider of healthcare to Americans. I mean, we are a big payer, and Medicare and Medicaid actuarially can't sustain itself. We have got to figure out a way to do that.

In the private sector, in the competitive market environment, price is determined by, I mean, a consumable good, the consumer chooses, based upon cost and quality of care. I always believe it is best for the individual in a free market society to make that decision, because those are consumers that want higher quality, they will pay a higher cost. But when you have a big Federal bureaucracy that is trying to manage that, that is really, I don't envy, I don't know how you really do it, because I always go back to the individual consumer, because that is where the responsibility should fall upon.

Now, we know we have consumers that are very diligent in looking at their payments and their bills, and they call us when they see billing questions and stuff, but a lot of them, we have developed a system where the public, especially those under these programs, really aren't as active as we would like them to be in what I would think is a consumer-driven--and I think healthcare across the country is moving to the point of wholeness and wellness. Even in the insurance industry, if we keep people well, keep healthy lifestyles, that affects our bottom line in the future.

So, I mean, that is my little filibuster, and that is where we want to go, but there is a lot of perceived damage along the way, and I don't know if we'll ever get there. I don't know how a large, bureaucratic pricing control system really encourages individuals to shop around and know their doctor, get advice and counsel, address wellness and wholeness issues, and how that has empowered in the individual.

Again, that is just my statement for the record, but I need to ask about a letter that Tom Allen and I sent, which is also coauthored by 40 Members of Congress who are requesting an Administration and budget

neutral correction to the practice expense calculations for cardiothoracic surgeons, asking you all to restore reimbursement to those surgeons for the clinical staff that they bring into the operating room. Can you comment on that letter and that request?

DR. MCCLELLAN. I don't have the letter in front of me. I would be happy to get back to you in more detail. I can tell you we have been working closely with the thoracic surgeons who have some great ideas that they are actually implementing to get to better reimbursement, including reimbursement that would pay better support for the whole surgical team, to prevent complications and get better outcomes for the operations. The Society of Thoracic Surgeons in particular has helped the way in some of these efforts to identify opportunities to improve care.

Many of the surgical groups have written me, have written the committees, to say that look, better care isn't more expensive. We can do this better, we need to focus on--surgeons are very outcome focused. You know, they want to get fewer complications and better results for patients, and they have got some good ideas about how to do it. We don't provide enough support for that now, and just going back to your earlier point, that is why I have been in this job for the last couple of years, because I firmly believe we can do better by getting better measures of what it is that we really want in healthcare, that patients and doctors can use, and by putting our money behind those efforts, rather than these bureaucratic processes paying for each individual lab test, and regulating the prices, and bringing them down and so forth.

We can do a lot better than we are doing now. It is not easy, but it can clearly happen. We saw it with Part D, when people chose the drug plans, their premiums are 40 percent lower than had been predicted, or if the Government had designed the system and implemented it themselves. So, there were lots of opportunities to help the cardiothoracic surgeons and any other physician group do what they want to do, which is deliver better care, and prevent complications and unnecessary costs.

MR. SHIMKUS. Thank you, and I appreciate your service. And I also appreciate the service of those who are in the hearing room, providing, really a quality of care to our citizens. Chairman, with that, I will yield back.

MR. BURGESS. I thank the gentleman for yielding back. The gentleman from Maine, Mr. Allen. The gentleman from Tennessee, Mr. Gordon, you are recognized for 5 minutes for questions.

MR. GORDON. Thank you, Mr. Chairman, and thank you, Ranking Member. And Mr. McClellan, thanks, or Dr. McClellan, thanks for joining us today.

As I have said on a number of occasions, I am very concerned that we are on the verge of national access to healthcare crisis. I witnessed firsthand in Tennessee, when TennCare, which was well intended, was rushed into play without giving adequate stakeholders thoughtfulness, and again, it was a money sort of deal. But it has been counterproductive. I don't want to see that happen on a national level, so we do need to think through these well intentioned approaches.

We had a hearing the other day concerning defensive medicine, and it was pretty well acknowledged that that is an expense to this country, and I am concerned that if we don't thoughtfully look into this pay-for-reporting plan, that you know, one program doesn't fit all specialties.

DR. MCCLELLAN. Right.

MR. GORDON. And if we are going to have a 10 point plan, and we are going to get the same type of defensive medicine, by virtue of doing maybe number 3 and number 7, which really isn't needed in specialty 24, or whatever it might be.

So, with that editorial, let me get into my question. In your testimony, you inferred that since some hospitals are reporting in Medicare, it would be no problem for physicians to report as well. However, I think there may be some differences in these two provider types. Reporting for physicians won't be as simple as some make it out to be.

For example, isn't it true that most if not all hospitals have an infrastructure in place to report this information to CMS, yet many physicians do not have the health information technologies necessary for reporting, and additionally, isn't it true that while there are only a few thousand hospitals in the country, there are more than 800,000 physicians in many different specialties, providing many different types of care? And additionally, I don't disagree that we need to work toward getting physicians to report information, but I don't think it is quite as simple as applying what the hospitals are doing, to doctors. I believe that some more work has to be done, and isn't it true that we do not yet have an approved quality measure for all physicians' specialties?

And finally, since we have so many different physician specialties within Medicare, and we only have 5 months to go before January, what really do you expect to get done in January, and what happens if half of the specialties have worked out a program and the other half haven't?

DR. MCCLELLAN. Congressman, those are all very good questions that we are working very hard with the physician groups and many other stakeholders to address. That is why we are implementing a voluntary reporting program. Right now, we have got thousands of physicians participating who don't have electronic records, in reporting on some of the quality measures that have been through this process, that the doctors

think are valid and important ways of measuring the quality of care. They are reporting on, through the claim systems, not through electronic records, that is the most feasible approach.

MR. GORDON. And I know, and you have mentioned that it is going well. So, what do you expect on January 1, that you are going to implement, and what is going to happen if all the specialties--

DR. MCCLELLAN. Well, first of all, we are not implementing anything unless it comes through you, because we don't have the authority to implement any kind of mandatory program on quality reporting, or any tie of our payment systems to paying more for reporting on quality, without Congressional action. We can do pilot programs. We can do voluntary programs, and that is what we are doing now. What I can tell you is that 34 specialties have developed measures that can be reported, using claims-based systems, that are being evaluated right now in these pilots, in these voluntary reporting systems. There are only five specialties that don't have any measures. There are more of these measures in process, and what I can also tell you, you are right. Time is short. It is only 5 months away. But the only other alternative here seems like is just putting more money into the current system, which means higher costs for everyone, and higher beneficiary premiums.

By the way, going back to your point about liability, I think you are exactly right. We could save billions of dollars while improving quality of care, by implementing liability reform now. There is strong evidence of that. CBO will score the savings. That would be one way to pay--

MR. GORDON. Well, I agree, but in retrospect, looking at what happened in Tennessee, I think most folks would have said we wish we had waited another year to get it right, and so, I guess my question to you, are you going to oppose any type of increase in physician reimbursement, if we don't have it ready to go right this year?

DR. MCCLELLAN. The Administration's position is that we want to see budget neutral reforms in physician and other payment systems, the payment reforms that don't increase costs of beneficiaries and taxpayers, by providing better support for quality care. This is going to be a gradual process. Not everything is going to be implemented in one fell swoop on January 1. That is what has happened with hospitals--

MR. GORDON. I guess the only thing that will be implemented under what you are talking about is no increase in physician reimbursement. That is the only thing that we know for sure that you are proposing.

DR. MCCLELLAN. Well, we know that reporting on quality can lead to better care. We know from the pilot programs that we have implemented and that the private sector has implemented, that many

Medicaid programs have implemented, that you can prevent costly complications, coordinate care more effectively, avoid unnecessary costs.

MR. GORDON. These are all anecdotes, but you are talking about changing a whole system. Thank you, Mr. Chairman, for your time.

DR. MCCLELLAN. We would want to do it gradually, not rush into anything all of a sudden on January 1, and you have some very good points.

MR. BURGESS. Thank you, Mr. Gordon. You yield back, I presume. I do want the gentleman from Tennessee to know that there actually is a lot of work going on on the ground right now, H.R. 5866 is a House bill that provides a framework for dealing with a lot of these issues. It repeals the SGR, replaces it with MEI, and builds on the work that is already being done by various quality organizations, such as the AMA and our friends in the Medical Specialty Alliance. It builds on the work that they have already been doing on the parameters that were laid down with Mr. Thomas and Mr. Grassley last year.

So, there is work going on in that, and it is not just the inevitable 4.4 percent negative update that we faced January 1, which is the only certainty. If the committee is willing to do its work, and the Congress is willing to do its work, I believe this is something that we can get done this year.

MR. GORDON. I agree, Mr. Chairman--

MR. BURGESS. It is incumbent upon us.

MR. GORDON. --that progress is being made, but--

MR. BURGESS. Reclaiming my time, because our time is short.

MR. GORDON. Did you have time? I thought you were editorializing.

MR. BURGESS. Oh, no, I guess I was. I will be happy to yield.

MR. GORDON. Well, I would just follow the footsteps of that great philosopher that once said "No wine before its time." This may very well be a good program, and we are making progress, but I have seen a disaster in Tennessee by not implementing it at the right time, and so hopefully, we can get it right.

MR. BURGESS. But you also acknowledge the pending disaster and the crisis of access that you so eloquently alluded to that will occur if we don't fix it, and again, I think we have available to us the minds that can help us do this. As Dr. McClellan so correctly pointed out, it is an incremental, it is an evolutionary process, and medicine is constantly evolving, constantly changing.

The practice that I left in 2002 was vastly different than the type of medicine I practiced in 1981, and it happened slowly. It wasn't painful. The types of operations I was doing in 2002, I would have never dreamed I was going to do in 1981. It is just part of the process. No one

came to me and said you have got to do it this way, because it is better quality, and you get patients out of the hospital faster. It was just it was the right thing to do.

We had better start my time. I was asked yesterday if I had any additional question, and actually, I had an additional page of questions. I have a page of questions that I am going to submit in writing, because the 5 minutes does go very fast, and would ask for a response for that.

MR. GORDON. I do too.

MR. BURGESS. You probably could just comment on some of the colloquy that was just going on. What about building on the work that has already been done by a lot of the various quality organizations? I know my TMF back in Texas has been working on this for some time. I know the AMA has been working on it. Again, the sort of gentleman's agreement after the DRA last year. Do you have any thoughts on that?

DR. MCCLELLAN. That is exactly the right approach, and I can say we have seen an acceleration, I think, over the past year, in leadership, and in activity from many of those physician groups across a broad range of specialties, the AMA, I mentioned the ACP and family practitioners earlier, the Alliance for Specialty Medicine. Across the board, we are seeing increasing activity, and developing and testing ideas.

I want to give a particular note of thanks to the Ambulatory care Quality Alliance, or it is now just known as the AQA, which in just a couple years, has taken these ideas to actually getting implementation. We are doing six pilot programs that we are supporting around the country now, that the AQA has led, that is resulting in quality measurement, quality improvement efforts, quality reporting for ambulatory care. It is going to lead to, I think, better quality care and better information that doctors and patients can use to get the right care, and it fits very well with some of the ideas in your new bill, Mr. Chairman.

MR. BURGESS. Thank you, and again, Mr. Gordon referenced it, and I was pleased and happy that he did, but it bears mentioning again. We have talked about some things, that perhaps some other things besides quality reporting that could help. Balanced billing was brought up, balanced billing as it would pertain to those identified by the income relating the Part B premiums as being at the upper end of the income scale.

Additionally, liability reform, and like you, I believe there is significant savings to be had. Whether it is pursuing what was worked so well in Texas, with capping non-economic damages. We heard a panel just the other day talk about a philosophy of early settlement, early offer. I think we have to change some things at the National Practitioner Data Bank aspect to get that done, but these are intriguing prospects, and I

believe it was your study 10 years ago that showed just how much money could be saved if the practice of defensive medicine could be curtailed just a little bit, and make no mistake about it, defensive medicine goes on every day.

DR. MCCLELLAN. Right.

MR. BURGESS. We are going to hear testimony in our second panel from our friends at the Alliance of Medical Specialties, and in their testimony, they talk about the fact that if doctors follow the quality measures as outlined here, that CMS has provided for us, there may be a shorter hospitalization. There may be an avoided hospitalization. There may be a simpler surgery, rather than a more complicated surgery. So, the savings that are available by following these quality measures, it is hard to know where that savings has come from, and our good friends at CBO were, in fact, unable to identify money that was saved from a hospitalization that didn't happen.

So, they raised the very valid point that because you have got the funding silos in the Medicare program, the savings are occurring because of the quality measures on the Part B program. How do you get the money back into the Part B program to pay for the best doctors in the world to practice the best medicine in the world on patients who are arguably going to be our sickest and most complex, our seniors?

DR. MCCLELLAN. That is exactly the right question and the right approach. We need to find a way to get past the silos to enable physicians and their group practices to get better support when they take steps that bring overall costs down. We are actually doing this now for large physician groups. In our Physician Group Practice Demonstration program, there are a number of clinical quality measures that are tracked, along with the overall costs of care, Part A and Part B costs, for a Medicare beneficiary that is getting their care through that multi-specialty group. And when the group improves quality of care and reduces the trend in healthcare costs, we share those savings back with the group.

We are also doing a demonstration program now, under Section 646 of the Medicare Modernization Act, that enables multiple healthcare organizations to come together and capture those savings, from taking steps like investing in interoperable health IT, or better coordination of care, better integration of care, to keep costs down. So, we are doing this on a demonstration basis now. I would like to see it happen more nationally. One challenging area is the individual and the small group practitioners, where you know, for a large multi-specialty group, you can set up this system based on the overall costs of care; individual practitioners, that is a little bit more challenging, but we are also doing demonstration programs there.

It is exactly the right question that this committee needs to answer, as to how to make sure the savings that are achieved in overall care get channeled back to support the physicians and the physician groups that are making that happen.

MR. BURGESS. I appreciate that, and not necessarily rewarding the multi-specialty group over the solo practitioner, or the one or two physician offices.

DR. MCCLELLAN. Right.

MR. BURGESS. Thank you. We will now recognize the gentlelady from California, Ms. Capps, for 5 minutes, for questions.

MS. CAPPS. Thank you, Mr. Chairman, and thank you, Dr. McClellan, for appearing yet another time.

DR. MCCLELLAN. Good to see you again.

MS. CAPPS. I am concerned about the rush, as some of my colleagues are, to implement a nationwide system linking payments to reporting.

I want to talk about costs, because as we discussed in this first segment of the hearing on Tuesday, we know our system of physician reimbursement is in dire need of a change, and as you know, I associate myself strongly with my colleague who spoke earlier, or questioned you about a situation in Northern California, Central Coast, and other parts, actually, 32 States have disparities in reimbursement. But don't you think we should first improve our basic fee for service payments before we complicate it with reporting requirements? That is one sort of rhetorical question.

And another. How are doctors expected to pay for expenses associated with more in-depth reporting requirements, when we are asking them to do that, on one hand, and on the other hand, cutting their reimbursements. But more specifically, then I will allow you to answer, how would you account for comorbidity, for example, when determining reporting standards for specialists? And also, different risks exist for patients in different regions of the country, different income levels. Will that be compensated for as well?

DR. MCCLELLAN. Those are definitely issues that must be addressed. I would connect your--

MS. CAPPS. Have they been?

DR. MCCLELLAN. Well, let me go through your questions.

MS. CAPPS. Sure.

DR. MCCLELLAN. Your first question is, well, what about improved payments, and if by improved payments, you mean increased payments, I mean sure, you know, in an ideal world, we would be able to pay physicians large amounts of money for everything that they do. The problem is that is not reality. We are seeing rapid growth in Medicare

costs, rapid increases in Part B premiums paid by beneficiaries, and if we simply add more money into the payment systems, those payments are going to go up even more.

With respect to your second question, about how can doctors pay for this, well, that is why we are asking and working closely with physicians and physician groups to identify ways in which they can deliver better care at a lower cost. So, yes, it is some effort to report, but it is also a lot of effort to report now, to go through all the Medicare paperwork, for lab tests and other procedures that are billed low--

MS. CAPPS. And comorbidity?

DR. MCCLELLAN. With the work with the physician groups, we want to get to measures that are clinically valid, and that means--

MS. CAPPS. But we haven't yet.

DR. MCCLELLAN. --for comorbidity. Well, the measures that have been endorsed are measures that broad groups of physician experts are saying do account for comorbidity. You are a health professional. You know that the best place to look for what it is that we ought to be supporting for healthcare--

MS. CAPPS. It is pretty complicated, though, right?

DR. MCCLELLAN. It is from the health professionals.

MS. CAPPS. And also, then, getting into different geographic levels, different income levels, and so forth. There is a lot of differences around the country. But I want to switch, I know there is never enough time, but I want to focus the rest of my time with you on why we are doing this in the beginning.

You ask patients why they seek out a doctor, especially as they get older. They often rely on recommendations from their family, their friends, or their health providers. Is there any reason to believe that Medicare patients who are, by definition, either older or disabled are going to spend time reviewing reporting results from physicians in order to determine who they are going to make an appointment with? I mean, that must be why we are getting at this.

And what about cases, and this is getting back to the previous topic, so many areas of the country, the problem is not finding the right physician. It is finding a physician who will take Medicare. I mean, so, what are we going to do, well, how will you address this goal, linking payments to reporting, with the fast disappearing number of providers who will serve the Medicare population?

DR. MCCLELLAN. Well, I am very concerned about that, which is why I think we need to get to a better--that are sustainable--

MS. CAPPS. How are we going to get to that through this legislation?

DR. MCCLELLAN. Well, that is what--that is the whole point, I think, of the process that we are talking about here. Not expecting that we can

make a massive change immediately on January 1, 2007, but recognizing that if we don't make some progress now, we are going to be facing both higher costs and problems in access to care. The GAO did a recent study showing that at this point, the vast majority of Medicare beneficiaries do have access to providers, but that is no reason for us to step back.

We need to act now to improve the payment system, to get to a more sustainable payment system as soon as we can. So, I think those are important steps that we can take right now together to address this issue.

MS. CAPPS. I guess that begs me back to the first part. Aren't we--

DR. MCCLELLAN. Sorry, you had a lot of questions there, and I am trying to answer all of them.

MS. CAPPS. I did, and I know there is just never enough time. It seems to me that we should focus on one beginning, and with this goal, we are putting the cart before the horse in so many ways, because we are back to the same point. If they are not being compensated, reimbursed adequately, they are not even able to make the expenses of a Medicare provider, why is this going to help them to stay in business?

DR. MCCLELLAN. Because when I talk to many of these doctors, they are saying they are being compensated for the wrong things. We will pay them more when they order a duplicative lab test, or when their patient has a preventable complication.

MS. CAPPS. Is this bill, is this going to get at that?

DR. MCCLELLAN. It does, by asking doctors and working with physician groups to identify what it is that we want in our healthcare system that we are not getting today. There are many examples why we have the best healthcare system in the world. There are many examples where it is falling short, where we are seeing big variations in the use of many procedures without any consequences for patient health, where we are seeing many examples of where early intervention, more prevention oriented care, could keep people well, keep them out of the hospital.

The measures that are in development are all focused on evidence-based steps, identified by health professionals, that can lead to better quality care and lower costs, so that we can take down the pressure right now that we are facing on Medicare's payment system, and on beneficiary premiums, by getting to better care. We can get people healthier the same time as we are getting costs down. Our payment system today does not do that. It creates a lot of paperwork and a lot of frustration and barriers to healthcare professionals delivering the best care at the lowest cost.

MS. CAPPS. With your last statement I totally agree. I guess I would differ on--

MR. BURGESS. The gentlelady's time--

MS. CAPPS. --on ways to get there.

DR. MCCLELLAN. Well, we need to get there.

MR. BURGESS. --has expired, and we are going to recognize the gentleman from Maine for 5 minutes for questions. Mr. Allen.

MR. ALLEN. This is one of those microphones that just doesn't move. I thank the gentleman for the hearing. And Dr. McClellan, a couple of questions.

My understanding is every 5 years, the AMA has a Relative Value Update Committee that evaluates the work values assigned to many of the procedures codes that physicians use and are billed under Medicare.

DR. MCCLELLAN. That is correct.

MR. ALLEN. That is made up from experts from a variety of different specialties, and they are charged with making recommendations.

DR. MCCLELLAN. Right.

MR. ALLEN. I understand there is an unusual situation that has developed with CMS, as a result of this, or in accordance with this 5-year review of the physician payment rule. My understanding is that according to the CMS-proposed rule, there will now be more work value in a three artery heart bypass surgery than in a four artery procedure, and I don't quite understand how removing an extra artery from a leg or wherever, and how that winds up being less work than the other one.

In addition, a heart transplant has always been considered the most difficult medical procedure, but not any more. Now, there are seven procedures, I understand, upon the proposed codes, that are more difficult than transplanting a human heart. So, since the RUC, the AMA's committee, are experts at valuing physician work, and the CMS is not, the CMS has traditionally accepted, my understanding, 95 percent of their recommendations, but this year, when it comes to values for heart and lung surgery, CMS rejected 98 percent of the recommendations. Can you help me? Can you explain what is going on?

DR. MCCLELLAN. I am not sure the numbers are right, and I would be happy to get back to you with the specific details. The RVU committee this year made some very important and actually, very significant reform recommendations that have the effect of putting a lot more value on spending time with patients, evaluating the patient, explaining to the patient their options, counseling them about what they need to do, which I think is a very important step. We are not paying enough to surgeons or any other doctor today for getting patients involved in their care, making sure they understand what to expect, and they will get better outcomes and fewer complications as a result of that very valuable physician time.

That is the overall thrust of the recommendations this year, which we fully support. We did put this proposal out for comment. I think we followed probably 95 percent of the recommendations of the RVU committee again, just as we have in the past. If there are some specific areas where we can do better, that is why we have it out for comment now.

So, I look forward to going over the details with you.

MR. ALLEN. Well, I will give you a chart. This is something that you can't really see from where you are, but essentially, it shows that virtually all of the recommendations, with respect to codes, virtually, with almost all of the RUC-recommended proposals, CMS is well below. But--

DR. MCCLELLAN. For cardiothoracic surgery in particular?

MR. ALLEN. Yes.

DR. MCCLELLAN. Okay. Well, we--

MR. ALLEN. Adult cardiac and general thoracic surgery.

DR. MCCLELLAN. Okay. We want to get it right.

MR. ALLEN. And I will provide this to you.

DR. MCCLELLAN. Okay. Thank you.

MR. ALLEN. Second question. Many of the pay-for-performance or value purchasing initiatives to date focus on groups of doctors, and in Maine, and lots of places around the country, we still have solo practitioners, believe it or not, in rural areas. And so, a group practice-based pay-for-performance strategy may not work for those people.

Many practitioners still use paper claims, making reporting of measures more difficult, and they need funding to do the transition. So, could you comment on how we can ensure that rural and solo practitioners are not going to be penalized in a pay-for-performance system, and in particular, what if anything CMS is doing with respect to that?

DR. MCCLELLAN. Well, of course, we have been focusing on reporting that can work for rural doctors who do not have electronic records, and are in solo practice. We need to find an approach that is feasible for them, and I am very pleased that many of the participants in our voluntary reporting program are from solo or small practices, and are giving us some firsthand opportunities to make sure that we have a reporting system that can work for doctors in exactly those circumstances.

These reports are based off of claims filing systems that the rural doctors are already used to. That is how they bill Medicare today, so that is where we want to start. We are also looking at pilot programs for paying more for quality in these settings. We want to pilot this first, in

addition to the quality reporting, to enable the small practitioners to fully participate as well.

So, just as we have gone in a gradual process, from reporting to moving towards performance-based payments for hospitals, physicians are behind that, and there are definitely some special challenges for the rural doctors, but that is why we are working with them now on voluntary reporting and on pilot programs for these payment reforms.

MR. ALLEN. Thank you. My time is really almost up. I just want to pose one problem. The work is going forward to move forward with pay-for-performance, but you recognize that not all specialties have the right criteria, and so, there is an issue here, I think, about how you move forward with a system when perhaps not all specialties are going to be part of that system, and whether those who haven't will be penalized in some way, and--

DR. MCCLELLAN. Well, if I could just briefly respond, we have seen a lot of progress in recent months, from a broad range of specialties at this point, 34 medical specialties, accounting for over 90 percent of Medicare spending, have developed measures that are going through this consensus process, that we talked about before.

So, we are seeing some very broad participation, and we want to help every specialty along. We are going to keep doing all we can to make sure that we are doing as much as we can for every specialty, to improve quality and keep costs down.

MR. BURGESS. The gentleman's time has expired. The gentleman from Illinois, Mr. Rush, is recognized for 5 minutes for questions.

MR. RUSH. Thank you, Mr. Chairman. Dr. McClellan, I want to ask you for your indulgence, because I want to move quickly from Medicare to Medicaid. It is an extremely important issue in my district and in my State.

Dr. McClellan, it is my understanding that the Administration is now crafting rules that will severely restrict Medicaid funding to government providers, and in Illinois, in Cook County, there is a heavy user--Illinois and Cook County are heavy users of the IGTs, and this money is being used to provide low-income healthcare services to all of our citizens, and last year, the Administration's budget assumed that these changes to Medicaid financing had to come from Congress, and Congress rejected IGT and other Medicaid changes in the DRA, the Deficit Reduction Act.

I have two questions. What exactly is the Administration proposing with these rule changes in Medicaid, and secondly, why do you not seek Congressional authority?

DR. MCCLELLAN. Well, we wouldn't propose anything in regulation where we don't think we already have the regulatory authority. In fact, under the Medicaid statute, we are required by law to make sure that the

dollars spent on the Federal Medicaid program are going to pay for patient care, necessary services, and that they are matched by State or locally contributed dollars through intergovernmental transfers, and any regulation that we put out would be absolutely consistent with this statutory requirement of the Medicare program. There are many uses of IGTs in this country that are, as you point, contributing importantly to the quality for Medicaid beneficiaries, and any such legitimate IGTs would not be affected by any of these regulations at all.

At the same time, as Medicaid costs have increased rapidly in the last few years, we have seen more use by more States of what are called recycling methods, where IGT dollars are really, at least in part, Federal dollars that are recycled back through, that get away from the requirements of the Medicaid statute, that the State has to put up matching funds.

So, to make sure that we are addressing this effectively, and to make sure that we are promoting more use of Medicaid dollars for improving patient care, we will have proposed regulations in this area. There will be a full opportunity for public comment on that, to make sure we are getting it right.

Again, what we have seen over the last few years is that when we work together with the State, we can often get more for the dollars that we are spending. Massachusetts just yesterday got a waiver approved that is taking a lot of dollars, including some that involved IGTs or institutional care contributions and so forth, and are now directing it to providing more affordable insurance for potentially everyone in the State.

So, that is the goal that we have, is to make sure that Medicaid dollars are going to their intended purpose, which is, as you said, to serve very vulnerable populations, and that we are using those dollars as effectively as possible, and we will look forward to discussing any regulations we propose with you, to make sure that we are implementing them effectively.

MR. RUSH. Well, last year, didn't the President's budget assume IGT reform needed Congressional approval?

DR. MCCLELLAN. The President's budget had some proposals for a range of IGT reforms which might need Congressional approval. Again, we would not propose any reforms that we don't have the statutory authority, in fact, the statutory mandate to implement. The reforms proposed in our budget represent less than 0.5 percent of State spending, and represent only a fraction of the increase in spending that we have seen over the last few years.

And again, I am convinced, having worked with a lot of States to take a look at where their money is going, and many times, States don't

know what they are getting for a lot of these IGTs or institution-based payments. As they look more closely, we can find ways to use those dollars better, to get more people into good health insurance, just as we have done in Massachusetts, we have done in Arkansas, we have done in many other States, and I want to work to address your concerns in Illinois as well.

MR. RUSH. Okay. Let me just give you an example. The Administration's proposal to cut hospitals under Medicaid, which is pay no more than cost, was considered under the DRA and rejected. Is that right? And why do you think you should now move forward with a proposal that Congress rejected last year?

DR. MCCLELLAN. I think you will find that the proposal that, to the extent we move forward with these proposals, they are going to be different from some of the ideas under consideration last year, and they are going to reflect steps that we need to take in order to make sure that the Medicaid dollars are spent according to the statute.

MR. RUSH. So, you don't see any provision, or any move in the near future to get Congressional approval?

DR. MCCLELLAN. I am sure, Congressman, that we are going to have a lot of ongoing discussions. We already have, with the letters that you mentioned earlier. We will be responding to those. Around any regulations we propose, I am sure there will be many comments on those, so there will be plenty of opportunity to make sure that we are doing things that are within the statutory mandate. In fact, I think we are compelled to do many of these steps to make sure that the Medicaid dollars go to their intended purposes, and that they are having the biggest impact possible on actually improving care for Medicaid beneficiaries.

MR. RUSH. Well, I know that my entire caucus, the Democratic caucus, has sent you a letter--

DR. MCCLELLAN. Yes.

MR. RUSH. When do you think we will see these proposed regulations, and--

DR. MCCLELLAN. As--

MR. BURGESS. Last question.

DR. MCCLELLAN. Quick answer, as soon as we can make sure we are doing them right, and--

MR. BURGESS. There you go.

DR. MCCLELLAN. --take account of some of the concerns raised.

MR. BURGESS. The gentleman's time--

MR. RUSH. Thank you, Mr. Chairman, for all your indulgence.

MR. BURGESS. --has expired.

This committee will stand in recess, subject to the call of the chair. I do want to thank Dr. McClellan, once again, for being here and being with us.

DR. MCCLELLAN. Thank you.

MR. BURGESS. I do believe we could solve this problem. The only thing that stands in our way is a political wall, and we will have the second panel after the reconvening of the committee.

[Recess]

MR. FERGUSON. We will now get started with our second panel of today's portion of the hearing. I will introduce each of the panelists, and then invite Dr. Wilson to begin, and we will go this way.

But we have for our second panel, Dr. John Brush, from the American College of Cardiology; Dr. Marilyn Heine, from the Alliance of Specialty Medicine; Dr. Lynne Kirk, on behalf of the American College of Physicians; Dr. Paul Martin, on behalf of the American Osteopathic Association; Dr. Frank Opelka, on behalf of the American College of Surgeons; Dr. Deborah Schrag, who is the Past Chair of the Health Services Committee at the American Society of Clinical Oncology; Dr. Jeffrey Rich, on behalf of the Society of Thoracic Surgeons; and Dr. Cecil Wilson, who is Chair of the Board of Trustees of the American Medical Association.

Welcome to you all. We appreciate your patience and your understanding with this crazy schedule that we live, but we are delighted that you are here. We appreciate your making yourselves available today.

Dr. Wilson, will you please begin. We have your testimony. It has been made a part of the record. We would ask you to summarize your testimony in 5 minutes.

STATEMENTS OF DR. CECIL B. WILSON, CHAIR, BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION; DR. MARILYN J. HEINE, ON BEHALF OF ALLIANCE OF SPECIALTY MEDICINE; DR. JEFFREY B. RICH, MID-ATLANTIC CARDIOTHORACIC SURGEONS, ON BEHALF OF SOCIETY OF THORACIC SURGEONS; DR. FRANK OPELKA, ASSOCIATE DEAN OF HEALTHCARE QUALITY AND MANAGEMENT, LSU HEALTH SCIENCES CENTER DEAN'S OFFICE, ON BEHALF OF AMERICAN COLLEGE OF SURGEONS; DR. LYNNE M. KIRK, ASSOCIATE DEAN FOR GRADUATE MEDICAL EDUCATION, UNIVERSITY OF TEXAS SOUTHWESTERN MEDICAL SCHOOL, ON BEHALF OF AMERICAN COLLEGE OF PHYSICIANS; DR. DEBORAH SCHRAG, PAST CHAIR, HEALTH SERVICES

COMMITTEE, AMERICAN SOCIETY OF CLINICAL ONCOLOGY; DR. JOHN E. BRUSH, ON BEHALF OF AMERICAN COLLEGE OF CARDIOLOGY; AND DR. PAUL A. MARTIN, CHIEF EXECUTIVE OFFICER AND PRESIDENT, PROVIDENCE MEDICAL GROUP, INC. AND PROVIDENCE HEALTH PARTNERS, LLC, ON BEHALF OF AMERICAN OSTEOPATHIC ASSOCIATION

DR. WILSON. Well, thank you, Mr. Chairman. My name is Cecil Wilson. I am Chair of the Board of Trustees of the American Medical Association, and I am also an internist from Winter Park, Florida.

The AMA commends you, Mr. Chairman, and members of the subcommittee, for your leadership in addressing the flawed Medicare payment system, in order to assure access and quality of care for Medicare patients. We also thank Dr. Burgess, for making an important step toward replacing the flawed SGR through introduction of House bill 5866.

The Medicare physician payment system is broken. The Medicare trustees project physician pay cuts totaling 37 percent from 2007 through 2015. These cuts will follow 5 years of payment updates that have not kept up with practice cost increases, and as the overhead shows, payment rates in 2006 are about the same as in 2001.

In building a new physician payment system, Congress and policymakers envision physician investment in health information technology, and participation in quality improvement programs as a means to continue the hallmark of Medicare, access to the highest quality of care. However, physician payment updates that accurately reflect increases in medical practice costs are vital for the significant financial investment required for health information technology and quality improvement.

We urge the subcommittee to ensure that Congress acts before the October target adjournment date to avert the 5 percent cut to 2007, set the update at 2.8 percent, as recommended by MedPAC, and replace the SGR with a system that adequately keeps pace with increases in practice costs. This will give physicians the needed tools to continue advancing quality care for Medicare payments.

Quality improvement has long been a priority for the AMA and our physician members. In 2000, we convened the Physician Consortium for Performance Improvement. The Consortium will help develop approximately 150 measures by the end of 2006. This includes measures for conditions that account for the vast majority of Medicare spending.

In addition, the AMA has developed CPT II codes for all Consortium measures, along with a process to expedite approval of these codes as

measures are completed. These measures and codes can be used in the development of a Medicare quality reporting program.

Physicians, however, must have confidence that a reporting program will meet its quality improvement goals. Therefore, we urge adherence to several key principles. First, all performance measures must be developed through the consortium endorsed by the National Quality Forum, and implemented through the Ambulatory Quality Alliance, to ensure that a uniform set of measures is used by all parties. Second, a reporting program must offset physicians' administrative costs in reporting quality data. And finally, it is critical that Congress recognize that a quality improvement program is incompatible with the use of SGR.

Quality improvements may save dollars for the Medicare program as a whole by avoiding costly Part A hospitalizations and readmissions. The dilemma is that this will increase Part B spending, and this concept conflicts with the SGR, which penalizes physicians with pay cuts for Part B spending increases. In addition, several of the Medicare payment policy changes set for 2007 will result in further cuts for many individual physician services. A 2006 AMA survey shows that steep cuts will impair access for Medicare, as well as TRICARE patients, who already have access difficulties.

And further, as the overhead shows, more than 35 States will lose over $1 billion each by 2015. Florida and California will each lose almost $300 million in 2007, and more than $17 billion from 2007 through 2015. Texas will lose $13 billion, New Jersey almost $8 billion, Ohio more than $7 billion, and Georgia, about $5 billion over this time period. We urge this subcommittee to avoid the serious consequences for patients that will occur if the cuts take effect.

We look forward to working with the subcommittee and CMS to ensure a positive 2.8 percent update in 2007, achieve a long-term payment solution that will support investment in health information technology and participation in quality improvement programs, and ensure access to the highest quality of care for our Medicare patients.

And Mr. Chairman, I thank you for the opportunity of being here, and look forward to the question period.

[The prepared statement of Dr. Cecil B. Wilson follows:]

PREPARED STATEMENT OF DR. CECIL B. WILSON, CHAIR, BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION

The American Medical Association (AMA) appreciates the opportunity to provide our views regarding "Medicare Physician Payment: How to Build a Payment System that Provides Quality, Efficient Care for Medicare Beneficiaries." We commend you, Mr. Chairman, and Members of the Subcommittee, for all your hard work and leadership in recognizing the fundamental need to address the fatally flawed Medicare physician

payment update formula, called the sustainable growth rate, or SGR, and enhance quality of care for our nation's senior and disabled patients.

The AMA was founded in 1847 to advance quality of care and that goal remains paramount to the AMA and its physician members. Over the last 158 years, AMA efforts have strengthened medical licensure requirements, reformed medical training programs, and provided oversight for continuing medical education activities.

To further advance quality improvement, the AMA also convened the Physician Consortium for Performance Improvement (the Consortium) in 2000, well in advance of the current quality improvement environment that has since emerged across various sectors of the health care industry. The Consortium currently is working to meet its commitments to Congress and the Centers for Medicare and Medicaid Services (CMS) in furtherance of the development of physician performance measures, as discussed below. These efforts will assist Congress and CMS in advancing their goal of a physician payment system that delivers the highest quality of care to patients using health information technology (HIT) and quality improvement initiatives.

It is important to recognize, however, that the current Medicare physician payment update formula cannot coexist with a payment system that rewards improvement in quality. Quality improvements are aimed largely at eliminating gaps in care and are far more likely to increase rather than decrease utilization of physician services. In fact, data from the Medicare Payment Advisory Commission (MedPAC) suggest that some part of the recent growth in Medicare spending on physicians' services is associated with improved quality of care. Under the SGR, however, physicians are penalized for this growth with annual cuts in Medicare payments. While Congress has intervened to avert these cuts in 2003 through 2006, it has done so by delaying cuts and pushing the problem into the future rather than adding more funds to the system. As a result, the gap between actual and allowed spending under the SGR has mushroomed to nearly $50 billion, half of which is attributable to the temporary "fixes" that were made in each of the last four years.

The Administration has often made the point that "it supports reforms in physician payment that provide better support for increasing quality and reducing overall health care costs, without adding to Medicare expenditures." It is difficult to see how structuring payments to reward quality could possibly eliminate the enormous SGR deficit that is triggering nine consecutive years of 5% physician pay cuts. Positive annual physician payment updates, that accurately reflect increases in physicians' practice costs, are vital for encouraging and supporting the significant financial investment required for HIT and participation in quality improvement programs. Currently, due to the SGR, the Medicare Trustees are forecasting payment cuts totaling 37% from 2007 through 2015.

We urge the Subcommittee to ensure that Congress acts this year before the October adjournment target date to: (i) avert the 5% cut for 2007 and enact a 2.8% physician payment update, as recommended by the Medicare Payment Advisory Commission (MedPAC); and (ii) repeal the SGR physician payment system and replace it with a system that adequately keeps pace with increases in medical practice costs. We emphasize to Congress that every time action to repeal the SGR is postponed, the cost of the next legislative fix, whether a short-term or long-term solution, becomes significantly higher and increases the risk of a complete meltdown in Medicare patients' access to care.

ADVANCES IN QUALITY IMPROVEMENT

In 2000, the AMA convened the Physician Consortium for Performance Improvement for the development of performance measurements and related quality activities. The Consortium brings together physician and quality experts from 70+ national medical specialty societies and almost 20 state medical societies, as well as representatives from the Centers for Medicare and Medicaid Services, the Agency for

Healthcare Research and Quality (AHRQ), and the Consumer-Purchaser Disclosure Project. The Joint Commission on Accreditation of Healthcare Organizations and the National Committee for Quality Assurance (NCQA) are also liaison members.

The Consortium has become the leading physician-sponsored initiative in the country in developing physician-level performance measures. CMS is now using the measures developed by the Consortium in its large group practice demonstration project on pay-for-performance, and plans to use them in demonstration projects authorized by the MMA. Further, the Consortium has been working with Congress to improve quality measurement efforts, as well as with CMS to ensure that the measures and reporting mechanisms that could form the basis of a voluntary reporting program for physicians reflect the collaborative work already undertaken by the AMA, CMS, and the rest of the physician community. To achieve our mutual quality improvement goals, the AMA has taken the following steps:

- The AMA has allocated significant additional resources to accelerate the development of physician performance measures. We are in the process of doubling the staff dedicated to performance measure development, which is allowing us to significantly accelerate the work of the Consortium. By the end of 2006, the Consortium plans to have developed at least 140 physician performance measures.
- To date, the Consortium has developed 98 measures covering 17 clinical conditions, and an additional 52 measures have been drafted and are moving through the Consortium approval process. They are expected to be completed by the end of this year.
- Consortium measures developed to date account for conditions covering a substantial portion of Medicare spending. For example, according to the Congressional Budget Office, 85% of Medicare spending is "strongly linked" to high-cost beneficiaries with chronic conditions like coronary artery disease, chronic obstructive pulmonary disease, congestive heart failure and diabetes. Completed Consortium measures address these four conditions.
- The AMA's Current Procedural Terminology (CPT) Editorial Panel has also put in place an expedited process for developing and approving CPT II codes. Use of CPT II will allow physicians to submit quality data to CMS on the claim form for the particular service furnished to the patient, and many stakeholders believe this is a better alternative than the proposed G codes developed by CMS for reporting quality data. The AMA has developed and approved CPT II codes for all completed measures, and will continue to fast-track approval of these codes as additional measures are developed.
- The AMA/Consortium is continuing to accelerate the development of measures and is working through the National Quality Forum (NQF) for endorsement and Ambulatory Care Quality Alliance (AQA) for implementation to ensure that a uniform set of measures is used by all parties.
- The AMA is continuing to expand educational activities for our member physicians on incorporating quality measurement and improvement in their practices.

As the AMA continues in our ongoing efforts to enhance quality improvement, we strongly urge federal policymakers to ensure the development of a quality reporting program that physicians are confident will improve quality of care. To maximize such physician confidence, certain principles are paramount. First, performance measures should be developed through a transparent and consistent process through the Consortium. They should then be reviewed and endorsed by the NQF and implemented in a uniform manner across all payers and other entities through the Ambulatory Care Quality Alliance AQA. The AMA believes it is critical for CMS to work through these

existing multi-stakeholder groups to pursue its quality roadmap. CMS already participates in these groups as well. Without input and buy-in from physicians, patients, private sector purchasers and health plans, establishing successful quality improvement initiatives will be extremely difficult.

Second, the selection of performance measures must be governed by certain tenets: (i) measures should be developed for areas of medical care where there is the greatest need for quality improvement; (ii) there should be evidence showing that a measure is meaningful, *i.e.,* that following the guidelines specified by the measure will actually improve quality of care; (iii) measures should be developed for medical conditions that have a high cost for the health care system; and (iv) measures should cut across as many specialties as possible, with uniformity across all specialties that treat that same medical condition.

In developing physician measures, it is critical to recognize the complexities involved in developing and selecting performance measures for the physician community, as compared to other types of health care providers, such as hospitals. It is extremely difficult to develop measures that apply to many or all physicians because there are so many different types of medical specialties that treat multiple medical conditions. Hospitals and other health care institutions, by comparison, are more homogenous and thus it is easier to develop measures that apply to most or all hospitals.

Third, the primary factor in creating physician confidence in a reporting program is a Medicare physician payment system that adequately reflects increases in medical practice costs, as well as one that offsets physicians' costs incurred in reporting quality data. As noted above, the SGR and a system that rewards quality improvement are incompatible. Quality improvements are expected to encourage more preventive care, better management of chronic conditions, lower rates of hospital-acquired infections and fewer complications of surgery. While such results would reduce spending for hospital services covered by Part A of Medicare, they do so by increasing spending for the Medicare Part B physicians' services that are included in the SGR, and thus cannot compensate for the $50 billion deficit that has already accumulated in the SGR.

The majority of performance measures, such as those focused on prevention and chronic disease management, ask physicians to deliver more care. This conclusion is consistent with a long-term national study (*The Rewarding Results Project*) by the Leapfrog Group, including seven experimental projects designed to test a variety of pay-for-performance models. The study showed significant increases in physician visits for many services. MedPAC also evaluated the impact on quality of care with regard to 38 quality measures for ambulatory care. Initial results show that the number of patients receiving appropriate care increased for 20 of the 38 measures and remained the same for most others. Significantly, the study also found that for several measures, increases in the use of physician services was associated with declines in potentially avoidable hospitalizations.

More physician services means increased Medicare spending on physician services. The SGR imposes an arbitrary target on Medicare physician spending and results in physician pay cuts when physician spending exceeds the target. Thus, more physician services under a quality reporting program will result in more physician pay cuts.

Further, pay-for-performance programs depend on greater physician adoption of information technology, which was indicated by the Leapfrog study, at great cost to physician practices. A study by Robert H. Miller and others found that initial electronic health record costs were approximately $44,000 per full-time equivalent (FTE) provider per year, and ongoing costs were about $8,500 per FTE provider per year. (*Health Affairs*, September/October, 2005). Initial costs for 12 of the 14 solo or small practices surveyed ranged from $37,056 to $63,600 per FTE provider. Unless physicians receive positive payment updates, these HIT investments will not be possible. In fact, a 2006 AMA survey shows that if the projected nine years of cuts take effect, 73% of responding

physicians will defer purchase of new medical equipment, and 65% will defer purchase of new information technology. Even with just one year of cuts, half of the physicians surveyed will defer purchases of information technology.

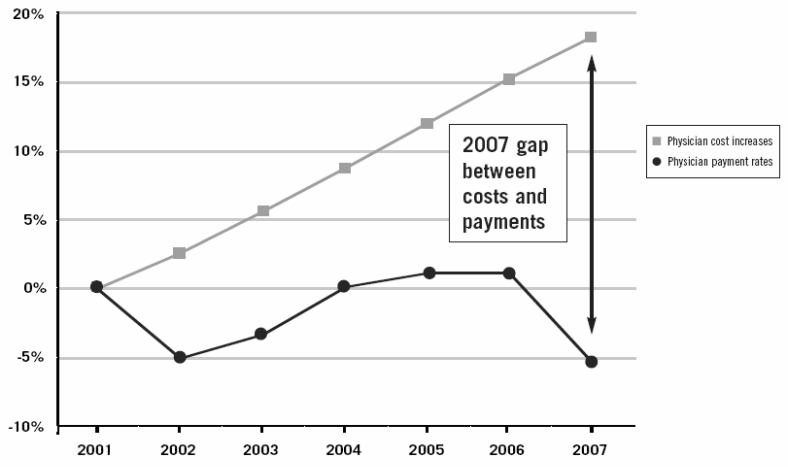
Because of the potentially significant administrative costs to physicians in reporting the quality data, we urge the Subcommittee to ensure that any quality reporting program are premised on: (i) positive Medicare payment updates that reflect increases in physicians' practice costs; and (ii) additional payments to physicians for reporting quality data.

The AMA looks forward to continuing our work on quality improvement with Congress and CMS. Working together, the Administration, Congress, and the physician community can strengthen the Medicare program by maximizing quality of care, as well as establishing a stable physician payment system, with adequate, positive updates that preserve Medicare patient access to their physician of choice.

CONGRESSIONAL ACTION IS NEEDED THIS YEAR TO HALT PHYSICIAN PAYMENT CUTS

The AMA is grateful to the Subcommittee and Congress for taking action to forestall steep Medicare physician payment cuts in each of the last four years. Yet, a crisis still looms, and, in fact, is getting worse. **Congress must act this year, before the October target adjournment date, to avert the almost 5% physician pay cut that is projected for January 1, 2007, along with a total of 37% in cuts from 2007 through 2015.**

These cuts will occur as medical practice costs, even by the government's own conservative estimate, are expected to rise by 22%. They follow five years of payment updates that have not kept up with practice cost increases. As the chart below illustrates, payment rates in 2006 are about the same as they were in 2001. In fact, data in a recent proposed rule impacting physician payments indicate that Medicare now covers only two-thirds of the labor, supply and equipment costs that go into each service.



There is widespread consensus that the SGR formula needs to be replaced: (i) there is bipartisan recognition in this Subcommittee and Congress that the SGR, with its projected physician pay cuts, must be replaced with a formula that reflects increases in practice costs; (ii) MedPAC has recommended that the SGR be replaced with a system that reflects increases in practice costs, as well as a 2.8% payment update for 2007; (iii)

CMS Administrator McClellan has stated that the current physician payment system is "not sustainable;" and (iv) the Military Officers Association of America (MOAA) has stated that payment cuts under the SGR would significantly damage military beneficiaries' access to care under TRICARE, which will have long-term retention and readiness consequences.

Only physicians and other health professionals face such steep cuts. Other providers have been receiving updates that fully keep pace with their costs (and will continue to do so under current law). In 2006, for example, updates for other providers were as follows: 3.7% for hospitals, 3.1% for nursing homes, and 4.8% for Medicare Advantage (MA) plans (which are already paid at an average of 111% of fee-for-service costs). In addition, CMS announced earlier this year a 7.1% update for MA plans for 2007, which is used to develop a benchmark against which MA plans submit bids (for providing Part A and B benefits to enrollees). Using this as a benchmark, CMS expects an average MA update of 4% in 2007, with some plans still receiving up to 7.1%.

Physicians and other health care professionals (whose payment rates are tied to the physician fee schedule) must have payment equity with these other providers. Physicians are the foundation for our nation's health care system, and thus a stable payment environment for their services is critical.

THE MEDICARE SUSTAINABLE GROWTH RATE FORMULA

Fundamental Flaws with the SGR

The projected physician pay cuts are due to the SGR formula, which has two fundamental problems:

1. Payment updates under the SGR formula are tied to the growth in the gross domestic product, which does not factor in patient health care needs, technological advances or physician practice costs; and
2. Physicians are penalized with pay cuts when Medicare spending on physicians' services exceeds the SGR spending target, yet, the SGR is not adjusted to take into account many factors beyond physicians' control, including government policies and other factors, that although beneficial for patients, increase Medicare spending on physicians' services.

Because of these fundamental defects, the SGR led to a 5.4% cut in 2002, and additional reductions in 2003 through 2006 were averted only after Congress intervened and replaced projected steep negative updates with positive updates of 1.6% in 2003, 1.5% in each of 2004 and 2005, and a freeze in 2006. We appreciate these short-term reprieves, yet, even with this intervention, the average Medicare physician payment updates during these years were less than half of the rate of inflation of medical practice costs.

Now physicians are facing nine additional years of cuts. The vast majority of physician practices are small businesses, and the steep losses that are yielded by what is ironically called the "sustainable growth rate," would be unsustainable for any business, especially small businesses such as physician office practices.

Increases in Volume of Services

Some have argued that the SGR formula is needed to restrain the growth of Medicare physicians' services. The AMA disagrees.

Spending targets, such as the SGR, cannot achieve their goal of restraining volume growth by discouraging inappropriate care. Spending target systems are based on the fallacious premise that physicians alone can control the utilization of health care services, while ignoring patient demand, government policies, technological advances, epidemics, disasters and the many other contributors to volume growth. In addition, expenditure targets do not provide an incentive at an individual physician level to control spending,

nor do they distinguish between appropriate and inappropriate growth. At a recent hearing before this Subcommittee concerning Medicare imaging cuts, CMS officials argued that recent rapid increases in the use of imaging service raises questions about whether such growth is appropriate, but CMS did not provide the Subcommittee with any evidence of inappropriate growth.

Further, volume growth has continued at a relatively constant rate despite the SGR, and any assumption that this growth is inappropriate ignores the fact that spending on physician services is growing for a number of legitimate reasons. The number of elderly Americans is increasing and more of them suffer from obesity, diabetes, kidney failure, heart disease, and other serious chronic conditions. In addition, last year, Medicare officials announced that spending on Part A services was decreasing. This suggests that, as technological innovations advance, services are shifting from Part A to Part B, leading to appropriate volume growth on the Part B side. In fact, new technology and drugs have made it possible to treat more people for more diseases and provide this treatment in physicians' offices rather than in more expensive hospital settings. Quality improvement initiatives in providing medical services have also reached out to more beneficiaries, which, in turn, has increased volume. This has led to fewer hospital admissions, shorter lengths of stay, longer life spans with better quality of life, and fewer restrictions in activities of daily living among the elderly and disabled. One of the more interesting findings in MedPAC's 2006 Report to Congress is that, based on its 38 quality tracking measures, more Medicare beneficiaries received necessary services in 2004 than in 2002 and potentially avoidable hospitalizations declined as well.

The foregoing suggests that a number of factors drive appropriate volume growth and that spending on physicians' services is a good investment. In fact, the government recently reported that U.S. life expectancy reached a record high of 77.9 years. In addition, the National Center for Health Statistics reported that there were 50,000 fewer U.S. deaths in 2004, the biggest single-year drop in mortality since the 1930s. Despite the aging of the population and growing rates of obesity, reductions in deaths due to heart disease, cancer and stroke accounted for most of the improvement.

We urge Congress, in developing a new physician payment system, to ensure that the first priority is to meet the health care needs of our elderly and disabled patients, as well as avoid a system that forestalls the major improvements in medical care and quality of care described above. To achieve this goal, Congress and policymakers should not impose spending targets that effectively penalize all physicians for volume growth — whether appropriate or inappropriate. **Rather, if there is a problem with inappropriate volume growth regarding a particular type of medical service, Congress and CMS should address it through targeted actions that deal with the source of the increase. This would give Congress more control over the process than exists under the current system.**

COMPOUNDING FACTORS TO THE SGR IN 2007

In addition to the 2007 physician cuts, due to the flawed SGR, other Medicare physician payment policy changes will take effect on January 1, 2007, and will have a significant impact on a large number of physicians. These include: (i) expiration of the MMA provision that increased payments in 58 of the 89 Medicare payment localities; and (ii) recent CMS proposals that will change both the "work" and "practice expense" relative values, each of which are components in calculating Medicare physician payments for each individual medical service. These changes, many of which were supported by the AMA, will mitigate the impact of the SGR cuts for some specialties. However, a required budget neutrality adjustment could lead to cuts of 5% or more for other physicians' services, and we are concerned that the combined impact of the SGR cut with these budget neutrality adjustments could jeopardize the financial viability of some practices.

The AMA is also concerned about cuts in imaging services furnished in physicians' offices, as mandated by the DRA, which are scheduled to be implemented beginning January 1, 2007. These imaging cuts will exacerbate the looming Medicare payment crisis, and the AMA requests that these cuts be repealed or delayed in accordance with AMA policy adopted by our House of Delegates in June 2006.

The Medicare physician payment system has a multitude of moving parts. We urge the Subcommittee to recognize that, for many physicians, these foregoing factors will compound the 2007 physician pay cuts due to the SGR and, taken together, these cuts will substantially deter the existing momentum in the physician community to move in the direction of adopting HIT and making the financial investment necessary to participate in quality improvement programs. Congress must provide physicians' with an adequate payment system that supports Congress' goal of an HIT- and quality improvement-based system.

It is also important to recognize that despite all the different factors that will affect Medicare physician payment rates in 2007, physicians are united in their view that the most important problem that Congress needs to address is the 5% pay cut scheduled to take effect January 1, 2007. This cut will reduce payments for all specialties and all payment localities, and action by Congress to replace this 5% cut with a positive 2.8% update for 2007 will help physicians in every state and specialty.

ACCESS PROBLEMS FOR MEDICARE BENEFICIARIES UNDER THE CURRENT MEDICARE SGR PHYSICIAN PAYMENT FORMULA

AMA Survey Shows Patient Access Will Significantly Decline if the Projected SGR Cuts Take Effect

Physicians simply cannot absorb the pending draconian payment cuts, and an inadequately funded payment system will be most detrimental to Medicare patients. Although physicians want to treat seniors, Medicare cuts are forcing physicians to make difficult practice decisions. According to a 2006 AMA survey:

- Nearly half (45%) of the responding physicians said that if the scheduled cut in 2007 is enacted, they will be forced to either decrease or stop seeing new Medicare patients, and 43% responded the same with respect to TRICARE patients.
- By the time the full force of the cuts takes effect in 2015, 67% of physicians will be forced to decrease or stop taking new Medicare patients. The same percentage of physicians responded in the same way with respect to TRICARE patients.
- If the cut in 2007 goes into effect, 71% of responding physicians said they will make one or more significant patient care changes, including reducing time spent with Medicare patients, increasing referral of complex cases and ceasing to provide certain services.
- Almost two-thirds of responding physicians said that in their community: (i) more Medicare patients are being treated in the emergency room for conditions that could have been treated in a physician's office; (ii) more physicians are referring Medicare patients with complex problems to other physicians; and (iii) it has become more difficult to refer Medicare patients to certain medical and surgical specialists.
- In rural areas, more than 1/3 of physicians (37%) said they will be forced to cut off outreach services if the scheduled cut in 2007 is enacted, with more than half (55%) discontinuing rural outreach services if the cuts are enacted through 2015.

Continual physician pay cuts put patients' access to care at risk, and there are signs of a problem already. A MedPAC survey found that, in 2005, 25 percent of Medicare

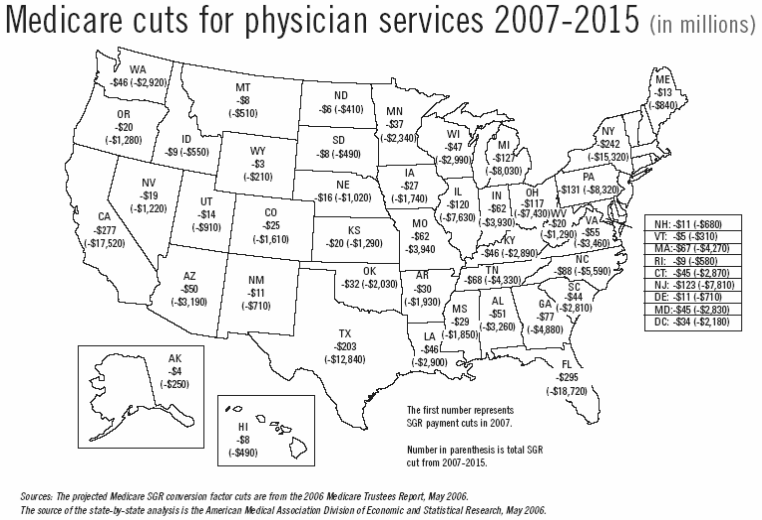
patients looking for a new primary care physician had some problem finding one and that a growing number had a "big problem." It concluded that some beneficiaries "may be experiencing more difficulty accessing primary care physicians in recent years and to a greater degree than privately insured individuals."

In the long-run, all patients may have more trouble finding a physician. The Congressionally-created Council on Graduate Medical Education is already predicting a shortage of 85,000 physicians by 2020, and multi-year cuts in Medicare are nearly certain to exacerbate this shortage by making medicine a less attractive career and encouraging retirements among the 35 percent of physicians who are 55 or older. These predictions of shortages are underscored by the demographics of practicing physicians in certain states. For example, nearly half of the practicing physicians in California and Florida and nearly 40% of practicing physicians in Georgia, Ohio and Texas are above the age of 50. A survey by a national physician placement firm found that just over half of physicians between the ages of 50 and 65 plan to take steps in the next one to three years that would either take them out of a patient care setting or reduce the number of patients they see.

Medicare physician cuts have a ripple effect across the entire health care system and drive down payment rates from other sources. For example, TRICARE, which provides health insurance for military families and retirees, ties its physician payment rates to Medicare, as do some state Medicaid programs. Thus, Medicare cuts trigger TRICARE and Medicaid cuts as well. In fact, MOAA has sent letters to Congress urging Congressional action to avert the physician payment rate cuts, which would "significantly damage" military beneficiaries' access to health care services. MOAA stated that "[w]ith our nation at war, Congress should make a particular effort not to reduce health care access for those who bear and have borne such disproportionate sacrifices in protecting our country."

Impact of Projected SGR Cuts on Individual States

If Congress allows the pay cuts forecast by the Medicare Trustees to go into effect, there will be serious consequences in each state across the country. As the map below illustrates, more than 35 states will see their health care funds reduced by more than one billion dollars by the time the cuts end in 2015. Florida and California are the biggest losers, with each of these states losing close to $300 million in 2007 alone. Medicare payments in Florida would be cut by more than $18 billion from 2007-2015; California will lose more than $17 billion over the 9-year period, and Texas is not far behind with nearly $13 billion in cuts. Ohio is facing losses of more than $7 billion and Georgia will see about $5 billion in cuts.



Seniors cannot afford to have their access to physicians jeopardized by further reducing Medicare payment rates below the increasing costs of running medical practices. Ohio's 1.6 million Medicare beneficiaries comprise 14% of the state's population and Florida's nearly 3 million beneficiaries are 16% of its population. Even before the forecast cuts go into effect, Georgia only has 208 practicing physicians per 100,000 population and Texas has 207 practicing physicians per 100,000 population, which means both states are far below the national average of 256. Florida only has 15 practicing physicians for every 1,000 Medicare beneficiaries, 25% below the national average.

The negative effects of the cuts in the Medicare physician payment schedule are not only felt by patients, but also by the millions of employees that are involved in delivering health care services in every community. Data from the Bureau of Labor Statistics show that the physician payment cuts will affect: 80,274 employees in Georgia; 112,176 employees in Ohio; 195,288 employees in Florida; 200,469 employees in Texas; and 292,171 employees in California.

We urge the Subcommittee to avoid the serious consequences for patients that will occur if the projected SGR cuts take effect, and establish a Medicare physician payment system that helps physicians serve patients by providing the positive payment updates and incentives needed to invest in HIT and quality improvement programs.

The AMA appreciates the opportunity to provide our views to the Subcommittee on these critical matters. We look forward to working with the Subcommittee and CMS to achieve a long-term, permanent solution to the chronic under-funding of physicians' services for our nation's senior and disabled patients and ensuring their access to the highest quality of care.

MR. FERGUSON. Thank you, Dr. Wilson. Dr. Heine.

DR. HEINE. Good afternoon. My name is Dr. Marilyn Heine. I am an emergency physician from Norristown, Pennsylvania. On behalf of the Alliance of Specialty Medicine, a coalition of 11 medical specialty societies, representing nearly 200,000 specialty physicians, thank you for

the opportunity to speak with the subcommittee today about the pay-for-reporting and pay-for-performance initiatives.

Patient safety and quality are cornerstones of the care we deliver. Alliance physicians are highly trained, and meet rigorous continuing medical education standards throughout our careers. We have been at the forefront of developing clinical guidelines based on sound evidence. The concepts of pay-for-reporting and pay-for-performance are consistent with your practice of medicine. In other words, while we have a diversity of patients, practice types, settings, and degree of specialization, we all share a commitment to improving patient safety and quality.

At the same time, we realize the limitations of medicine, such as when a patient is noncompliant. Consider a patient whom I will call Robert, a 67 year old man who came to my emergency department with seizures, worsening of his diabetes, and a life threatening heart rhythm. He was there because he had not followed his physician's recommendations for care. Fortunately, our team successfully resuscitated him. His case points out, though, that the best practice of medicine cannot produce the desired outcome if a patient like Robert does not follow his physician's advice.

As we move to a federally mandated pay-for-performance system for physicians, please remember that hospitals started with a reporting program with only 10 measures that were widely applicable across all hospitals, developed over many years in an incremental and orderly process, while hospitals were receiving yearly positive payment updates based on inflation. In addition, hospitals generally have an infrastructure that enables them to collect and report data.

In contrast, a majority of physicians are in small practices without such an infrastructures. Physicians perform about 10,000 different procedures, and have faced statutory Medicare payment reductions that were averted only by Congressional action. Please also remember that steps for submitting and obtaining final approval of quality measures are complex and lengthy, and can take at least 2 years. As we move forward, we urge you to clearly define the measure development process, especially since it is not delineated in either law or regulation.

The Alliance is expeditiously engaged within the Physician Consortium and other groups, including the Ambulatory care Quality Alliance and National Quality Forum. We also have worked closely with CMS on their Physician Voluntary Reporting Program. We are concerned, though, that most measures presented by Alliance societies were not included, preventing most of our physicians from participating in this program.

For a program to be successful, all physicians must have the opportunity to participate. That includes all specialists and all subspecialists. Even though a specialty may have a measure for a specialty in the program, the measure may not pertain to all the subspecialists in that field. Therefore, we urge you to incorporate the feedback you receive from us and other medical societies. In fact, quality measures should be generated by the medical specialty societies with expertise in the area of care in question.

The program should include risk stratification to account for patient demographics, severity of illness, and comorbidities, to ensure that the system does not penalize physicians who treat patients with complex medical problems, and create incentives for physicians to avoid sicker patients, or increase health disparities. We also urge Congress and CMS to establish national standards for health information technology to ensure prudent investment by physicians in HIT systems. Performance quality must remain confidential, and not be subject to discovery in legal or other proceedings.

Finally, financing for the system is critical. A physician who participates in a new data collection and reporting initiative should be rewarded with bonus payments, in addition to receiving existing Medicare reimbursement.

It is also vital to consider that physician compliance with this initiative may increase the volume of physician services and, therefore, the cost. The current Medicare physician payment formula is based on a flawed sustainable growth rate that must be replaced with a more equitable, stable payment system before we implement a pay-for-reporting or pay-for-performance program. This would allow physicians to pilot test data collection methods and quality measures. In addition, savings to Medicare Part A resulting from physicians' efforts should flow to Medicare Part B.

The Alliance of Specialty Medicine appreciates the leadership of this subcommittee in preventing cuts in physicians' Medicare payments since 2003. I particularly thank Dr. Burgess for his introduction of H.R. 5866. We pledge to work with you to build a payment system that provides quality, efficient care for Medicare beneficiaries.

Thank you.

[The prepared statement of Dr. Marilyn Heine follows:]

PREPARED STATEMENT OF DR. MARILYN HEINE, ON BEHALF OF ALLIANCE OF SPECIALTY CARE

Mr. Chairman and members of the subcommittee, let me first thank you for holding this important hearing on Pay-for-Reporting and Pay-for-Performance. I appreciate your giving me the opportunity to present the perspective of medical specialists on this

initiative, as well as provide recommendations on how to create a system that enhances our ability to deliver high-quality, evidence-based medical care.

In addition to working as an emergency physician in Norristown, Pennsylvania, I also serve as Chair of the Federal Government Affairs Committee for the American College of Emergency Physicians (ACEP). I am here today representing the Alliance of Specialty Medicine – a coalition of 11 medical societies, representing nearly 200,000 specialty physicians.

The Alliance of Specialty Medicine represents physicians who care for millions of patients each year. Patient safety and quality are cornerstones of the patient care we deliver. Even before the concept of Pay-for-Reporting or Pay-for-Performance was introduced on Capitol Hill, medical specialty societies within the Alliance were already developing, and constantly updating, best practices and clinical guidelines to ensure our patients receive the best medical care possible, based on sound clinical evidence and principles. In fact, some of the Alliance specialty societies were, and continue to be, involved with developing and reporting hospital measures that were included in the "Medicare Prescription Drug, Improvement and Modernization Act of 2003" (P.L. 108-173).

Hospital reporting measures were not created overnight, but in an incremental, orderly process that has been ongoing for years. These measures are voluntarily reported. However, P.L. 108-173 provided a new, strong incentive for eligible hospitals to submit their quality data. The law specifies that if a hospital does not submit performance data, it will receive a 0.4 percent reduction in its annual payment update for fiscal years 2005, 2006, and 2007. In contrast to recent years where physicians have been exposed to statutory Medicare payment reductions, which were only averted due to congressional action, hospitals receive yearly, positive payment updates based on inflation. It is also important to understand that hospitals are currently involved with a Pay-for-Reporting program and not Pay-for-Performance – there is a distinct difference between the two initiatives.

Every Alliance organization is a member of the Physician Consortium for Performance Improvement (Physician Consortium) of the American Medical Association and has a committee focused on Pay-for-Performance (P4P) or Quality Improvement. Each organization has targeted efforts on turning evidence-based clinical guidelines into quality measures, or developing guidelines where none previously existed. However, there are challenges in creating standard quality measures for the diverse medical specialists and sub-specialists that we represent. For example, only 10 to 20 percent of a medical specialty may be represented by a given quality measure due to the high rate of sub-specialization.

Clinical practice guidelines are the foundation for developing quality measures, and for various reasons, such as liability concerns or lack of an appropriate level of supporting evidence, not all medical specialty societies have developed practice guidelines. Also, due to the nature of certain specialty care, no randomized, controlled clinical trial data exists that would lead to the development of practice guidelines in these areas.

Measure Development Process

The Alliance of Specialty Medicine members have worked diligently to prepare physicians for a quality improvement initiative that rewards physicians for providing, or improving their delivery of high-quality medical care. We have worked closely with the Centers for Medicare & Medicaid Services (CMS) on the initial development of quality measures that could be voluntarily reported through a claims-based system and helped develop the new CMS Physician Voluntary Reporting Program (PVRP). Unfortunately, some of the measures presented by medical specialty societies were not included in the final PVRP, because those measures had not been properly scrutinized through the

consensus-building process. Therefore, most of our medical specialty organizations have not been able to participate.

As with many newly created programs, the PVRP, while a promising first step, could use refinement in selected measures and processes. The current structure for the submitting and approving quality measures can be a long, complex process – one that has never been formally identified in either statute or regulation.

The members of the Physician Consortium understand the current measure development process to include (1) a medical specialty organization proposes a quality measure, based on a practice guideline; (2) the measure is reviewed by the Physician Consortium; (3) the Physician Consortium-approved measure is submitted to the National Quality Forum (NQF), which endorses the measure and gathers stakeholders – including health plans, employers, consumers, etc. – to review and approve; (4) the NQF-approved measure is then submitted to the Ambulatory Care Quality Alliance (AQA), which focuses on how the measure could be implemented; and (5) once the quality measure has been cleared by the Physician Consortium, the NQF and the AQA, it is sent to CMS for implementation. So how long does it take for a quality measure to go from its initial Physician Consortium submission to CMS implementation? The answer is two years or more. Of course, this does not take into account the medical society's own timeframe to discuss, develop, test and approve the original practice guideline that is the foundation for the quality measure.

Our medical specialty societies are working as expeditiously as possible within the process operated by the Physician Consortium, and there are, thus far, a number of quality measures that have been developed by Alliance members currently under review by various Physician Consortium committees.

While the measure development process should be fully understood and uniformly applied across all organized medicine, as well as scrupulously followed, it has been vulnerable to misunderstanding. For example, we are aware of an effort by CMS to circumvent the consensus-driven measure development process by requesting the AQA review several measures that have not yet been approved by the Physician Consortium.

We urge Congress to clearly define the measure development process before moving toward a Pay-for-Reporting or Pay-for-Performance initiative. While it may be necessary to streamline this process in order to meet statutory or regulatory deadlines that may be imposed, we urge caution because quality may be sacrificed in an expedited process. For these reasons, the Alliance of Specialty Medicine will make a formal request to Congress and the Administration for clarification of the procedure to be followed by medical societies that have quality measures that they would like to submit for implementation by CMS.

As Congress continues to discuss the creation of a statutory Pay-for-Reporting or Pay-for-Performance initiative, the Alliance of Specialty Medicine would like to share our clinical experience, expertise and recommendations with you in terms of what should be considered when developing its Pay-for-Reporting or Pay-for-Performance initiative.

Pay-for-Reporting/Pay-for-Performance Recommendations

We urge you to make sure quality measures are developed by the medical specialty societies with expertise in the area of care in question, based on factors physicians directly control, and kept current to reflect changes in clinical practice over time. Risk stratification should be considered to appropriately account for patient demographics, severity of illness and co-morbidities in order to provide meaningful information, and ensure the system does not penalize physicians who treat patients who have complex medical problems, create incentives to avoid sicker patients, and increase healthcare disparities.

In addition, quality measures must be pilot-tested and phased-in across a variety of specialties and practice settings to help determine what does and does not improve

quality. If successfully pilot tested, Pay-for-Reporting or Pay-for-Performance should be phased-in over a period of years to enable participation by all physicians in all specialties.

Understanding that a suitable platform must be identified to allow physicians to report on their implementation and use of quality measures, it is important that the federal government establish national standards for Health Information Technology (HIT) systems to ensure prudent investment by physicians in HIT systems that will not become obsolete. Many solo practitioners or small group practices will need financial assistance to make up-front investments in HIT and Congress and the Administration should recognize that lost productivity and practice disruption typically occur when a fundamental change in work processes takes place, such as the implementation of new HIT systems.

In addition to these fundamental and technical issues, there are legal issues that must be considered as well when developing and implementing a Pay-for-Reporting or Pay-for-Performance system. Performance quality must remain confidential at all times and not be subject to discovery in legal or other procedures – such as credentialing, licensure and certification – aimed at evaluating whether or not a physician has met standards of care. Because state peer-review laws vary in the scope of protections afforded to physicians participating in quality improvement activities, a national standard (similar to the one included in recently enacted federal patient safety legislation, P.L. 109-41) should be implemented. A non-punitive auditing system is necessary to ensure accurate information is entered into the system. Prior approval from patients to collect and report data must not be required and HIPAA should be amended as needed to facilitate data collection efforts.

Financing of a Pay-for-Reporting or Pay-for-Performance system is critical. Physicians, as is currently the case with hospitals, should be rewarded with "bonus" payments for participating in a new data collection and reporting initiative. Such bonus payments should be in addition to, or outside the scope of, the current Medicare physician payment system. If additional money is not provided for a Pay-for-Reporting or Pay-for-Performance initiative, and there are still physicians who are not yet able to participate because their measures have not completed the lengthy development and approval process mentioned previously, the system would become punitive, potentially further eroding physician availability for Medicare beneficiaries.

Physician compliance with a Pay-for-Reporting or Pay-for-Performance system has the potential to increase the volume of physician services and, therefore, the annual Medicare Sustainable Growth Rate (SGR) expenditure target formula must be replaced.

Finally, due to the nature of the funding silos that exist in the Medicare program, when physicians' efforts result in fewer complications and fewer or briefer hospitalizations for Medicare beneficiaries, thereby creating additional savings to Medicare Part A, that money should flow to Medicare Part B in recognition of where the savings were generated.

Medicare Payments

The Alliance of Specialty Medicine recognizes and appreciates the leadership of this committee in preventing cuts in physicians' Medicare payments since 2003, and we hope to have your continued support. We understand that Congress and the Administration are intent on moving the Medicare program into a quality-reporting and value-based purchasing system. We are asking Congress to acknowledge the fundamentally flawed Sustainable Growth Rate (SGR) Medicare physician payment formula is incompatible with Pay-for-Reporting or Pay-for-Performance systems. For physicians to embrace Pay-for-Reporting or Pay-for-Performance, it is critical for the SGR to be replaced with a more equitable and stable payment system so that physicians can invest in HIT and pilot-test data collection methods and quality measures as steps toward establishing a Pay-for-Performance system that actually improves care for the Medicare patients we serve.

Conclusion

The Alliance of Specialty Medicine's physician organizations are continually striving to offer the highest level of quality care to all of our patients. The recommendations we have made here today are crucial in moving to a system that produces a more efficient, reliable and stable patient care system. We stand ready to work with Congress and the Administration to enhance quality measurement for the specialty care provided to our nation's seniors and individuals with disabilities.

MR. FERGUSON. Thank you, Dr. Heine. Dr. Rich.

DR. RICH. Thank you. Good afternoon, Chairman Ferguson and members of the subcommittee. Thank you for inviting the Society of Thoracic Surgeons to this hearing. My name is Jeffery Rich, and I am a practicing cardiac surgeon at Sentara Healthcare. I am testifying on behalf of the Society of Thoracic Surgeons, where I serve on the Board of Directors and chair the Taskforce on Pay-for-Performance.

As many of you know, the members of the STS have been measuring and improving patient outcomes in cardiac surgery for nearly 2 decades. We are currently involved in several pay-for-performance initiatives with private plans, and believe it is time for the Government to undertake similar initiatives, which have been shown to reduce costs while saving lives.

Over the years, we have encountered several serious pitfalls to avoid. We have also found that improved quality can save money, and that significant cost reductions are within our reach. Our goal now is to implement P4P programs that will replicate the work of the Society of Thoracic Surgeons. Today, I would like to talk about the experience that we have had in this area, and the lessons learned along the way. Slide 1, please.

[Slide]

First, let me illustrate how powerful a quality improvement tool the database has been. In slide 1, on the left side, you can see that our patients are older and sicker, and have an expected mortality rate that has increased by 35 percent over the last decade. Yet, in the graph on the right, you can see that by using information from the database, STS cardiac surgeons have managed to achieve a 30 percent reduction in risk adjustment mortality. This has been achieved through the collection of accurate clinical data and feedback to providers on their performance as compared to national benchmarks. However, we have gone one step further. The STS participants in the State of Virginia have formed a true hospital/physician quality alliance, and have created a unique database. Slide 2, please.

[Slide]

This database is a blend of the STS clinical database and the CMS financial database, creating a clinical/financial tool that allows cardiac surgery teams in the State to monitor quality improvement and examine

its impact on the cost of care. As seen in this chart, the incremental costs of the major complications associated with cardiac surgery have been identified. Obviously, complications are costly, and can easily double or triple the cost of an operation. Slide 3, please.

[Slide]

Armed with this data, we have identified best practices and implemented State-wide protocols to reduce complications, such as atrial fibrillation, a common heart arrhythmia following surgery. As seen in the slide, within 6 months of State-wide implementation, the rate has already declined 15 percent from its baseline. The individual hospital rates are seen on the bottom for 2004, and also, in 2005, and the marked reduction can be seen. So, how has this impacted costs? Slide 4.

[Slide]

This illustrates the savings achieved by our efforts. The top left graph shows the incidence of frequently seen complications, including atrial fibrillation. The bottom left chart shows the cost of each of these complications. The top right graph shows the estimated savings in Virginia, and the bottom right, the estimated savings in the country. Please move the cursor to 5 percent.

This represents the reduction in atrial fibrillation we have achieved. As you can see, as the rate of complication fell, savings accrued through reductions in costs. Again, these are real cost savings, achieved through quality improvement efforts, and are based on real data. The top line in the two right hand graphs gives total savings for the State, and in theory, the Nation; $3 million has been saved in the State just for this one complication, and if we apply these same principles across the Nation, approximately $250 million would have accrued already. Please run the slide.

This illustrates the real impact of continuous quality improvement on costs, with growing savings to the healthcare system as quality is improved, and please note that these are on the basis of outcomes measures, not process measures. Because of these results, Wellpoint/Anthem and the Virginia members have developed a P4P program with incentive payments for quality to both the hospitals and physician, a real functioning program that has been in existence at least, on the hospital side, for 2 years.

Much has been learned from these experiences, and we wish to share four of those with this subcommittee. Lesson one. Every effort must be made to encourage the development of accurate clinical databases. Lesson two, not all measures are equal. Structural, process, and outcomes measures have markedly different attributes, and yield differing results under P4P programs. Outcome measures must be the

ultimate goal of P4P, as they will promote ownership in the healthcare system, and create needed cost savings.

Lesson three, the use of quality data solely for profiling physicians and other providers will miss an opportunity to make broad improvements in quality, and may have unintended consequences. Lesson four, no single P4P program will fit all physicians or apply to all patients. The concept that one size fits all will not improve quality. Hospital-based physicians will need different measures and incentive structures than ambulatory care physicians. The STS has real experience in these areas.

In conclusion, the STS has proposed a 10 step roadmap, in our written document, for P4P, and I will highlight just four of those. Number one, begin with structural measures and pay-for-participation in clinical databases. Number two, create an interoperable data repository that can accept data from specialty society clinical databases, and can match clinical with financial data from CMS, as we have done in Virginia, so that providers will have the right tool to improve quality and contain costs.

Number three, identify and preferentially reward risk-adjusted outcome measures that have links to cost containment. Four, develop P4P programs unique to the setting of care. One size does not fit all. And finally, put ownership back in the healthcare system, and put ownership back in the vocabulary of all providers, by rewarding physicians for quality improvement and efficient care delivery.

Thank you for this opportunity to appear before you today.

[The prepared statement of Dr. Jeffrey B. Rich follows:]

PREPARED STATEMENT OF DR. JEFFREY B. RICH, MID-ATLANTIC CARDIOTHORACIC SURGEONS, ON BEHALF OF SOCIETY OF THORACIC SURGEONS

Good morning Chairman Deal, Ranking Member Brown, and members of the Subcommittee. Thank you for inviting The Society of Thoracic Surgeons (STS) to discuss Medicare physician payment and explore new ways to provide quality and efficient care for Medicare beneficiaries. My name is Jeffrey Rich and I am a practicing cardiothoracic surgeon at Sentara Healthcare in Norfolk, Virginia. I am testifying on behalf of the STS where I serve on the Board of Directors and Chair the Taskforce on Pay for Performance. I also serve on the Board of Directors and Steering Committees of multiple other national and regional quality improvement organizations and alliances including the National Quality Forum (NQF), the AQA, the Hospital Quality Alliance (HQA), and the Virginia chapter of the STS, also known as the Virginia Cardiac Surgery Quality Initiative (VCSQI).

As many of you know, the members of The Society of Thoracic Surgeons have been systematically measuring and improving patient outcomes in cardiac surgery – both nationally and in local collaborative efforts – for nearly two decades. We are currently involved in several pay for performance initiatives with private health plans and believe it is time for the government, i.e. Medicare, to undertake similar initiatives which have been shown can reduce costs while saving lives.

Over the past 18 years, we have gained significant experience in what has been proven effective in quality measurement and improvement, and have also encountered several serious pitfalls to avoid. We have found that improved quality can save money and that significant cost reductions are within our reach – but how these are implemented may determine success or failure.

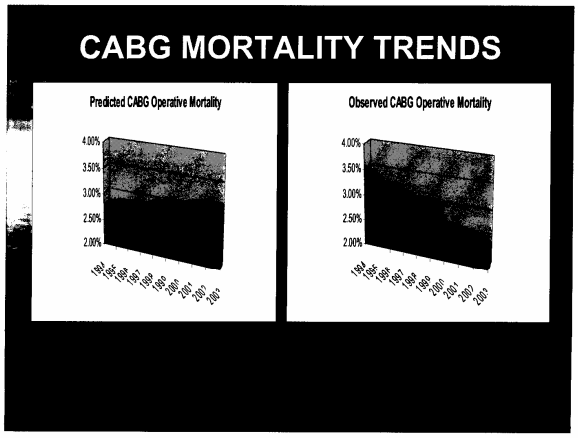
The key messages we hope to impart to you today are:

1. Data source is critical – Claims data are not sufficient to measure outcomes and are incapable of allowing the significant risk adjustment that can prevent patient access disparities – usually for the sickest patients.
2. All measures are not created equal – To best determine "value" in health care, patient outcomes over the episode of care are the best measurement.
3. The incentives must encourage continuous quality improvement – paying bonuses for compliance with generally expected processes of care or basic safety procedures will yield little improvement and drive up costs.
4. The best use of quality data is to improve the quality of all providers – Use of data for simply profiling providers and steering patients will further exacerbate gaps in quality. We have shown that we can improve quality while eliminating variation among providers. This will yield the most savings for the program.

We are here today to discuss how physician payment can be changed to promote quality and efficiency. Quality measurement and improvement have not proceeded at the pace or scope proposed in the Institute of Medicine's "Crossing the Quality Chasm" report in 2001. In addition, we are facing exhaustion of the Medicare Trust Fund in 2018, threatening the program that elderly Americans cannot do without at a time when baby boomers will begin to need it the most. Multiple reasons exist for the financial insolvency of Medicare including the expanding elderly population, healthcare costs rising at a pace faster than inflation, and an expansion of physician services exceeding all expectations. It is this last point and the lack of quality improvement perceived to exist in the healthcare system that brings us here today. Current reimbursement models, in particular the Sustainable Growth Rate formula (SGR) have failed to engage providers in addressing these issues, and it is the feeling of policy makers and legislators that rewarding quality and efficiency measurement and reporting will provide solutions. The STS believes that there may be validity to this argument, but also strongly feels that any reimbursement system developed to reward performance in quality and efficiency must be designed properly to achieve these goals.

Today I would like to talk about the experience that the STS has in this area and the lessons learned along the way.

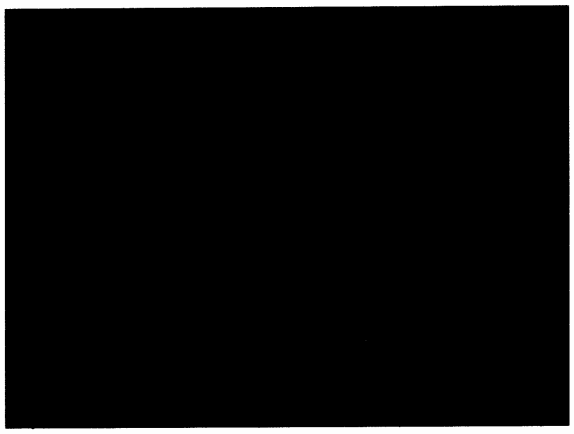
The STS has nearly 18 years of experience in quality measurement, monitoring and improvement through the use of our national cardiac database (NCD). With nearly 80% of hospitals and surgeons who deliver cardiac surgical care participating, the NCD now has over 3 million patient records on which to analyze and report the major morbidities and, most importantly, the risk-adjusted mortality associated with these procedures. By providing feedback through the use of the NCD, the STS participants have managed to achieve a 30% reduction in risk-adjusted mortality in the face of rising patient acuity. Our patients are older and sicker and have, as the chart below shows, an expected mortality rate that has increased by 35%.



In short, many more patients are surviving these difficult operations in an uncomplicated way. This has been achieved through the collection of accurate clinical data and feedback to providers of their performance based on regional and national benchmarks. In addition, the STS has promoted the development of regional collaboratives, true hospital/physician quality alliances that have worked to share data and identify best practices in order to improve quality. Examples of such are found in the states of Virginia, Michigan, Iowa, Washington and the northern New England region. Because of the strength and credibility of the database and in an effort to promote accountability the STS has vetted 15 of its measures related to the morbidities and mortality associated with cardiac surgery through the NQF consensus development process and is currently working with the HQA and CMS to adopt these measures for inclusion in the Hospital Compare website.

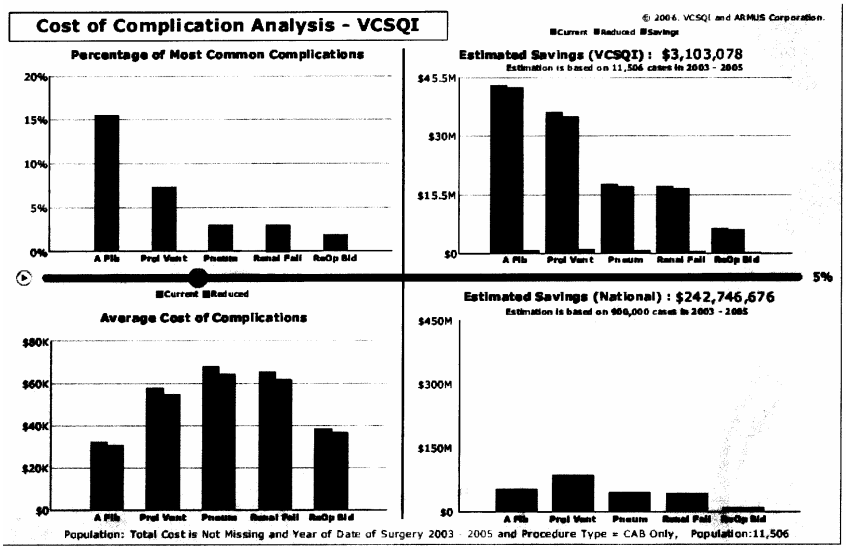
However, we have gone one step further. The STS participants in the state of Virginia formed the Virginia Cardiac Surgery Quality Initiative (VCSQI), a collaborative of 16 hospitals and 50 surgeons in order to improve quality and contain costs through the use of a unique database. This database is a blend of the STS **clinical** database and the CMS **financial** database creating a clinical/financial tool that enables providers in the state to monitor quality improvement and examine its impact on cost of care delivery.

As seen in this chart, the incremental costs of the major complications associated with cardiac surgery have been identified. This represents data from a 3-year period and over 30,000 patients. Armed with this data, the VCSQI has identified best practices and implemented statewide protocols to reduce complications, such as atrial fibrillation, a common heart arrhythmia following surgery.

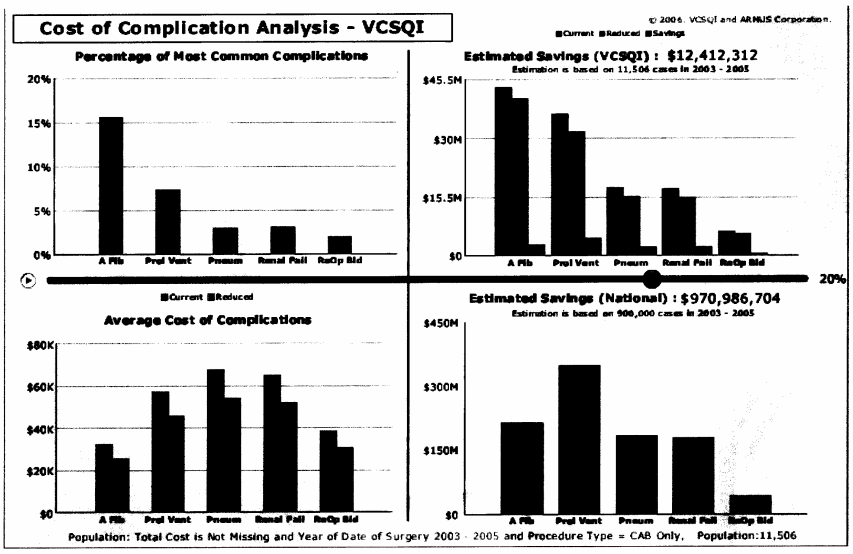


In a single institution, this complication has fallen from an incidence of 21% to 5% and within six months of statewide implementation the rate has already declined 15% from its baseline in Virginia. As seen in this interactive slide and charts provided in the written statement, we could now show the real cost savings achieved for the state of Virginia and can also extrapolate those nationally.

With the reduction in atrial fibrillation and work we are doing to reduce other complications we have already achieved a savings of $3,103,078 in the state and if we had implemented this protocol nationally would have achieved a $242,746,676 savings nationally.



By reducing these and other complications even further to a very achievable 20% reduction below their current levels, $12,412,312 will be saved in Virginia and $970,986,704 nationally.



These results and the results of other STS regional and national efforts have led to a recently announced data sharing agreement between WellPoint/Anthem in the private sector in an effort to drive quality improvement. In addition, WellPoint/Anthem and the VCSQI members have developed a bimodal P4P in the state of Virginia with incentive payments for quality to both the hospitals and physicians. The Quality Hospital Incentive Program (QHIP) has completed two years of activity and the Virginia STS members (VCSQI) are about to launch the physician component of this P4P program, the Quality Physician Payment Program (QP3). Finally, the STS has written a proposal for a national pilot P4P program, "Quality Focused Cost Containment in Cardiac Surgery for Medicare Beneficiaries", which will apply the principles derived from the state of Virginia to achieve national savings in Medicare.

Much has been learned from these experiences and we wish to share those lessons with this Subcommittee in order to enable all providers to engage in quality improvement and to create efficiencies in care delivery allowing more widespread cost containment in the healthcare system.

LESSON ONE: Every effort must be made to encourage the development of accurate clinical databases. Reliance on administrative (or claims) data for performance measurement, particularly outcomes data, is inaccurate and may lead to payments to the wrong providers for the wrong reasons under P4P programs. On the other hand, clinical databases lack financial information and leave a gap when attempting to develop and implement measures of efficiency. The solution is to blend credible clinical databases with the financial database of CMS so that both goals can be achieved. This will require the development of an interoperable IT system that will allow a single common platform for data aggregation and a common pipeline for data reporting.

LESSON TWO: Not all measures are equal. Structural, process and outcomes measures have markedly different attributes and yield differing results under P4P programs, and the attributes of measures of efficiency have not yet been defined. **Structural** measures such as participation in a clinical database and adoption of electronic health records (EHR) have an upfront cost and it should not be the expectation that providers will bear this burden alone. Their use, however, will provide the necessary tools for quality improvement efforts and participation in a database will allow the creation of a culture of quality that will provide improvements beyond measurement in limited fashion. **Process** measures must be linked to quality improvement and care must be taken in choosing them. If process measures merely encourage expanded testing without feedback to and action by providers, then they will have the unintended consequence of expanding healthcare costs and the volume of physician services. **Outcome measures**, on the other hand, should be the ultimate goal of P4P. They must be risk-adjusted and the level of analysis (hospital, physician, physician group) must be set appropriately so that they promote **ownership** in the healthcare system.

A race to get individual physician data may neglect the most important aspect of care delivery, that of systems of care. Physicians working in hospitals are part of a team delivering complex care to individual patients. If we insist on measures that focus on the individual physician we will end up with simple process measures which they can control but which will provide much less benefit, both to the patient and in terms of savings to the system. If we measure both hospitals and physicians on the same measure then each will have ownership in the performance of the other and will encourage hospital physician collaboration. Only by focusing on systems of healthcare delivery will we be able to address quality in the continuum through transitional care models and most

importantly, efficiencies of care within and across care settings. I urge you as legislators to put in place the incentives to encourage providers to undertake the hard work of true quality improvement and move providers from structural, to process measures, and on to measure patient outcomes and value in patient care.

LESSON THREE: The use of quality data solely for profiling physicians and other providers will miss an opportunity to make broad improvements in quality and may have unintended consequences. The experience we have gained through public reporting programs in several states has shown that the unintended harmful effects on patient care can outweigh the perceived benefits of transparency if publicly reported data are not sufficiently risk adjusted. In fact, Dr. McClellan coauthored a paper on our experience with public reporting in New York state and Pennsylvania and found that risk aversion led to changes with serious ramifications for patients with heart disease. The authors found

> *"On net, these changes were particularly harmful. The less effective medical therapies that were substituted for CABG and PCTA, combined with delays in treatment, led sicker patients to have substantially higher frequencies of heart failure and repeated AMIs and ultimately higher total costs of care"*

Transparency in the healthcare system for quality and pricing is currently a high priority for CMS and the administration. It is felt that this data will lead the charge for consumer driven healthcare choice and purchaser/payer preferred provider selection. The STS absolutely supports accountability. In fact, we have developed a risk calculator and placed it on our website which enables patients and doctors to go to the web and calculate the predicted risk for their procedure. However, quality information on providers must be used for more than profiling. Profiling falls short of the goals for healthcare with respect to quality improvement and efficiency. Importantly, claims data cannot be sufficiently risk adjusted to make clinical judgments on provider quality. Only a clinical database with sufficient clinical variables can be risk adjusted enough to yield accurate findings. CMS and Congress should encourage the development of such clinical data either through EHR or through specialty society led efforts.

Broad gains in the improvement of patient care, and hence savings to the program will only be achieved through quality and efficiency measurement and feedback to providers to drive improvement in both areas. The STS through the use of the NCD has proven that continuous quality improvement can be achieved by the creation of information feedback loops and the development of refined processes of care that will impact outcomes. Support for the creation of regional and national collaboratives among providers will be necessary. Finally, public reporting of quality information is a science and not simply

done. The STS has appointed a taskforce to work with biostatisticians examining a variety of modeling techniques, including those found in educational testing, to create appropriate composite measures of quality. Medicare beneficiaries must be given credible but understandable data in order to make their healthcare choices.

LESSON FOUR: No single P4P program will fit all physicians or apply to all patients. The more cross-cutting the measures are, the less relevant to each patient's care they will be. The concept that "one size fits all" will not improve quality. Hospital based physicians will need different measures and incentive structures than ambulatory care physicians. Regardless of the setting, payments should be additive to historic baselines and must be based on credible and achievable thresholds of performance. They must reward not only achievement of thresholds but quality improvement efforts. Encouragement to share and act upon data is essential. The STS has real experience in these areas. We have recently entered into a data sharing agreement with WellPoint/Anthem and as mentioned earlier the Virginia physicians have developed P4P programs that reward quality improvement efforts and recognize that QI will lead to cost containment. We are participating in a joint hospital/physician quality improvement effort with Blue Cross/ Blue Shield of Michigan that will improve patient care quality while saving that health plan millions. Measures in these programs are the same for hospitals and physicians to promote the concept of joint ownership for both clinical and financial outcomes. This subcommittee and others must look strongly at shared savings models where savings can be divided among CMS/physicians/hospitals as they are achieved. Only then will we create systems of care that can address quality and efficiency.

The STS proposes the following 10 step roadmap:

1. Begin with structural measures and pay for participation in clinical databases, creation of patient registries and adoption of EHR
2. Create an interoperable data repository that can accept data from specialty society credible clinical databases and that can match clinical data with financial data from CMS so that providers will have a clinical/financial tool to drive QI and develop cost savings models and efficiencies in care
3. Pay only for process measures that are linked to quality and do not promote unnecessary resource consumption or the expansion of the volume of physician services. Remove financial incentives for overuse of testing/diagnostics.
4. Identify and **reward preferentially** risk-adjusted outcome measures that have links to cost containment as demonstrated today and that promote ownership by providers in the healthcare system
5. Define efficiency measures as the costs associated with an acceptable quality of care and reward those who can deliver the highest quality of care at the lowest cost through shared savings models

6. Encourage healthcare setting specific alliances (hospital/physician, clinic/physician) that address both quality and efficiency at the system level of care delivery
7. Develop P4P programs unique to the setting of care delivery, and medical condition being treated. – "one size does not fit all"
8. Congress should enact national pilot programs to test P4P prior to implementation
9. Promote transparency but use quality information for more than profiling
10. Put "ownership" in the healthcare system back in the vocabulary of all providers by **rewarding** physicians for QI and efficient care delivery

The members of the STS firmly believe that our greatest privilege is to provide high quality care to all patients. We also believe that our greatest responsibility is to ensure that healthcare is available in the future to Medicare beneficiaries. However, this is a shared responsibility of all of us, and a responsibility in which we have joint ownership.

Thank you for this opportunity to appear before you today.

MR. FERGUSON. Thank you, Dr. Rich. Dr. Opelka, 5 minutes, please.

DR. OPELKA. Mr. Chairman, Congressman Allen, and members of the subcommittee, thank you for the opportunity to testify today on behalf of the American College of Surgeons. My name is Frank Opelka, and I practice colorectal surgery in New Orleans, and serve as the

Associate Dean for Healthcare Quality and Safety at LSU. I also serve as the Chair of the Surgical Quality Alliance, or SQA, through which specialties that provide surgical care are collaborating to improve care for all our patients, and to divine principles of surgical quality measurement and reporting.

We are grateful to you for holding this hearing on how to build a payment system that provides high-quality, efficient care for the Medicare beneficiaries. The College has been a leader in the effort to improve the quality of our Nation's surgical care for many years. You can see details of this in our written testimony.

We fully support the concept of value-based purchasing. Hopefully, we can offer a potential solution that would significantly improve the payment system and allow quality improvement efforts to thrive. First of all, it is important to keep in mind that there are unique issues confronting performance measurement in surgery. For example, surgical care is provided as part of a system or a team, which complicates development of performance measures that address accountability at the surgeon level.

Secondly, for many procedures performed in a hospital setting, risk-adjusted patient outcomes are the preferred method of measuring performance. Accurate risk adjustment can only be made using clinical, rather than administrative data.

Third, an increasing number of procedures are now performed in an office or an ambulatory surgical center. The SQA has developed four global process measures for surgical care that have been submitted to CMS, along with detailed comments on the existing PVRP measures. We have also made progress in developing global quality measures for ambulatory surgical care.

With respect to the PVRP, many note that the College initially welcomed its introduction as to the pilot tests we had requested prior to the implementation of the payment-related quality reporting system. Nonetheless, a number of problems have been identified as obstacles to surgeons participating in the program. So far, these have not yet been addressed by CMS.

In particular, the surgical measures reflect broader hospital accountability, and do not focus directly on the surgeon's responsibility. Secondly, many surgical measures contain serious flaws. To highlight an obvious example, the PVRP now asks the surgeons to report on steps taken to avoid deep vein blood clots during procedures to harvest organs from cadavers. We brought these issues to CMS's attention, and are hopeful that the agency will soon develop a process through which surgeons can have input into the adoption of performance measures, and so participate in the pilot.

While value-based purchasing can improve the quality of care patients receive and allow healthcare stakeholders to make more informed decisions, it cannot fix a broken Medicare physician payment system. We urge Congress to prevent the 4.7 percent payment cut that will go into effect on January 1st, 2007, and to explore long-term solutions to this ever growing problem.

While all policymakers agree that there are problems with the SGR formula, what receives less attention is the devastating impact policies are having on specific specialties and the patients they treat. For surgeons, reimbursements have declined steeply over the past 2 decades, even though service volume for major procedures has remained stagnant, growing by less than 2 percent per year. While volume increases in certain areas are justified, and can lead to better overall healthcare, surgeons are now subsidizing these increases.

The College supports MedPAC's recommendations to replace the SGR with an updated system that reflects real increases in the cost of providing care. For that reason, we are grateful for the efforts by Representative Burgess and others to find a way to reach the solution that has continued to elude us. But if we cannot eliminate the expenditure targets entirely, the College, along with the American Osteopathic Association, has developed an alternative that we believe has the potential to solve, at least part, many of our current problems.

Our proposal would replace the universal SGR with a new service category growth rate, the SCGR, that recognizes the unique nature of different services by setting targets for six distinct physician service categories already used by CMS. These are the evaluation and management services, major procedures, minor procedures, radiology, diagnostic laboratory, and physician-administered Part B drugs.

The SCGR would be based on the current SGR factors, except that the GDP would be eliminated from the formula and replaced with a 7 percentage point growth allowance for each service category. Like the SGR, the annual update for service category would be the MEI plus the adjustment factor. The Secretary could set aside up to 1 percent point of the conversion factor for any service category for pay-for-performance incentive plans. By recognizing the unique nature of the different physician services, we believe the SCGR would enable better assessment of the volume growth of different physician services to determine whether or not that volume growth is appropriate. In addition, we believe it would provide a framework for the development of value-based purchasing systems that are tailored to differences in the way various physician services are provided.

Thank you for providing this opportunity to share with you the challenges facing surgeons under the Medicare program today. The

College looks forward to continuing to work with you to reform the Medicare physician payment system, and to ensure that Medicare patients will have access to the high quality surgical care they need.

[The prepared statement of Dr. Frank Opelka follows:]

PREPARED STATEMENT OF DR. FRANK OPELKA, ASSOCIATE DEAN FOR HEALTHCARE QUALITY AND MANAGEMENT, LSU HEALTH SCIENCES CENTER DEAN'S OFFICE, ON BEHALF OF AMERICAN COLLEGE OF SURGEONS

Chairman Deal, Ranking Member Brown, and distinguished subcommittee members, thank you for the opportunity to testify today on behalf of the 71,000 Fellows of the American College of Surgeons (ACS). My name is Frank Opelka. I practice colorectal surgery in New Orleans, and serve as Associate Dean for Healthcare Quality and Safety at Louisiana State University. I also serve as the Chair of the Surgical Quality Alliance.

We are grateful to you for holding this hearing on the Medicare physician payment system and, specifically, how to build a payment system that provides high-quality and efficient care for Medicare beneficiaries. ACS has been a leader in the effort to improve the quality of our nation's surgical care for many years. A detailed description of key ACS efforts is included at the end of this testimony in Attachment A.

ACS supports the concept of value-based purchasing and shares the view that it holds real potential to bring value to patients through improved quality and informed choices. Our concerns arise in reference to the development and implementation of some of these specific value-based purchasing programs.

This morning, I would like to discuss some of the current quality improvement efforts and some of the unique issues confronting performance measurement in surgery. In addition, I would like to discuss the relationship between value-based purchasing and the current physician payment environment. Quality improvement programs will only reach their full potential if an appropriate payment system is created in which high-quality care and quality improvement are encouraged. This is impossible under the constructs of Medicare's current physician payment system, which we all understand is unsustainable. ACS believes that we have a solution that would significantly improve the payment system and allow quality improvement efforts to thrive.

Unique Issues Confronting Performance Measurement in Surgery

Surgical care is provided in a variety of settings including hospitals, offices, and ambulatory surgery centers. While our ability to provide care in diverse settings can bring value to the patient and the healthcare system, it also creates complexities. For example, responsible reporting of clinical information for quality monitoring and improvement can be especially difficult when a patient's course of treatment occurs across multiple settings.

Regardless of the setting, surgical care is provided as part of a system or team. The surgeon is one member of a team that also includes nurses, anesthesiologists, technicians, and other staff. Many gaps in the quality of surgical care exist in areas of overlap between participants in the system. For instance, the surgeon, anesthesiologist, nurse, and pharmacist all contribute to the patient receiving appropriate and timely prophylactic antibiotics. This team-oriented approach to surgical care can complicate the development of measures addressing accountability at a physician level rather than system level. Divergent views on whether measures in a pay-for-performance system should focus on surgeon or system performance have become a serious obstacle to measure development and implementation. Indeed, given the unique team-oriented environment in which surgeons practice, few performance measures existed that focused on the individual

surgeon. ACS has been working with the surgical specialty societies over the past year to identify areas that can be attributed directly to the surgeon, such as ordering of various therapies, for use in value-based purchasing initiatives.

Additionally, each surgical setting presents its own unique challenges in measuring performance. For many procedures performed in a hospital setting, risk-adjusted patient outcomes are the preferred method of measuring performance. Risk adjustment is a necessary component of surgical outcomes data and should include adjustment for age, weight, and co-morbid conditions, such as diabetes, that could affect the patient's risk. Currently, accurate risk-adjustment models can only be used in conjunction with clinical data because administrative data do not capture all of the necessary data points required for accuracy. In addition, claims are submitted well before the 30-day outcome of an operation is known, making them a poor vehicle to report outcomes data. Finally, current risk-adjustment tools focus on a system of care as with ACS National Surgical Quality Improvement Program (NSQIP) data, instead of on an individual physician or surgeon.

On the other hand, most procedures performed in an office or ambulatory surgery center have extremely good outcomes with few complications. This presents a challenge for some surgical specialties in the development of useful and valid measures that close a gap in care and can be used in value-based purchasing programs. Traditional outcome and process measures are not appropriate in these settings if a gap in care cannot be identified. This challenge of measurement must be addressed as we move toward a pay-for-performance system.

Finally, surgery has become a highly specialized profession in which a surgeon may only perform a small fraction of the thousands of CPT codes that address surgical procedures. Developing measures that capture a significant portion of each specialty's procedures or that are applicable to multiple specialties has been a challenging and time-consuming task. The Surgical Quality Alliance (SQA) took on this daunting task and developed four global, process measures for surgical care. These measures were twice submitted along with proposed revisions to the Centers for Medicare & Medicaid Services (CMS) for inclusion in the Physician Voluntary Reporting Program (PVRP).

- Preoperative Smoking Cessation – Smoking prior to surgery can lead to increased incidence of wound complications, diminished vascularity, and poor wound healing. Preoperative smoking cessation results in fewer complications and faster healing leading to an easier recovery for the patient and reduced strain on the healthcare system.
- Surgical Timeout – Participation in a preoperative surgical timeout in which the patient, procedure(s), and surgical site(s) are identified and agreed upon by the surgical team leads to fewer adverse events including wrong-site, wrong-side, wrong-procedure, and wrong-person operations.
- Patient Copy of Preoperative Instructions – Adverse events occur when patients are not fully informed prior to surgery. Patients should be given a copy of preoperative instructions that can be taken home, easily read and referred to, and shared with appropriate family, friends and/or caregivers prior to surgery.
- Patient Copy of Postoperative Instructions – Keeping patients informed and engaged in their own care leads to fewer complications and readmissions following surgery. Postoperative instructions should be easy to read and reference and should include information on activity level, diet, discharge medications, proper incision care (if applicable), symptoms of surgical site infection, what to do if symptoms worsen, and follow-up appointments.

Physician Voluntary Reporting Program (PVRP)

ACS welcomed the introduction of the PVRP as the "pilot test" physician organizations had requested prior to implementation of a payment-related quality reporting system. A voluntary program is a vital step to examine potential administrative

and workflow challenges involved in collecting data from individual physicians on performance-related issues. Nonetheless, the following points have been identified by ACS and other surgical societies as obstacles in the PVRP as it is currently constructed that need to be addressed:

- The surgical measures reflect broader hospital accountability and do not focus directly on the surgeon's responsibility. This focus on the facility/system in a physician–oriented program severely limits the usefulness of the data collected for quality improvement purposes.
- Many numerators and denominators are incorrect, and CMS has been unresponsive to surgery's efforts to recommend changes. The rationale behind CPT codes selected for the program and those excluded is not apparent, and codes appear to have been selected randomly. In addition, some of the codes challenge the credibility of the program, which further presents obstacles to encouraging participation by surgeons.
- As the PVRP measures are currently defined, it is difficult for surgeons to participate. The CPT codes included in the surgical measures are limited and do not allow for participation by many surgical specialties. As a result, we are not really "testing" how patient care information can be retrieved and reported across inpatient and outpatient settings.

In a live surgical patient, a deep vein thrombosis (DVT) (or blood clot) is a severe and potentially life-threatening complication; fortunately, a number of preventive measures are effective in reducing the incidence of DVT. However, it is unnecessary to guard against DVT in procedures involving a cadaver donor. Yet, CMS' list of procedures for which DVT prevention is to be used includes four procedures for harvesting an organ(s) from a cadaver--lung (CPT code 32850), heart-lung (code 33930), liver (code 47133) and kidney (code 50300). To further show the arbitrary nature of the list, CMS properly excludes harvesting only the heart (code 33940).

A prophylactic antibiotic should be given when there is significant risk of acquiring an infection during a surgical procedure. While many factors contribute to a patient's risk for a surgical site infection, one determinant is the length of the procedure. Whipple-type procedures are open procedures in which part of the pancreas is removed and extensive surgery is performed on nearby organs. We can obtain the length of the time from incision to closing of the wound (known as "skin-to-skin" time) from a database maintained by the American Medical Association/Specialty Society Relative Value Update Committee (RUC) and available to CMS. The skin-to-skin times for the four Whipple-type procedures are 290 to 360 minutes. Yet, none of the four Whipple-type procedures is on the list for antibiotic administration.

Throughout the codebook, there are codes for procedures that are not listed in CPT. (For example, code 43999 is "Unlisted procedure, stomach".) We expected that CMS would be consistent in their treatment of these codes, but they are not. The PVRP includes unlisted procedures for the intestine, rectum and cardiac surgery, but not for the esophagus, stomach, liver or other anatomical areas.

End stage renal disease (ESRD) patients on hemodialysis need vascular access to connect their bloodstream to the dialysis machine. There are many types of vascular access, but fistulas have the lowest failure and complication rates. Fistula access involves connecting a patient's own vein and artery, instead of connecting a prosthetic tube to the artery or placing a plastic catheter into the vein, both of which are associated with higher morbidity and mortality rates. It is important to place a native access in patients before they advance to ESRD status because a fistula cannot be used immediately as it needs time to mature. However, the PVRP measure for receipt of autogenous arteriovenous fistula applies only to ESRD patients. The SQA, including the Society for Vascular Surgery, proposed the addition of advanced chronic kidney disease

patients to promote fistula use prior to ESRD and to obtain a more accurate representation of current fistula use.

Our concerns with the PVRP are outlined in two letters from the SQA to CMS Administrator Mark McClellan, MD, PhD. The letters also include the four global, process measures for surgery listed above. The March 1 and June 1 letters are included as Attachment B to this testimony.

Progress in the development of surgical measures

In addition to the measure revisions and global process measures submitted to CMS by the SQA, the surgical community has been working with various quality organizations to develop and implement surgical performance measures. ACS continues to work with the AMA's Physician Consortium for Performance Improvement (PCPI) serving as the lead organization for two Perioperative Care Workgroups. The first perioperative workgroup focused on the assessment of cardiac risk, while the second is focused on the prevention of surgical site infections and DVT. The current measure set includes appropriate timing, selection, and discontinuation of prophylactic antibiotics as well as appropriate DVT prophylaxis for selected surgical procedures. The measure set is open for public comment through August 4. Surgical specialty societies are also working with the PCPI to develop measure sets for eye care, osteoporosis, stroke, and skin cancer.

The Society for Thoracic Surgeons participated in the National Quality Forum's (NQF) project to develop a set of consensus standards for cardiac surgery. A slightly refined version of the NQF-endorsed cardiac surgery measure set, specific to coronary artery bypass graft, was also approved by the AQA as the starter set for measuring cardiac surgery. In addition, ACS continues to participate in the NQF's cancer care project and has submitted measures relating to diagnosis and treatment of colon and breast cancer, some of which we are told are being considered for modification and inclusion in the PVRP.

The SQA recently embarked on a project to address surgical performance measurement in the ambulatory and office settings. As stated earlier, these environments provide unique challenges in a quality improvement initiative because patient outcomes are extremely good. SQA project participants met earlier this month and developed a starter set of measures that include structure, process, adverse-event reporting, and patient satisfaction measures applicable to ambulatory and office-based care.

Reporting Quality and Performance Data

Healthcare is comprised of many stakeholders, including the purchasers of health insurance, the insurers who sell and contract for care, the providers including physicians, hospitals, and nursing homes, and most importantly, the patients. Each stakeholder has a unique perspective, investment, and interest in quality improvement and reporting. Patients use reports to make informed decisions about healthcare providers; payers and purchasers use reports to contract with providers who produce high-quality and efficient care; and, providers use reports to influence the strategic direction of internal quality improvement efforts.

Given the important and distinctive interests of each stakeholder, reports and performance measures must be developed and designed with a specific goal in mind. Different data elements are important to different healthcare stakeholders. For instance, complex clinical data points may not be as valuable to consumers as they are to providers for internal quality improvement efforts.

Regardless of the audience, however, accurate data and the appropriate context of that data are integral to improving quality. It is easy to make incorrect assumptions about the quality of a healthcare provider based on incomplete data. Current performance measure sets are comprised primarily of process measures that examine a point of care, including assessment of elderly patients for falls for primary care physicians and ordering

of antibiotics for surgeons. Process measures are important to quality improvement efforts because they are an actionable item for the physician or system being measured. In addition, process measures have been favored because they are easily reported using the claims processing system. However, process measures alone do not define the quality of a surgeon, because compliance with process measures does not guarantee high-quality outcomes. For example, a surgeon who complies with antibiotic process measures but has high morbidity rates due to poor technique is not a high-quality surgeon.

To accurately represent the overall quality of a surgeon, a report must contain many variables, including risk-adjusted outcome (observed outcome/expected outcome), process, structure, patient satisfaction, and quality-of-life measures. ACS continues to collaborate with multiple stakeholders in an effort to develop an appropriate and comprehensive measure set that incorporates many quality areas.

Another important component in value-based purchasing is the cost of the services provided. As our nation's healthcare expenditures continue to rise, methods to reduce cost have been widely examined. Cost of care measures are controversial, complex, and are easy to misuse. In linking cost of care measures to quality to develop "efficiency" measures, there is the potential to greatly amplify the errors that exist in the cost component of the measure.

The Current Payment Crisis

While value-based purchasing can improve the quality of care patients receive and allow healthcare stakeholders to make informed decisions about healthcare, it cannot fix the broken Medicare physician payment system. The benefits of a value-based purchasing system will not be fully realized until a stable, fair physician payment system is implemented. The College urges Congress to prevent the 4.7 percent payment cut that will go into effect on January 1, 2007, and explore long-term solutions to this ever-growing problem.

The Sustainable Growth Rate Formula is Broken

For the sixth year in a row, Medicare payments to physicians are scheduled to be cut under the sustainable growth rate (SGR) formula. In 2002, Medicare physician payment was cut by 5.4 percent, and in 2003, 2004, 2005, and 2006 Congress took action to override the SGR and prevent the predicted payment cuts. The Medicare Payment Advisory Commission (MedPAC), CMS Administrator McClellan, and numerous other authorities and policymakers have acknowledged the SGR's problems and limitations and have called on Congress to fix the broken formula. Under the SGR formula, Medicare physician payment will be cut across-the-board by more than 37 percent by 2015, while at the same time the cost of providing care will increase by 20 percent. Simultaneously, other providers, including hospitals and skilled nursing facilities, are enjoying yearly increases in payment rates.

The 4.7 Percent January 1, 2007 Cut Must be Prevented

While ACS greatly appreciates Congress' actions over the past six years to prevent the payment cuts, it is more important than ever that Congress take action to prevent the 4.7 percent cut scheduled for January 1, 2007. The conversion factor increases and freezes over the past several years have not kept pace with the rising cost of delivering care to Medicare beneficiaries. Since 2001, the Medicare Economic Index (MEI) has risen 16 percent, but the conversion factor has decreased and is less than it was in 2001. These differences have been offset by physician practices that are not likely to be able to absorb additional disparities. In its March 2006 report, MedPAC recommended a 2.8 percent positive update for physicians in 2007, and the College supports this recommendation

It is important to understand that in 2007 substantial changes to other components of the Medicare payment formula will shift billions of dollars from certain specialties and practice types to others, which will lead to cuts of up to 10 to 12 percent for some physician services. It is essential that Congress act to provide a rational update to the conversion factor in order to bring some element of stability to an already turbulent system and to help alleviate the payment cuts caused by unrelated policy changes. The non-SGR related changes to physician payment in 2007 include:

1. Five-Year Review

Every five years, CMS is required by law to comprehensively review all work relative value units (RVUs) and make needed adjustments. These adjustments must be made in a budget neutral manner. Changes related to the third five-year review will be implemented on January 1, 2007. In total, more than $4 billion will be shifted to evaluation and management (E/M) codes alone, which will be increased by upwards of 35 percent in some instances. The $4 billion needed to fund these increases is more than total Medicare physician spending on general surgery, cardiac surgery, neurosurgery, colorectal surgery and vascular surgery *combined*. In order to fund these increases, the work RVU of every code on the fee schedule will be reduced by an estimated 10 percent or there will need to be an additional 5 percent cut to the conversion factor. Because there are so many payment changes being implemented as a result of the five-year review, it is difficult to predict the exact impact on various specialties and services. Some services, including the E/M services, will receive overall increases in payment while others, including several key surgical codes, will receive reductions in addition to the budget neutrality adjustments being made because of changes in the time and intensity related to these codes. Further, codes that were not examined in the five-year review will be decreased between 3 and 6 percent to pay for the increases to the E/M codes. For example, if a code has the same value in the 2007 fee schedule as it did in the 2006 fee schedule, it will nonetheless be cut between 3 to 6 percent as a result of increases to other codes. These codes are not being cut because the work and intensity of the codes has changed, but instead are being cut to fund increases to other services in the budget neutral environment.

2. Practice Expense

In its June 20 Notice of Proposed Rule Making, CMS announced significant changes to the formulas used to determine the practice expense RVUs. These changes are also budget neutral and will shift approximately $4 billion to nine medical specialties. These increases will again be paid for by cuts to other specialties, most notably neurosurgery, orthopaedic surgery, ophthalmology, and cardiothoracic surgery.

3. Geographic Practice Cost Index (GPCI)

The Medicare Prescription Drug, Modernization and Improvement Act of 2002 (MMA) included a three-year floor on work GPCI adjustments. Nationwide, 58 of the 89 physician payment areas received a 1 to 2 percent benefit from this provision, which will expire on December 31, 2006. Without the provision, certain providers, mainly in rural areas, will see their payments cut by an additional 1 or 2 percent.

This unprecedented and dramatic shift in the allocation of funding will have a remarkable impact on many physician practices across the country. The College is deeply concerned about the consequences of an SGR-imposed cut in conjunction with those that will result from a reallocation of funding and policy changes. While the total impact of the changes will vary by specialty, geographic location, and practice composition, physicians specializing in certain types of services could see cuts of up to 12 percent before any adjustments to the conversion factor are made as a result of the SGR. Almost all surgical services will receive cuts of 2 to 8 percent in 2007 as a result of

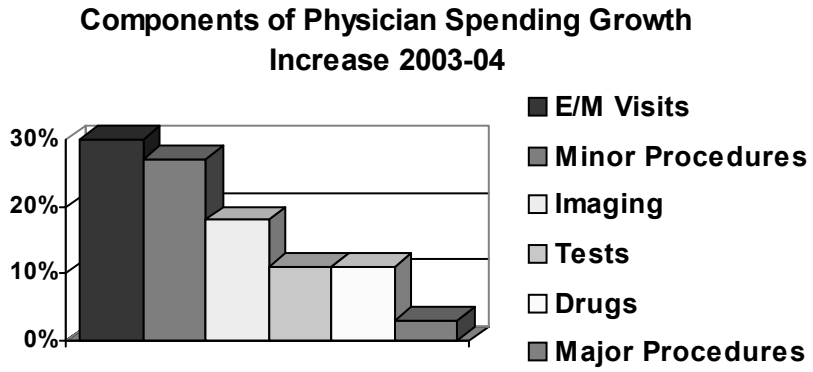
these changes. To bring stability to the payment system, offset the reductions some specialties will experience, and maintain the increases granted to other specialties, ACS strongly encourages Congress to provide a positive update to the conversion factor for 2007.

The Impact of the Current Payment Policy

While it seems all policymakers agree there are problems with the SGR formula, what receives less attention is the devastating impact current payment policies are having on specific specialties and the patients they treat. For surgeons, reimbursements have declined exponentially since the inception of the Resource Based Relative Value System (RBRVS) in 1992 and the SGR in 1996. While some of these decreases are related to actual decreases in the time and intensity of a specific service due to advances in technology, many are not. In general, reimbursement policies have shifted billions of dollars from surgery to other medical specialties.

1. Volume Increases

In the past five years, spending on Medicare physician services has increased between 7 and 14 percent per year. These increases are fueled by growth in the volume and intensity of E/M services, imaging, lab tests, physician-administered drugs, and minor procedures. However, volume for major procedures, those with a 10 or 90 day global period, have remained stagnant--growing by less than 2 percent a year. While other specialties have increased Medicare billings by increasing the volume of the services they provide, surgeons have not. It is much more difficult for surgeons to compensate for payment reductions by providing additional services or by seeing an individual patient more often. As a result, between 1998 and 2005, spending on major procedures and related anesthesia services dropped from 22 percent of total Medicare spending to less than 14 percent. While volume increases in certain areas are justified and can lead to better overall healthcare for beneficiaries, under the current payment system, surgeons are subsidizing these volume increases. For the short term at least, we can anticipate this problem of cross-subsidizing the cost care to become worse, as efforts to increase preventive care and better manage chronic conditions lead to further volume increases in non-surgical service categories,



2. Decreasing Reimbursements/Rising Costs

Since the inception of the Resource-based Relative Value Scale, reimbursement for many surgical procedures has been cut by more than 50 percent, before the effects of inflation are taken into account. At the same time, costs for providing services has increased and policies related to practice expense have shifted funds away from the

surgical specialties. While the MEI is similar for all specialties, the surgical specialties have been impacted disproportionately by rising professional liability premiums. The average premium for surgeons is more than eight times that of other specialties, with certain surgical specialties like neurosurgery paying more than $200,000 a year. Medicare reimbursement rates have not changed proportionately to reflect these changes in the market. A recent study from the Center for Studying Health System Change found that surgeons' income fell by 8.2 percent between 1998 and 2003 despite the fact that the time surgeons spent providing direct patient care increased by 6.2 percent during this same period, widening the gap between hours worked by surgeons and by other physician specialties. Also during that same period, overall professional income in the United States rose by more than 7 percent.

Service	**1989 avg.**	**2006 avg.**	**2007 est.**	**% change**
Cataract removal	$1573	$684	$608	**-61%**
Total knee replacement	$2301	$1511	$1314	**-43%**
TURP - prostatectomy	$1139	$695	$738	**-35%**
Colectomy	$1256	$1226	$1134	**-10%**
Laminectomy	$2078	$1051	$962	**-54%**
CABG	$3957	$2049	$2051	**-48%**
Mastectomy	$1051	$997	$958	**-9%**
Repair retinal detachment	$2833	$1375	$1274	**-55%**
Craniotomy for hematoma	$2018	$1749	$1677	**-17%**
Caesarian delivery	$1038	$1884	$1814	**75%**
Office visit	$31	$53	$60	**94%**

2007 estimates based on CMS June 20, 2006 Notice of Proposed Rule Making

3. Effects on Medicare Beneficiaries

The effects of Medicare payment trends are being felt throughout the healthcare system. In May, the Institute of Medicine concluded in a series of reports entitled the *Future of Emergency Care* that many of the nation's emergency departments and trauma centers are experiencing shortages in the availability of on-call specialists. Surgeons provide lifesaving care to beneficiaries suffering from both traumatic injuries and medical emergencies. Patients suffering from strokes, blockages, and injuries often require timely treatment in order to prevent permanent disability or even death. Without the prompt availability of on-call surgeons, these beneficiaries do not receive the crucial care that they need.

In a report entitled *A Growing Crisis in Patient Access to Emergency Surgical Care*, ACS documented this phenomenon even further. The supply of surgeons has not kept pace with the patient population and a third of all practicing surgeons are nearing retirement age. Across the country, surgeons have reduced their call schedules and dropped or reduced risky or poorly paid services in order to maximize their time in the office.

Many medical students are avoiding a career in surgery all together. In 2006, only 60 percent of first-year surgical residency slots were filled and only 38 percent were filled with U.S.-trained medical students. For some surgical specialties, including cardiac

surgery, resident match numbers continue to plummet as medical students choose more lucrative specialties and those that offer more attractive lifestyles.

Reforming Medicare's Physician Payment System

While, in the short term, ACS sincerely hopes that Congress will act to increase Medicare physician payments in 2007, the College just as strongly supports Medicare payment reform that yields a long-term solution to the future problems posed by the current Medicare physician payment system.

In addition to the immediate challenges posed to surgical care by the pending 4.7 percent cut and the upcoming fee schedule changes for 2007 outlined earlier, there are larger systemic challenges that seriously threaten Medicare beneficiaries' ability to access surgical care in the future. Nowhere was this reality more evident than in this year's Medicare Trustees Report, which was the first report to project nine straight years of cuts in Medicare physician reimbursement, totaling over 37 percent in cuts over that period.

This hearing, along with others held by the Health Subcommittee, demonstrates that the Medicare physician payment crisis is not lost on the Energy and Commerce Committee or on the Congress as a whole. The College greatly appreciates the efforts Committee Chairman Barton, Subcommittee Chairman Deal, Ranking Members Dingell and Brown, and the Committee staff have put forth to study how best to address the long-term challenges posed by the current structure. The College also greatly appreciates Dr. Burgess's recent introduction of the "Medicare Physician Payment and Quality Improvement Act of 2006" and believes his legislation furthers this effort by recognizing the need to replace the current structure with meaningful, lasting reforms.

The College also appreciates the support of this Committee and the Congress to avert Medicare cuts every year since 2003. Unfortunately, these temporary measures have not eliminated the challenges posed by the SGR, and creating a rational payment system that provides incentives for high-quality care and quality improvement is virtually impossible under the construct of Medicare's current physician payment system. That said, this does not mean that a rational payment system that provides incentives for quality care is unattainable, and we believe that a Medicare payment system that recognizes the unique nature of various physician specialties and services would bring the rational structure for comprehensive reform, including a structure that could more easily facilitate the move to a value-based purchasing system in which surgeons can participate.

One of the most irrational elements of the current method for determining physician reimbursement is the universal application of the volume and spending target imposed by the SGR. Even though the nature and type of services provided by different physician specialties often bear little resemblance to those provided by their colleagues in other specialties, the SGR subjects all specialties and services to an universal target on volume and spending that fails to recognize the unique nature of the care and services provided by the different specialties, or different degrees to which various specialties contribute to overall increases in Medicare physician spending. In addition to the obvious differences in the type of care provided by surgeons and other physicians, the services they provide are also billed differently. For example, surgical services are paid on a global basis, which means that, after the initial consultation, all pre- and post-operative care associated with a procedure (up to 90 days after the operation) is included in one payment bundle, regardless of complications or how many post-operative services are required.

With respect to service volume, for surgery generally--especially for major procedures—volume growth has been relatively inelastic, with volume growth averaging between 3 and 4 percent per year. In fact, in its recently released report on Medicare Physician Services, the General Accounting Office (GAO) found that from April 2001 to April 2005, the number of major procedures has declined by 3 percent. The GAO further found that volume generally increased for evaluation and management, minor procedures, imaging, and tests. There are several reasons for this inelastic growth in major

procedures, including the fact that patients rarely self-refer to surgeons; rather, in most cases, surgeons only see patients after another physician has determined that a surgical assessment is needed. As a result, surgeons--along with other physicians who provide services with lower growth rates--bear a disproportionate cost of increased utilization of services they do not provide, regardless of whether or not that growth is justified. This difference in volume elasticity was recognized as far back as 1989, when the current payment system was initially constructed to include different volume growth targets for two, and later three, categories of service.

While the College, along with other physician organizations, has advocated for an elimination of the SGR expenditure target system, that remedy has been elusive for many reasons, not the least of which has been cost concerns. As a result, the College has developed an alternative proposal that we believe has the potential to solve, at least in part, many of the problems posed by the SGR, and has the potential to provide a rational structure that could serve as the basis for other reforms such as value-based purchasing. This proposal also enjoys the support of the American Osteopathic Association.

The Solution – The Service Category Growth Rate

Our proposal would do the following:

- Replace the universal SGR volume target and replace it with a new system, known as the Service Category Growth Rate (SCGR) that recognizes the unique nature of different physician services by setting targets for six distinct categories of physician services, based on the Berenson-Eggers type-of-service definitions already used by CMS:
    - Evaluation and management services;
    - Major procedures (includes those with 10 or 90 day global service periods) and related anesthesia services;
    - Minor procedures and all other services, including anesthesia services not paid under physician fee schedule;
    - Radiology services and diagnostic tests;
    - Diagnostic laboratory tests; and
    - Physician-administered Part B drugs, biologicals, and radiopharmaceuticals.
- The SCGR target would be based on the current SGR factors (trends in physician spending, beneficiary enrollment, law and regulations), except that GDP would be eliminated from the formula and be replaced with a statutorily set percentage point growth allowance for each service category. To accommodate already anticipated growth in chronic and preventive services, we estimate that E/M services would require a growth allowance about twice as large as the other service categories (between 4 and 5 percent for E/M as opposed to somewhere between 2 and 3 percent for other services). Like the SGR, spending calculations under the SCGR system would be cumulative. However, the Secretary would be allowed to make adjustments to any of the targets as needed to reflect the impact of major technological changes.
- Like the SGR, the annual update for a service category would be the MEI plus the adjustment factor. But, in no case could the final update vary from the MEI by more or less than 3 percentage points; nor could the update in any year be less than zero.
- The Secretary could set aside up to one percentage point of the conversion factor for any service category for pay-for-performance incentive payments. In addition, different set aside percentages could be established for each service category.

- The SCGR would provide a framework for the development of value-based purchasing systems that are tailored to differences in the way various physician services are provided.

By recognizing the unique nature of different physician services, the SCGR would enable Medicare to more easily study the volume growth in different physician services and determine whether or not that volume growth is appropriate. In spite of the fact that the only area that many physicians have in common with their colleagues in other specialties is the fact that they are medical school graduates, for reimbursement purposes, Medicare treats all physicians to one global target for the services they provide, even though services often bare little resemblance to those provided by their colleagues. Like the SGR, the SCGR would retain a mechanism for restraining growth in spending for physician services. It would also recognize the wide range of services that physicians provide to their patients. As a result, unlike the current universal target, which penalizes those services with low volume growth at the expense of high volume growth services, the SCGR would provide for more accountability within the Medicare physician payment system by basing reimbursement calculations on targets that compare like services, and providing a mechanism to more closely examine those services with high rates of growth without forcing low growth services to subsidize them, as is the case under the current system.

In addition, the SCGR would provide a framework for starting a basic value-based purchasing system. One of the ideas often floated among our meetings with policymakers is their desire to find a set of measures, a number between 3 and 5 is often mentioned, that broadly apply to all physicians. Given the diversity of physician services provided to patients, this is an almost impossible task. Yet, under the SCGR this task for measure development should be much easier since similar services will be compared. For example, in the case of major procedures, preoperative smoking cessation, measures for marking the surgical site, a surgical timeout, and appropriate post-operative follow-up could apply to most situations, and measuring for such processes could actually be meaningful in improving patient outcomes.

Mr. Chairman, thank you for providing the American College of Surgeons this opportunity to share with you the challenges facing surgeons under the Medicare program today. Whether the focus is on value-based purchasing or on the sustainable growth rate, the College looks forward to continuing to work with you to reform the Medicare physician payment system to ensure that Medicare patients will have access to the surgical care they need, and that the surgical care patients receive is of the highest quality.

Attachment A

ACS History of Involvement in Quality Improvement Initiatives

In 1918, the College initiated a Hospital Standardization Program in an effort to ensure a safe environment and effective system of care for surgical patients and others who are hospitalized. That program ultimately led to the establishment of what is known today as the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO). This commitment continues through the participation of three ACS JCAHO commissioners, as well as through other programs and initiatives conducted by College committees and programs.

Commission on Cancer

In 1922, the College established the multidisciplinary Commission on Cancer to set standards for high-quality cancer care. Today, the commission is comprised of more than 100 individuals representing more than 39 national professional organizations. Among other initiatives, the Commission on Cancer has established cancer program standards and conducted the accreditation of nearly 1,500 hospital cancer programs. It also provides clinical oversight for standard-setting activities and for the development and dissemination of patient care guidelines; and it coordinates national cancer site-specific studies on pattern of care and patient management outcomes through the annual collection, analysis, and dissemination of data for all cancer sites through the National Cancer Database (NCDB).

The NCDB is a nationwide, facility-based, oncology data set that currently captures 75 percent of all newly diagnosed cancer cases in the United States. The database currently holds 15 million cases of reported cancer diagnosis for 1985 through 2002. Data collected includes patient characteristics, tumor staging and characteristics, type of first course treatment, disease reoccurance, and survival information.

American College of Surgeons Oncology Group

The American College of Surgeons Oncology Group (ACOSOG) was established in 1998, primarily to evaluate the surgical management of patients with malignant solid tumors. It includes general and specialty surgeons, representatives of related oncologic disciplines, and allied health professionals in academic medical centers and community practices throughout the U.S. and foreign counties.

The ACOSOG is one of 10 cooperative groups funded by the National Cancer Institute to develop and coordinate multi-institutional clinical trials and is the only cooperative group whose primary focus is the surgical management of patients with malignant solid tumors. Current clinical trials focus on tumors of the breast, melanoma, head and neck cancer, sarcoma and soft tissue tumors, thoracic tumors, and tumors of the central nervous, gastrointestinal, and genitourinary systems. ACOSOG's work will be vital to the development of future standards of care for the surgical management of trauma patients.

Committee on Trauma

The Committee on Trauma (COT) develops the standards that most states employ to designate trauma centers. Since 1989, ACS has been addressing the need for a strong, national, trauma care system through development of the National Trauma Data Bank (NTDB). Designed by a collaborative group of COT members, emergency medical organizations, government agencies, and trauma registry vendors, the NTDB now contains over 1.5 million cases from 565 trauma centers. This data represents the largest aggregation of trauma care data ever assembled.

National Surgical Quality Improvement Program

The National Surgical Quality Improvement Program (NSQIP) is the first nationally validated, risk-adjusted, outcomes-based program that has been demonstrated to accurately measure and improve the quality of surgical care. The program was initially developed by the Department of Veteran's Affairs (VA) in the early 1990s as an outgrowth of the National VA Surgical Risk Study. In the VA system, NSQIP had impressive results, with a 27 percent decline in post-operative mortality, a 45 percent drop in post-operative morbidity, a reduction in average post-operative length of stay from 9 to 4 days, and increased patient satisfaction. In 2001, the College developed its own NSQIP, which expanded the program to the private sector through a grant from the Agency for Healthcare Research and Quality.

The program employs a prospective, peer-controlled, validated database to quantify 30-day risk-adjusted surgical outcomes, allowing valid comparison of outcomes among the hospitals in the program. Medical centers and their surgical staffs are able to use the data to make informed decisions about their continuous quality improvement efforts. The program involves the following key components:

- Data Collection
- Data Monitoring
- Validation Report Generation
- Data Analysis

Of particular interest to hospitals is the generation of a risk-adjusted, observed-to-expected outcome ratio for each center, which can be compared to other participating centers on a blind basis. Statistical analysis of the pre-operative data identifies risk factors, and further analysis calculates the expected outcome for each hospital's patient population.

NSQIP involves a number of mechanisms to provide feedback to the participating hospitals and to the program as a whole. These mechanisms include annual data audits, site visits, and the sharing of best practices. This structured and careful feedback by program staff ensures the consistent reporting of data across sites and the rapid dissemination of information about successful surgical practices and the environments that produce the highest quality of care.

The College has expanded the NSQIP program to over 100 hospitals, including Partners HealthCare hospitals (the Harvard Medical School system). Many hospitals are in the queue for NQSIP adoption and are currently being added at a rate of five hospitals per month. In 2002, the Institute of Medicine named the NSQIP "the best in the nation" for measuring and reporting surgical quality and outcomes.

Surgical Care Improvement Project

The College is one of the 10 organizations on the Surgical Care Improvement Project (SCIP) steering committee. SCIP is a national partnership of organizations dedicated to improving the safety of surgical care by reducing post-operative complications. Its steering committee reflects the range of public and private organizations that must work together to reduce surgical complications, and includes groups representing surgeons, anesthesiologists, perioperative nurses, pharmacists, infection control professionals, hospital executives, and others who are working to improve surgical patient care.

The program was initiated in 2003 by the Centers for Medicare and Medicaid Services and the Centers for Disease Control and Prevention. This summer, the SCIP partnership will launch a multi-year national effort to reduce surgical complications by 25 percent by 2010.

SCIP quality improvement efforts are focused on reducing perioperative complications in the following four areas, where the incidence and cost of complications are significant:

- Surgical site infections
- Adverse cardiac events
- Venous thromboembolism
- Postoperative pneumonia

SCIP stresses that surgical care can be improved significantly through better adherence to evidence-based recommendations and increased attention to designing systems of care with thorough safeguards. Other evidence-based programs such as NSQIP, the National Nosocomial Infections Surveillance (NNIS) system, and the Medicare quality improvement organizations, have demonstrated this time and again. ACS is proud to play a leadership role in the development of the SCIP target areas, and our organization will continue to play a significant role in further developing SCIP initiatives.

ACS Bariatric Surgery Center Network Accreditation Program

Recently, ACS developed a Bariatric Surgery Center Network (BSCN) Accreditation Program to foster high-quality care for patients undergoing bariatric surgery for morbid obesity. The program describes the necessary physical resources, human resources, clinical standards, surgeon credentialing standards, data reporting standards, and verification/approvals processes required for designation as a "bariatric surgery center."

Severe obesity has reached epidemic proportions and because weight-reduction surgery provides an effective treatment for the condition -- and because the number of surgeons and hospitals providing this care has grown so quickly--the College decided to place a high priority on establishing this new accreditation program. The College contracts with hospitals and outpatient facilities that agree to implement this program and other resource standards by reporting outcomes data on all their bariatric surgery patients, submitting to site visits, and completing annual status reports. By reviewing existing studies and consulting with experts in the field, ACS has developed standards, defined necessary resources, organized the means of collect data, and organized the processes for conducting site visits to accredit hospitals and outpatient facilities in order to improve patient safety.

Surgical Patient Safety: Essential Information for Surgeons in Today's Environment

ACS has recently issued a patient safety manual titled Surgical Patient Safety: Essential Information for Surgeons in Today's Environment. This publication provides information and guidance for surgeons and others involved in surgical patient safety. It describes a variety of practical resources and provides a broad overview of key issues, such as the scientific basis of surgical patient safety.

Specifically, this manual analyzes the human factors, systems analyses, and processes affecting surgical patient safety. Issues such as decision-support, electronic prescribing, and error detection, analysis, and reporting are analyzed. Legal challenges for surgeon participation in patient safety activities are also reviewed. Broad error prevention methods such as the use of surgical simulation, educational interventions, and quality improvement initiatives are covered. In addition, the manual provides strategies for preventing wrong-site surgery and for safe blood transfusion and handling.

Surgical Quality Alliance (SQA)

The SQA is a collaboration among specialty societies that provide surgical care to improve the quality of care for the surgical patient, to define principles of surgical quality

measurement and reporting, and to develop awareness about unique issues related to surgical care in all settings. It has been an important avenue for education, discussion, and cooperation between surgical disciplines, as well as a means of participating in the multitude of quality efforts. At its first meeting in December 2005, SQA members developed four global process measures that were submitted to CMS on March 1 and June 1, 2006. In addition, the SQA has commented on National Quality Forum and AQA initiatives and continues to develop performance measures and reporting tools for surgery. The following specialty societies participate in the SQA:

- American Academy of Ophthalmology
- American Academy of Otolaryngology
- American Association for Hand Surgery
- American Association of Neurological Surgeons
- American Association of Orthopaedic Surgeons
- American College of Osteopathic Surgeons
- American College of Surgeons
- American Society of Anesthesiologists
- American Society of Breast Surgeons
- American Society of Cataract and Refractive Surgery
- American Society of Colon and Rectal Surgeons
- American Society of General Surgeons
- American Society of Plastic Surgeons
- American Urological Association
- Congress of Neurological Surgeons
- Society for Vascular Surgery
- Society of American Gastrointestinal Endoscopic Surgeons
- Society of Gynecologic Oncologists
- Society of Surgical Oncology
- Society of Thoracic Surgeons

ATTACHMENT B

March 1, 2006

The Honorable Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Dear Dr. McClellan:

On behalf of the respective members of the undersigned societies representing specialties that provide surgical care, we are pleased to comment on the surgical measures included in the Physician Voluntary Reporting Program (PVRP) as announced by the Centers for Medicare and Medicaid Services (CMS) on October 28, 2005 and as modified on December 27.

We understand that in the current health care environment, performance measurements are based on administrative data. These data are collected for reimbursement purposes and, as shown by numerous studies, are a poor proxy for quality and performance measurements. The surgical community strongly supports quality initiatives and believes the need for clinical data to replace the current proxy is essential to a successful program. In addition, physicians who participate in national, recognized clinical databases should have a mechanism to submit clinical data instead of administrative data for performance measurement.

Physician-specific performance measures defined by numerators, denominators, and inclusion and exclusion criteria represent a new means of capturing metrics. Our comments on the criteria in your proposal intend to better refine the codes to reflect a quality measure. For example, the use of CPT codes with 10-day and 90-day global categories is another option for the denominator, and could be an efficient means of organizing certain surgical measures. As your proposal currently stands, surgeons must keep a list of surgical procedures in front of them to know whether a procedure is subject to quality measures. A more global approach could enhance end-user acceptance and provide the added benefit that CMS does not have to go through the CPT annual update to identify and classify new CPT codes.

Instructions for the PVRP should specifically address what is to be displayed and/or left blank on the claim form. We request complete instructions for reporting Line 24, as there is a contradiction between current PVRP instructions and claim form instructions. For example, are place and type of service to be shown for PVRP line items? If so, are the same codes to be shown for the surgery? In addition, it is unclear if a G-code can be submitted on a supplemental form after the original claim has been submitted. There are two instances when a supplemental G-code may be necessary, 1) the G-code is accidentally omitted from a claim form, or 2) the G-code does not occur at the same time as the corresponding procedure, as with discharge instructions.

With respect to PVRP participation, it is important to keep in mind that without funding, a high level of participation will likely be difficult to attain. Adding an administrative burden with a clinical interface represents a material change in the workflow of a clinical office. CMS should consider funding pilot programs in the next phase of the physician quality initiative.

We appreciate your efforts to engage physicians on issues of performance measurement and quality improvement and hope that our comments will improve the PVRP and surgical patient care.

SUGGESTED REVISIONS TO SURGERY-RELATED MEASURES

The following are suggested revisions to surgery-related measures currently found in the PVRP**.**

1) Receipt of autogenous arteriovenous fistula in advanced chronic kidney disease patient and end-stage renal disease (ESRD) patient requiring hemodialysis

The current G-codes need to be expanded to include chronic kidney disease patients because a central goal of the Fistula First initiative is to place a native access in renal failure patients before they advance to ESRD. We also suggest that additional wording be added to clarify that the G-codes be applied when the patient has undergone a non-catheter hemodialysis access operation. The proposed update:

- *Allows for a more accurate representation of autogenous AV fistula use.*
- *Includes an exclusion code for patients who are not eligible for a fistula.*
- *Eliminates three CPT codes that are no longer relevant (36800, 36810 and 36815).*

Proposed Update: Receipt of autogenous arteriovenous fistula in end-stage renal disease patient requiring hemodialysis

GXXX1 (formally G8081): Advanced chronic kidney disease patient or end-stage renal disease patient undergoing non-catheter hemodialysis vascular access documented to have received autogenous AV fistula.

GXXX2 (formally G8082) Advanced chronic kidney disease patient or end-stage renal disease patient requiring non-catheter hemodialysis vascular access documented to have received AV access using other than autogenous vein.

GXXX3: Clinician documented that advanced chronic kidney disease patient or end-stage renal disease patient requiring hemodialysis vascular access was not an eligible candidate for autogenous AV fistula.

Denominator: CPT codes 36818, 36819, 36820, 36821, 36825, and 36830 with ICD-9-CM codes 585.4, 585.5, and 585.6.

2) Antibiotic prophylaxis in surgical patient

The current measure includes the language, "patient documented to have received antibiotic prophylaxis" making this a hospital-based measure. The proposed update:

- *More accurately measures a surgeon's performance by including the language "documentation in the medical record that surgeon ordered…"*
- *Expands the measure's applicability by including the use of antiseptics.*
- *Distinguishes between antibiotics/antiseptics not indicated for procedure and a medical or patient reason for not ordering antibiotics/antiseptics.*
- *Expands the denominator to include all non-emergency 10-day and 90-day global procedures.*

Proposed Update: Antibiotics or Antiseptics Ordered Prior to Incision

GXXX4 Documentation in the medical record that surgeon ordered prophylactic antibiotics or antiseptics be delivered within one hour of incision.

GXXX5 No documentation in the medical record that surgeon ordered prophylactic antibiotics or antiseptics be delivered within one hour prior to incision.

GXXX6 Documentation in the medical record of medical or patient's reason(s) for surgeon not ordering prophylactic antibiotics or antiseptics within one hour of incision.

GXXX7 Documentation in the medical record that prophylactic antibiotics or antiseptics are not indicated for procedure.

Denominator: All non-emergency 10-day and 90-day global procedures, and specified 0-day global procedures to be supplied by the American Academy of Otolaryngology.

3) Thromboembolism prophylaxis in surgical patient

As with the antibiotic prophylaxis measure, this measure's current wording makes it more applicable to hospitals than physicians. The proposed update:

- *More accurately measures a physician's performance by including the language "documentation in the medical record that surgeon ordered..."*
- *Distinguishes between DVT prophylaxis not indicated for procedure and a medical or patient reason for not ordering DVT prophylaxis.*
- *Expands the denominator to include all non-emergency 90-day global procedures.*

Proposed Update: DVT Prophylaxis

GXXX8 Documentation in the medical record that surgeon ordered appropriate DVT prophylaxis consistent with current guidelines.

GXXX9 No documentation in the medical record regarding appropriate DVT prophylaxis consistent with current guidelines.

GXX10 Documentation in the medical record of medical or patient's reason(s) for not ordering appropriate DVT prophylaxis consistent with current guidelines.

GXX11 Documentation in the medical record that DVT prophylaxis is not indicated for procedure.

Denominator: All non-emergency 90-day global procedures.

PROPOSED ADDITIONS TO THE PVRP

The following are proposed surgery-related additions to the PVRP.

1) Antibiotics or Antiseptics Administered Prior to Incision

In the case of prophylactic antibiotics or antiseptics prior to incision, it is not only important to measure weather the service was ordered by the surgeon, but also to measure the administration of the prophylactic antibiotics or antiseptics by the anesthesiologist or other physician.

Numerator:

GXX12 Documentation in the medical record that anesthesiologist or other appropriate provider administered prescribed prophylactic antibiotics or antiseptics within one hour prior to incision (within two hours for vancomycin).

GXX13 No documentation in the medical record that anesthesiologist or other appropriate provider administered prescribed prophylactic antibiotics or antiseptics within one hour of incision (two hours for vancomycin).

GXX14 Documentation in the medical record that prophylactic antibiotics or antiseptics were not ordered for the procedure.

Denominator: All non-emergency 10-day and 90-day global procedures and anesthesia CPT codes 00100-01995 and 01999.

2) Cardiac Risk, History, Current Symptoms and Physical Examination - Surgeon

Adverse cardiac events occur in 2-5 percent of patients undergoing non-cardiac surgery and in 34 percent of patients undergoing vascular surgery. The National Quality Forum (NQF) *Safe Practices for Better Healthcare* includes an evaluation of each patient undergoing non-emergency surgery for risk of an adverse cardiac event.

Numerator:

GXX15 Documentation in the medical record that the surgeon assessed the patient for history of conditions associated with elevated cardiac risk and examined the patient for current signs of cardiac risk.

GXX16 Documentation in the medical record that surgeon received a cardiac risk assessment from an appropriate provider.

GXX17 No documentation in the medical record that the surgeon or other appropriate provider assessed the patient for history of conditions associated with elevated cardiac risk and examined the patient for current signs of cardiac risk.

GXX18 Documentation in the medical record that history of conditions associated with elevated cardiac risk could not be obtained.

Denominator: All non-emergency 10-day and 90-day global procedures.

3) Cardiac Risk, History, Current Symptoms and Physical Examination - Anesthesiologist

Both the surgeon and anesthesiologist's cardiac risk assessment are vital to the safety of the patient. Both physicians should be able to report a cardiac risk assessment g-code.

Numerator:

GXX19 Documentation in the medical record that anesthesiologist assessed the patient for history of conditions associated with elevated cardiac risk and examined the patient for current signs of cardiac risk.

GXX20 Documentation in the medical record that anesthesiologist received a cardiac risk assessment from an appropriate provider.

GXX21 No documentation in the medical record that the anesthesiologist or other appropriate provider assessed the patient for history of conditions associated with elevated cardiac risk and examined the patient for current signs of cardiac risk.

GXX22 Documentation in the medical record that history of conditions associated with elevated cardiac risk could not be obtained.

Denominator: Anesthesia CPT codes 00100-01995 and 01999.

4) Preoperative Smoking Cessation

Smoking cessation measures have been endorsed by various quality organizations including the NQF, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and the Physician Consortium for Performance Improvement (PCPI) for patients with specific disorders.

Smoking prior to surgery can lead to increased incidence of wound complications, diminished vascularity and poor wound healing.

Numerator:

GXX23 Documentation in the medical record that surgeon provided patient with information on the benefits of preoperative smoking cessation.

GXX24 No documentation in the medical record that surgeon provided patient with information on the benefits of preoperative smoking cessation.

GXX25 Documentation in the medical record that patient does not smoke.

Denominator: All non-emergency 90-day global procedures.

5) Wrong-Side, Wrong-Site, Wrong-Person Surgery Prevention

Wrong-side, wrong-site, wrong-person surgery is included in NQF's *Serious Reportable Events in Healthcare* and *Safe Practices for Better Healthcare*. Though JCAHO introduced the Universal Protocol for Preventing Wrong Site, Wrong Procedure, and Wrong Person Surgery in July 2004, problems still exist. Between September 30, 2004 and September 30, 2005, 62 new cases of wrong-side, wrong-site, and wrong-person surgery were reported to JCAHO's Sentinel Event Database. We believe it is important to use every means possible, including quality programs, to prevent wrong-side, wrong-site, and wrong-person procedures.

Numerator:

GXX26 Documentation in the medical record that surgeon participated in a "time out" with members of the surgical team to verify intended patient, procedure, and surgical site.

GXX27 No documentation in the medical record that surgeon participated in a "time out" with members of the surgical team to verify intended patient, procedure, and surgical site.

Denominator: All non-emergency 10-day and 90-day global procedures.

6) Patient Copy of Preoperative Instructions

The NQF and the American Medical Association have written about the adverse events that occur when patients are not fully informed. We believe that patients should be given a copy of preoperative instructions that can be taken home, easily referred to, and shared with appropriate family, friends, and caregivers.

Numerator:

GXX28 Documentation in the medical record that surgeon gave, or directed staff to give, a copy of preoperative instructions to the patient.

GXX29 No documentation in the medical record that surgeon gave, or directed staff to give, a copy of preoperative instructions to the patient.

Denominator: All non-emergency 10-day and 90-day global procedures.

7) Patient Copy of Postoperative Discharge Instructions

JCAHO, NQF, and CMS have endorsed measures for discharge instructions for heart failure patients. We believe that discharge instructions should be given to all surgical patients as a means of educating the patient and their family about activity level, diet, discharge medications, proper incision care, symptoms of a surgical site infection, what to do if symptoms worsen, and follow-up appointments.

Numerator:

GXX30 Documentation in the medical record that surgeon provided, or directed staff to provide, written discharge instructions that address all of the following: activity level, diet, discharge medications, proper incision care, symptoms of surgical site infection, what to do if symptoms worsen, and follow-up appointments.

GXX31 No documentation in the medical record that surgeon provided, or directed staff to provide, written discharge instructions.

GXX32 Patient died prior to discharge.

Denominator: All 10-day and 90-day global procedures.

Thank you again for the opportunity to comment on the PVRP and for your efforts to improve the quality of our nation's healthcare. Please do not hesitate to contact us with any questions or concerns.

Sincerely,

American Academy of Ophthalmology
American Academy of Otolaryngology
American Association of Neurological Surgeons
American Association of Orthopaedic Surgeons
American College of Osteopathic Surgeons
American College of Surgeons
American Society of Anesthesiologists
American Society of Cataract and Refractive Surgery
American Society of General Surgeons
American Society of Plastic Surgeons
American Urological Association
Congress of Neurological Surgeons
Society for Vascular Surgery
Society of Thoracic Surgeons

cc: Trent Haywood, JD, MD

June 1, 2006

The Honorable Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Dear Dr. McClellan:

On behalf of the respective members of the undersigned societies representing specialties that provide surgical care, we appreciate the opportunity to expand on our March 1, 2006 letter, as well as previous meetings and calls, regarding the Centers for Medicare and Medicaid Services' (CMS) Physician Voluntary Reporting Program (PVRP). After reviewing the latest version of the PVRP (effective April 1), it is clear that the comments of the surgical community have not been incorporated into the program.

While we understand your interest in the measures being developed in the Physician Consortium for Performance Improvement (PCPI) and have been actively involved in that effort, we also understand that measures from the Perioperative Workgroup will not be finalized for many months. As your office has stated, the PVRP offers physicians an opportunity to report on performance measures as a "trial run". Unfortunately, many specialties, including plastic surgery, ophthalmology and anesthesiology are unable to participate because 1) the current measures do not relate to their specialty or 2) applicable specialty procedure codes are not included in the measure's denominator.

It is vital that physician measures represent physician activities. As stated by the PCPI, performance measures should be "potentially actionable by the user. The measure (should) address an area of health care that (is) potentially under the control of the physician, health care organization or health care system that it assesses." Hospital-level measures should not be used to measure physician performance.

On many occasions, CMS has stated that the current measure set has been through a consensus development process. Unfortunately, the PVRP contains hospital-level, surgical measures that have not been vetted for physician measurement, including the antibiotic and VTE prophylaxis measures.

While we appreciate your efforts to engage physicians on issues of performance measurement and quality improvement, it is also important to recognize quality efforts already in use. Specialty societies collecting clinical data should be allowed to use that data for quality improvement programs, including the PVRP. Clinical data is superior in measuring quality and should be used instead of administrative data when available.

It is our understanding that the first quarter of the PVRP will end June 30, with the second quarter running from July 1 through September 30. In addition, we understand that significant lead time is required for implementation and therefore ask that our proposed changes and additions be reviewed for incorporation into the program for the third quarter beginning October 1, 2006 to ensure the entire surgical community has the option of voluntary participation.

Thank you again for the opportunity to comment on the PVRP. We hope that our comments will improve the program and care for the surgical patient.

DENOMINATOR CHANGES NEEDED

The current surgical codes included in the antibiotic and VTE prophylaxis denominators need to be reviewed for accuracy. An example of current problems with the DVT Measure Denominator is below.

47133 – Donor Hepatectomy, (including cold preservation), from cadaver donor. DVT prophylaxis does not need to be received by a cadaver.

Developing denominators for performance measures that traverse many surgical specialties is a daunting task complicated by a paucity of reasonable evidence. For example, numerous common clinical practices do not address proper antibiotic or venous thromboembolism prophylaxis in surgery. In order to promote buy-in to the entire quality initiative, the surgical specialty societies and the American Society of Anesthesiologists are currently reviewing the evidence and guidelines for procedures in which antibiotic and venous thromboembolism prophylaxis are indicated. The societies will build consensus on codes for inclusion in these measures. During this process, societies are examining families of codes in addition to single codes from the family that may be appropriate for inclusion in the denominators. The Surgical Quality Alliance will provide a list of codes and will periodically update the list to maintain current measures.

SUGGESTED REVISIONS TO SURGERY-RELATED MEASURES

The following are suggested revisions to surgery-related measures currently found in the PVRP.

1) Receipt of autogenous arteriovenous fistula in advanced chronic kidney disease patient and end-stage renal disease (ESRD) patient requiring hemodialysis

Proposed Update

GXXX1 (formerly G8081): Advanced chronic kidney disease patient or end-stage renal disease patient undergoing non-catheter hemodialysis vascular access documented to have received autogenous AV fistula.

GXXX2 (formerly G8082) Advanced chronic kidney disease patient or end-stage renal disease patient requiring non-catheter hemodialysis vascular access documented to have received AV access using other than autogenous vein.

GXXX3: Clinician documented that advanced chronic kidney disease patient or end-stage renal disease patient requiring hemodialysis vascular access was not an eligible candidate for autogenous AV fistula.

Denominator: CPT codes 36818, 36819, 36820, 36821, 36825, and 36830 with ICD-9-CM codes 585.4, 585.5, and 585.6.

2) Antibiotic prophylaxis in surgical patient

Proposed Update

GXXX4 Documentation in the medical record that surgeon ordered prophylactic antibiotics be delivered within one hour of incision.

GXXX5 No documentation in the medical record that surgeon ordered prophylactic antibiotics be delivered within one hour prior to incision.

GXXX6 Documentation in the medical record of medical or patient's reason(s) for surgeon not ordering prophylactic antibiotics within one hour of incision.

GXXX7 Documentation in the medical record that prophylactic antibiotics are not indicated for procedure.

3) Venous thromboembolism (VTE) prophylaxis

Proposed Update

GXXX8 Documentation in the medical record that surgeon ordered appropriate VTE prophylaxis consistent with current guidelines.

GXXX9 No documentation in the medical record regarding appropriate VTE prophylaxis consistent with current guidelines.

GXX10 Documentation in the medical record of medical or patient's reason(s) for not ordering appropriate VTE prophylaxis consistent with current guidelines.

GXX11 Documentation in the medical record that VTE prophylaxis is not indicated for procedure.

PROPOSED ADDITIONS TO THE PVRP

The following are proposed surgery-related additions to the PVRP.

1) Antiseptics Ordered Prior to Incision

GXXX4 Documentation in the medical record that surgeon ordered prophylactic antiseptics be delivered within one hour of incision.

GXXX5 No documentation in the medical record that surgeon ordered prophylactic antiseptics be delivered within one hour prior to incision.

GXXX6 Documentation in the medical record of medical or patient's reason(s) for surgeon not ordering prophylactic antiseptics within one hour of incision.

Denominator: 66830, 66840, 66850, 66852, 66920, 66930, 66940, 66982, 66983, 66984, 66985, 66986.

2) Antibiotics Administered Prior to Incision

GXX12 Documentation in the medical record that anesthesiologist or other appropriate provider administered prescribed prophylactic antibiotics within one hour prior to incision or within two hours for vancomycin (from start time if no incision is required).

GXX13 No documentation in the medical record that anesthesiologist or other appropriate provider administered prescribed prophylactic antibiotics within one hour of incision or within two hours for vancomycin (from start time if no incision is required).

GXX15 Documentation in the medical record that prophylactic antibiotics were not ordered for the procedure.

GXXX7 Documentation in the medical record that prophylactic antibiotics are not indicated for procedure.

Denominator: Anesthesia CPT codes 00100-01995 and 01999.

3) Cardiac Risk, History, Current Symptoms and Physical Examination - Surgeon

GXX15 Documentation in the medical record that the surgeon assessed the patient for history of conditions associated with elevated cardiac risk and examined the patient for current signs of cardiac risk.

GXX16 Documentation in the medical record that surgeon received a cardiac risk assessment from an appropriate provider.

GXX17 No documentation in the medical record that the surgeon or other appropriate provider assessed the patient for history of conditions associated with elevated cardiac risk and examined the patient for current signs of cardiac risk.

GXX18 Documentation in the medical record that history of conditions associated with elevated cardiac risk could not be obtained.

Denominator: 10-day and 90-day global procedures.

4) Cardiac Risk, History, Current Symptoms and Physical Examination - Anesthesiologist

GXX19 Documentation in the medical record that anesthesiologist assessed the patient for history of conditions associated with elevated cardiac risk and examined the patient for current signs of cardiac risk.

GXX20 Documentation in the medical record that anesthesiologist received a cardiac risk assessment from an appropriate provider.

GXX21 No documentation in the medical record that the anesthesiologist or other appropriate provider assessed the patient for history of conditions associated with elevated cardiac risk and examined the patient for current signs of cardiac risk.

GXX22 Documentation in the medical record that history of conditions associated with elevated cardiac risk could not be obtained.

Denominator: Anesthesia CPT codes 00100-01995 and 01999.

5) Preoperative Smoking Cessation

GXX23 Documentation in the medical record that surgeon and/or anesthesiologist provided patient with information on the benefits of preoperative smoking cessation.

GXX24 No documentation in the medical record that surgeon and/or anesthesiologist provided patient with information on the benefits of preoperative smoking cessation.

GXX25 Documentation in the medical record that patient does not smoke.

GXX26 Documentation of emergency surgery that did not allow preoperative smoking cessation.

Denominator: 90-day global procedures.

6) Wrong-Side, Wrong-Site, Wrong-Person Surgery Prevention (Time-Out)

GXX26 Documentation in the medical record that surgeon participated in a "time out" with members of the surgical team to verify intended patient, procedure, and surgical site.

GXX27 No documentation in the medical record that surgeon participated in a "time out" with members of the surgical team to verify intended patient, procedure, and surgical site.

Denominator: 10-day and 90-day global procedures.

7) Patient Copy of Preoperative Instructions

GXX28 Documentation in the medical record that surgeon gave, or directed staff to give, a copy of preoperative instructions to the patient.

GXX29 No documentation in the medical record that surgeon gave, or directed staff to give, a copy of preoperative instructions to the patient.

GXX26 Documentation of emergency surgery that did not allow for preoperative instruction.

Denominator: 10-day and 90-day global procedures.

8) Patient Copy of Postoperative Discharge Instructions

GXX30 Documentation in the medical record that surgeon provided, or directed staff to provide, written discharge instructions that address all of the following: activity level, diet, discharge medications, proper incision care, symptoms of surgical site infection, what to do if symptoms worsen, and follow-up appointments.

GXX31 No documentation in the medical record that surgeon provided, or directed staff to provide, written discharge instructions.
GXX32 Patient died prior to discharge.

Denominator: 10-day and 90-day global procedures.

Thank you again for the opportunity to comment on the PVRP and for your efforts to improve the quality of our nation's healthcare. Please do not hesitate to contact Julie Lewis at the American College of Surgeons (jlewis@facs.org or 202.672.1507) with any questions or concerns.

Sincerely,

American Academy of Ophthalmology
American Academy of Otolaryngology – Head and Neck Surgery
American Association of Neurological Surgeons
American Association of Orthopaedic Surgeons
American College of Osteopathic Surgeons
American College of Surgeons
American Society of Anesthesiologists
American Society of Cataract and Refractive Surgery
American Society of Colon and Rectal Surgeons
American Society of General Surgeons
American Society of Plastic Surgeons
American Urological Association
Congress of Neurological Surgeons
Society for Vascular Surgery
Society of American Gastrointestinal Endoscopic Surgeons
Society of Thoracic Surgeons

MR. FERGUSON. Thank you, Dr. Opelka. Dr. Kirk, you are recognized for 5 minutes.

DR. KIRK. Thank you, Mr. Chairman, and members of the committee. I am Lynne Kirk, President of the American College of Physicians.

MR. FERGUSON. Dr. Kirk, would you just turn your microphone on, please?

DR. KIRK. I am Lynne Kirk, President of the American College of Physicians. I am a general internist and Associate Dean for Graduate Medical Education at UT Southwestern Medical Center in Dallas. For 26 years, I have had the privilege of providing healthcare to thousands of Texans, while training the next generation of physicians. My community is just a short distance, by Texas standards, from the districts represented by Chairman Barton, Mr. Hall, Dr. Burgess, and Mr. Green.

The ACP is the largest specialty society in the U.S., representing 120,000 internal medicine physicians and medical students. More Medicare patients receive their care from internists than from any other specialty. Medicare should support high quality, efficient care centered on patients' relationships with their personal physicians. Instead,

Medicare provides incentives that often result in fragmented, high volume, overspecialized, and inefficient care.

We are proposing the implementation of a model of healthcare that research suggests would improve healthcare outcomes, and ultimately, lower costs. In slide 1, in the chart on slide 1, under appendix A in your handout, the Medicare Payment Advisory Commission has reported that high quality ambulatory care can prevent hospital admissions for diseases like chronic lung disease and diabetes.

In the next chart, it shows 10 clinical conditions where, according to the Commonwealth Fund, effective diagnosis, treatment, and patient education can prevent or delay complications of chronic illness, thus reducing hospitalizations.

Unfortunately, Medicare payments do not support the organization of our practices to help prevent some of the complications for patients with chronic diseases. Medicare pays for office visits and procedures, but it will not reimburse for the time I spend following up with my patients on self-management plans, or for coordinating their care among other health professionals. It does not reimburse for information technologies that help me to track their patient information and improve the care I provide.

Today, we call on Congress to direct Medicare to pilot test a new model of care, called the patient-centered medical home. The American Academy of Family Physicians recently joined us in describing the four key elements of this patient-centered medical home. First, each patient has a relationship with a personal physician trained to provide first contact, continuous and comprehensive care, working with a team that collectively takes responsibility for the care of a group of patients. Second, this care is coordinated across all domains of the healthcare system, and is facilitated by patient registries and HIT. Third, patients participate in decision-making, and are provided with enhanced access through systems such as open scheduling and email consultations. Finally, patient-centered medical homes are accountable. Practices will demonstrate that they can provide patient-centered services, and will regularly report on the quality of care provided.

This patient-centered medical home requires a different way of reimbursing physicians. Payments should reflect the values of services involved in coordinating care that falls outside of the office visit. Payments should be sufficient to support needed HIT. Physicians should be able to earn higher performance-based payments, and share in savings from avoidable hospitalizations.

ACP also calls for a broad-based program to begin linking Medicare payments to reporting on quality measures. This program should be based on the work of AMA's consortium, the NQF, and the AQA. The AQA is engaged in selecting quality measures for both ambulatory and

inpatient care. The ACP was one of the four original founding members of the AQA, which now includes over a hundred stakeholders working collaboratively to select uniform, transparent, and evidence-based physician performance measures.

The ACP believes that a Medicare pay-for-reporting program should be voluntary. Physicians who participate should receive additional payments. Those who do not should not be penalized with cuts. It should be funded by creating a physician's quality improvement pool, in addition to allocating dollars to provide positive updates for all physicians. Our written statement includes a pathway for repealing the sustainable growth rate and providing stable and positive updates.

We commend Dr. Burgess for proposing a similar pathway, and we also appreciate Mr. Dingell's introduction of legislation to avert the SGR cuts. It should redirect a portion of savings in other parts of Medicare attributable to physicians' quality improvement efforts back to the physician quality improvement pool. It should begin with AQA's high impact clinical measures for ambulatory care, heart disease, and thoracic surgery. These address diseases that are prevalent in Medicare, expensive, and sensitive to reduced hospital admissions. It should allocate performance payments on a weighted basis, providing an incentive for physicians to report on measures to achieve the greatest quality strides, rather than on measures with little impact. It should take into account patient severity of illness and adherence to prevent adverse selection of patients.

In conclusion, the patient-centered medical home can put Medicare on a pathway to a system that facilitates high quality and efficient care, centered on patients' relationships with their primary care physicians.

I appreciate this opportunity to share out views, and am pleased to answer any questions.

[The prepared statement of Dr. Lynne Kirk follows:]

PREPARED STATEMENT OF DR. LYNNE M. KIRK, ASSOCIATE DEAN FOR GRADUATE MEDICAL EDUCATION, UNIVERSITY OF TEXAS SOUTHWESTERN MEDICAL SCHOOL, ON BEHALF OF AMERICAN COLLEGE OF PHYSICIANS

Summary

ACP believes that Congress should embrace the opportunity to report legislation this year that will transition dysfunctional Medicare payment policies to a bold new framework that will improve quality and lower costs by aligning incentives with the needs of patients. This transition should:

1) Lead to repeal of the SGR by a specified date;
2) Guarantee positive updates so that all physicians receive predictable and fair payments during any transition period;

3) Allow time for Congress to review alternative approaches to addressing inappropriate volume increases during such a transition;
4) Increase reimbursement for care provided by primary and principal care physicians;
5) Create a better process to identify potentially overvalued services;
6) Implement a pilot test of the patient-centered advanced medical home and other reimbursement changes to facilitate physician-guided care coordination;
7) Implement incentive-based payments for health information technology to support quality measurement and improvement; and

Initiate a voluntary pay-for-reporting program that begins with "high impact" measures that have been approved by the NQF and AQA and that reimburses physicians on a weighted basis related to the number, impact, and commitment of resources associated with the measures being reported.

Thank you, Chairman Deal and Ranking Member Brown:

I am Lynne Kirk, MD, FACP. I am President of the American College of Physicians, a general internist, and an Associate Dean for Graduate Medical Education at the UT Southwestern Medical Center in Dallas. For the past twenty six years, I have had the privilege to live and work in the great state of Texas, providing health care to thousands of Texans while training the next generation of American physicians.

The College is the largest specialty society in the United States, representing 120,000 internal medicine physicians and medical students. More Medicare patients count on internists for their medical care than any other physician specialty. Consequently, we have an abiding professional commitment to making sure that our Medicare patients get the best care possible, by advocating for Medicare payment policies that meet the needs of our elderly and disabled patients.

Regrettably, they do not.

Instead of encouraging high quality and efficient care *centered on patients' needs*, existing Medicare payment policies have contributed to a *fragmented, high volume, over-specialized and inefficient model of health care delivery that fails to produce consistently good quality* outcomes for patients.

Medicare Payment Policies are Dysfunctional

The College believes that Medicare payment policies are fundamentally dysfunctional because they do not serve the interests of patients enrolled in the program and the taxpayers that support the program:

1. <u>Medicare payment policies discourage internists and other primary and principal care physicians from organizing care processes to achieve optimal results for patients.</u>

Research shows that health care that is *managed and coordinated by a patient's personal physician*, using systems of care centered on patients' needs, can achieve better outcomes for patients and potentially lower costs by reducing complications and avoidable hospitalizations. Such care usually will be managed and coordinated by a primary care physician, which for the Medicare population typically will be an internist who is trained and practices in general medicine or geriatrics or a family physician. In some cases, a qualified internal medicine subspecialist, such as an endocrinologist, may fill this role as a "principal care" physician by accepting responsibility for managing and coordinating the total spectrum of a patient's health care needs rather than being limited only to providing care that falls within their specialized training.

The Medicare Payment Advisory Commission (MedPAC) has reported that "*potentially avoidable [hospital] admissions are admissions that high quality ambulatory care has been shown to prevent*." [MedPAC, A Data Source, Healthcare Spending and

the Medicare Program, June 2006, emphasis added]. The Commission identified congestive heart failure and diabetes as two conditions where the evidence shows that high quality ambulatory care can reduce avoidable hospital admissions. [See Appendix A].

The Commonwealth Fund has identified ten clinical conditions where "*effective diagnosis, treatment, and patient education* can help control the exacerbation of an illness and prevent or delay complications of chronic illness, thus reducing hospitalizations" [emphasis added]. [See Appendix B]. The Fund also concluded that "reducing preventable hospitalizations could help to preserve Medicare funds for needed services while concurrently improving patient health" and that "*facilitating access to primary care in underserved areas might reduce the higher rates of preventable hospitalizations* among Medicare beneficiaries" [emphasis added]. [Commonwealth Fund's Quality of Health Care for Medicare Beneficiaries: A Chart Book, May 2005].

Unfortunately, Medicare payment policies discourage primary and principal care physicians from organizing their practices to provide effective diagnosis, treatment and education of patients with chronic diseases:

- Medicare pays little or nothing for the work associated with coordination of care outside of a face-to-face office visit. Such work includes ongoing communications between physicians and patients, family caregivers, and other health professionals on following recommended treatment plans;
- Low fees for office visits and other evaluation and management (E/M) services discourage physicians from spending time with patients;
- Except for the one-time new patient Medicare physical examination and selected screening procedures, prevention is under-reimbursed or not covered at all;
- Low practice margins make it impossible for many physicians to invest in health information technology and other practice innovations needed to coordinate care and engage in continuous quality improvement;
- Medicare's Part A and Part B payment "silos" make it impossible for physicians to share in system-wide cost savings from organizing their practices to reduce preventable complications and avoidable hospitalizations.

2. <u>Medicare payment policies are contributing to an imminent collapse of primary care medicine in the United States</u>.

Last November, my esteemed colleague, Dr. Vineet Arora, appeared on the College's behalf before this Subcommittee. As a young internist who recently completed her training and is now practicing general internal medicine, she shared with the Subcommittee the reasons why so few of her colleagues view primary care as a viable career choice.

In my capacity as an educator at the UT Southwestern Medical Center, I've encountered hundreds of young people who, like Dr. Arora, are excited by the unique challenges and opportunities that come from being a patient's primary care physician. But when it comes to choosing a career path, very few see a future in primary care.

My medical students are acutely aware that Medicare and other payers undervalue primary care and overvalue specialty medicine. With a national average student debt of $150,000 by the time they graduate from medical school, medical students feel that they have no choice but to go into more specialized fields of practice that are better remunerated.

The numbers are startling:

- In 2004, only 20 percent of third year IM residents planned to practice general IM, down from 54 percent in 1998, and only 13 percent of first year IM residents planned to go into primary care;

- The percentage of medical school seniors choosing general internal medicine has dropped from 12.2 percent in 1999 to 4.4 percent in 2004;
- A 2004 survey of board certified internists found that after ten years of practice, 21 percent of general internists were no longer working in primary care compared to 5 percent for medical subspecialties working in their subspecialty.

This precipitous decline is occurring at the same time that an aging population with growing incidences of chronic diseases will need more primary care physicians to take care of them. Within 10 years, 150 million Americans will have one or more chronic diseases and the population aged 85 and over will increase 50 percent from 2000 to 2010.

Medicare payment policies are contributing to the impending collapse of primary care because Medicare:

- *Undervalues the time that primary and principal care physicians spend with patients in providing evaluation and management services.* CMS has published a proposed rule that will begin to make significant improvements in payments for office visits and other evaluation and management (E/M) services. The College strongly supports the proposed rule. Even with the proposed increases, however, E/M and other primary care services will continue to be systematically undervalued compared to many procedural services;
- *Overvalues many procedures* at the expense of services provided by primary care physicians. In a "budget neutral" payment system, overvalued procedures—combined with inappropriate volume increases—divert resources from primary care and other services that are undervalued by Medicare;

The Medicare Payment Advisory Commission has reported that *overvalued procedures create incentives for inappropriate volume growth that disadvantage evaluation and management services* provided by primary care physicians. According to MedPAC, an Urban Institute analysis of changes in the relative values assigned to services during the first 10 years' experience with the physician fee schedule demonstrated that evaluation and management services initially gained from implementation of a resource-based relative value scale in 1992, but those *gains have since been effectively nullified* because of growth in the volume and intensity of other categories of services. In 2002, evaluation and management services accounted for 49.7 percent of spending under the physician fee schedule. In 2003, the evaluation and management share was 49.2 percent, and in 2004 it dropped to 46.5 percent. [Source: Medicare Payment Advisory Commission, Report to Congress, June 2006];

- And, as noted previously, Medicare fails to reimburse primary and principal care physicians for organizing their practices to manage and coordinate care of patients with chronic diseases.

3. <u>The sustainable growth rate (SGR) formula has been wholly ineffective in restraining inappropriate volume growth, has led to unfair and sustained payment cuts, and has been particularly harmful to primary care</u>.

The SGR:

- Does not control volume or create incentives for physicians to manage care more effectively;
- Cuts payments to the most efficient and highest quality physicians by the same amount as those who provide the least efficient and lowest quality care;
- Penalizes physicians for volume increases that result from following evidence-based guidelines;

- Triggers across-the-board payment cuts that have resulted in Medicare payments falling far behind inflation;
- Forces many physicians to limit the number of new Medicare patients that they can accept into their practices;
- Unfairly holds individual physicians responsible for factors—growth in per capita gross domestic product and overall trends in volume and intensity—that are outside of their control;
- Is particularly detrimental to primary care physicians, because they are already paid less than other specialties and have such low practice margins that they cannot absorb additional payment cuts.

The College recognizes and appreciates that with the support of this Subcommittee, Congress enacted legislation earlier this year to reverse the 4.4 percent SGR cut in Medicare payments that took place on January 1, 2006. But because the legislation did not provide for an inflation update in 2006, this is the fifth consecutive year that Medicare payments have declined relative to increases in the average costs physicians incur in providing services to Medicare patients. The temporary measures enacted by Congress over the past four years to reduce without eliminating the SGR cuts were paid for in large part by creating a $50 billion "payment deficit" that will now need to be closed to prevent an additional cut of 4.6 percent in 2007 and cuts of 30 percent or more over the next five years.

Creating a Framework for a Better Payment and Delivery System

It is essential that Congress act this year to avert more SGR cuts, but we urge Congress not to simply enact another temporary fix without replacing the underlying formula. *The so-called sustainable growth rate is simply not sustainable.* We strongly urge this Subcommittee to report legislation that puts Medicare on a pathway to completely eliminate the SGR.

The College also urges the Subcommittee to go beyond just addressing the SGR in a piece-meal manner. *Instead, we call on the Subcommittee to report legislation that will create an entirely new framework for fundamentally reforming a dysfunctional Medicare payment system:*

1. Congress should set a specified timeframe for eliminating the SGR.

The College recognizes that the cost of eliminating the SGR on January 1, 2007 will be very expensive, but the cost of keeping it—as measured by reduced access and quality—is much higher. Instead of enacting another one year temporary reprieve from the cuts without eliminating the SGR, the College believes that it would be preferable to set a "date certain"—say, no more than five years from now—when the formula will be repealed. Such a timetable will allow for a transition period during which Congress and CMS could implement other payment reforms that can improve access and reduce costs, thereby reducing the perceived need for formula-driven volume controls like the SGR.

2. If there is a transition period before the SGR is repealed, Congress should mandate positive updates for all physicians in each year of the transition. The positive updates should reflect increases in the costs of providing services as measured by the Medicare Economic Index (MEI).

The College specifically recommends that any legislation that creates a pathway and timetable for repeal of the SGR should specify in statute the minimum annual percentage updates (floor) during the transition period. Establishing the minimum updates by statute

will provide assurance to physicians and patients that payments will be fair and predicable during the transition. The legislation should also direct the Medicare Payment Advisory Commission to report annually to Congress, during each year of the transition period, on the adequacy and appropriateness of the floor compared to changes in physician practice costs as measured by the MEI as well as indicators of access to care. Congress would then have the discretion to set a higher update than the floor based on the MedPAC recommendations.

3. During such a transition period, Congress would consider a longer term alternative approach for addressing inappropriate volume increases.

The Deficit Reduction Act of 2005 requires that the Medicare Payment Advisory Commission report to Congress in March, 2007 on alternatives to the SGR, which could be the starting point for a discussion of the pros and cons of alternative policies to address inappropriate volume increases.

We caution the Subcommittee not to conclude at this point that an alternative formula to control volume is needed or to decide on a specific formula to replace the SGR.

Changing the underlying payment methodologies to support high quality and efficient care, as discussed in our following recommendations, may eliminate the need to have a back-up mechanism to control volume, because physicians would have clear incentives to organize their practices to improve quality and provide care more efficiently.

Any consideration of alternative formula-based volume controls at this time should be mindful of the unintended consequences when Congress enacted ill-considered volume controls in prior legislation. The SGR was the result of legislation enacted in 1997 that has led to the adverse but largely unintended consequences that Congress is now struggling to correct. In 1989, Congress enacted Medicare "volume performance standards" that led to different updates for different categories of services, with the result that some services—including evaluation and management services provided by primary care physicians—received lower updates than surgical procedures, adding to the payment inequities that undervalue primary care. Congress then decided to end the policy of applying different targets and updates in 1997, replacing it with the SGR.

This history suggests that any alternatives that would replace one formula (the SGR) with another formula-based target or multiple targets need to be carefully considered. Otherwise, Congress might end up replacing the SGR with another methodology that will create more unintended consequences requiring legislative correction.

The College believes that it is important to get it right this time by carefully considering a full range of payment reforms that can improve quality and create incentives for efficient care before deciding that the SGR should be replaced by another volume target or targets. We suggest that the relatively short period of time left in this Congressional session does not allow for the kind of careful analysis of the potential unintended consequences of alternative volume controls. Instead, we strongly suggest that such decisions be made during that transition period to full repeal of the SGR.

The College does believe that there are some steps that can be taken now to address inappropriate volume increases. We support MedPAC's recommendation to establish an independent group of experts to review procedures that may be overvalued under the existing Medicare fee schedule. As noted earlier, services that are overvalued are more likely to be over-utilized by physicians. And, as discussed later in this testimony, we support reforms to create incentives for primary and principal physicians to organize their practices to provide consistently better care, at lower cost, to patients with chronic diseases. Substantial cost savings—mainly from reduced hospitalizations—could potentially be achieved through such reforms. We also believe a program to begin

linking payments to quality, as outlined later in our testimony, would create incentives for physicians to provide care that meets evidence-based standards of practice, resulting in quality improvements and potential cost efficiencies.

4. Congress should authorize and direct Medicare to institute changes in payment policies to support patient-centered, physician-guided care management based on the advanced (patient-centered) medical home.

The American Academy of Family Physicians and the American College of Physicians have developed proposals for improving care of patients through a patient-centered practice model called the "personal medical home" (AAFP, 2004) or "advanced medical home" (ACP, 2006). Similarly the American Academy of Pediatrics has proposed a medical home for children and adolescents with special needs. AAFP and ACP recently adopted a joint statement of principles that describes the key attributes of a patient-centered medical home:

Personal physician - each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

Physician- directed medical practice – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

Whole person orientation – the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life: acute care; chronic care; preventive services; end of life care.

Care is coordinated and/or integrated across all domains of the health care system (hospitals, home health agencies, nursing homes, consultants and other components of the complex health care system), facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it.

Quality and safety are hallmarks of the medical home:

- Evidence-based medicine and clinical decision-support tools guide decision making;
- Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement;
- Patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met;
- Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication;
- Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient-centered services consistent with the medical home model.

Enhanced access to care through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and office staff.

Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework:

- It should reflect the value of physician and non-physician staff work that falls outside of the face-to-face visit associated with patient-centered care management;

- It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources;
- It should support adoption and use of health information technology for quality improvement;
- It should support provision of enhanced communication access, such as secure e-mail and telephone consultation;
- It should recognize the value of physician work associated with remote monitoring of clinical data using technology;
- It should allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits);
- It should recognize case mix differences in the patient population being treated within the practice;
- It should allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting;
- It should allow for additional payments for achieving measurable and continuous quality improvements.

Such payments could be organized around a "global fee" for care management services that encompass the key attributes of the patient-centered medical home.

The College urges the Subcommittee to report legislation to direct HHS to design, implement and evaluate a nationwide pilot of the patient-centered medical home. Attached to this testimony is draft legislative language that the College has prepared that could be accepted as a starting point for legislation to mandate a nationwide pilot of the patient-centered medical home.

We also advocate incremental changes in the existing Medicare fee schedule to enable physicians to bill for separately-identifiable services relating to care coordination. In its June 2006 report to Congress on "Increasing the Value of Medicare," the MedPAC suggests that Medicare create mechanisms to directly and indirectly improve care coordination and chronic care management including:

- Medicare could increase payments for evaluation and management services or establish new billing codes to enhance payments for chronic care patients associated with face-to-face visits. These higher payments could be applied generally across all E/M codes, or they could be applied to services provided by patients with multiple chronic conditions;
- Other strategies include pay-for-performance initiatives and strategies to accelerate the adoption of information technology.

5. <u>Congress should direct Medicare to provide higher payments to physicians who acquire and use health information technology (HIT) to support quality measurement and improvement and authorize separate payments for e-mail and telephonic consultations that can reduce the need for face-to-face visits</u>.

MedPAC notes that "data management is a major component of care coordination programs. Initiatives to accelerate physician adoption and use of IT may also improve the coordination of care for Medicare beneficiaries. Indeed, pay-for-performance measures could spur physicians to adopt information technology that improves care." [Source: MedPAC, Increasing the Value of Medicare, June 2006].

The College commends the Energy and Commerce Committee for its leadership in reporting legislation to support health information technology. We believe, however, the

goal of accelerating the adoption of health information technology to support quality improvement also will require changes in Medicare reimbursement policy.

The College has endorsed the bipartisan National Health Information Incentive Act of 2005, H.R. 747. With 53 co-sponsors, this legislation is one of the most supported health information technology bills being considered by Congress. We commend the members of the Energy and Commerce Committee—Mr. Gonzalez, Ms. Wilson, Mr. Allen, Mr. Boucher, Mr. Green, Ms. Solis , Mr. Towns, and Mr. Wynn—who have co-sponsored this important bill.

Among other incentives for physician adoption of HIT, the legislation would direct Medicare to include an "add on" to office visit payments when such visits are supported by approved health information technology, conditioned on physician participation in designated programs to measure and report quality. The bill targets the "add on" to physicians in small and rural practices, because the cost of acquiring HIT are insurmountable barriers for many of those practices.

6. Congress should authorize CMS to begin a voluntary pay-for-performance program as soon as January 1, 2007.

The College believes that linking Medicare payments to quality should be part of an overall redesign of payment policies to support models of health care delivery that result in better care of patients.

ACP has been a lead organization in the development, selection and implementation of evidence-based performance measures for physicians through our participation in the American Medical Association's Physician Consortium for Performance Improvement ("the Consortium"), the National Quality Forum (NQF) and the AQA. The College was among the four principals, along with the American Academy of Family Physicians, America's Health Insurance Plans, and the Agency for Healthcare Quality and Research, who founded the AQA in November 2005. The AQA originally stood for the Ambulatory Care Quality Alliance, but is now known just by the acronym "AQA" because it has expanded its mission to include selection of measures for physician services provided in inpatient setting. The AQA now includes over 100 stakeholders—CMS, health plans, providers, AARP, and employers—that are working collaboratively to select uniform, transparent and evidence-based performance measures for implementation across payers and programs. It has endorsed a starter set of measures for ambulatory care, heart disease (American College of Cardiology measures), and thoracic and cardiac surgery (Society of Thoracic Surgery measures). It is also developing uniform guidelines on data aggregation and reporting of measures and has begun work on selecting cost of care measures for implementation.

The College believes that programs that link payments to quality need to be carefully designed to assure that they achieve the desired outcomes, however:

- They should be based on the best available evidence-based measures as defined by the medical profession and as reviewed and endorsed by appropriate multi-stakeholder groups including the NQF and AQA;
- They should not be punitive toward physicians who are unable to report on the initial measures;
- They should be applied consistently and uniformly across payers;
- They should not impose excessive administrative reporting burdens on practices;
- They should pay physicians on a "weighted" basis based on their individual contributions to achieving quality improvement; and
- They should include safeguards so that sicker and less compliant patients are not harmed.

Specifically, we recommend that any initial pay-for-reporting program should include the following elements:

A. *Physicians who agree to voluntarily participate in a CMS-approved quality measurement and improvement program should be eligible to share in additional performance-based payments*. Such payments would be in addition to the floor on updates specified in legislation during the transition to complete repeal of the SGR, as described earlier.

B. *The voluntary pay-for-reporting program should initially be funded by dedicating a designated amount of Part B funds into a physicians' quality improvement pool, which would be in addition to the floor on annual updates as described earlier*.

C. *Congress should specify that a portion of savings associated with reductions in spending in other parts of Medicare, which are attributable to quality improvement programs funded out of the physicians' quality improvement pool, should be redirected back to the pool. Such savings would include: reductions in Part A expenses due to reductions in avoidable hospital admissions related to improved care in the ambulatory setting and savings in non-physician Part B expenses (such as reductions in avoidable durable medical equipment expenses or laboratory testing resulting from better management in the ambulatory setting that results in fewer complications). MedPAC should be directed to recommend a methodology for measuring and attributing savings in other parts of Medicare that can be attributed to programs funded out of the physicians' quality improvement pool.*

As discussed earlier in this testimony, there is growing evidence that improved care in the ambulatory setting can reduce avoidable hospitalizations and other expenses under the Medicare program. The current pay "silos" make it impossible for physicians to share in such savings. Congress can begin to break down such silos by mandating that a portion of savings that are attributable to physicians' quality improvement efforts would be re-directed back to the physicians' performance improvement fund, allowing it to grow over time.

D. *The program should begin with those physicians who provide care for conditions where accepted clinical measures have been developed, endorsed, and selected for implementation through a multi-stakeholder process.* As long as all physicians are guaranteed a positive update (floor) by statute and the program is voluntary, Medicare should not wait until measures are developed and accepted for all physicians before the pay-for-reporting program can begin.

E. *Validation and selection for implementation by a multi-stakeholder process will assure that the measures meet criteria related to strength of the evidence, transparency in development, and consistency in implementation and reporting across Medicare and other payers.* The multi-stakeholder process should include endorsement by the National Quality Forum and review and selection by the AQA for implementation.

F. *The pay-for-reporting program should phase in measures based on a process of prioritization that takes into account the potential impact of the measure on improving quality and reducing costs*. The College believes it is more important to start with voluntary reporting on measures that can have the greatest impact on improving care for patients with multiple chronic diseases and reducing avoidable hospitalizations than developing more measures just to bring more specialties and physicians into the program. We also believe that robust evidence-based clinical measures of quality will have a greater impact than simple and basic cross-cutting measures that would be broadly applicable to all physicians.

Specifically, we recommend that a voluntary Medicare pay-for-reporting program start with the "high impact" measures selected by the AQA, because the AQA starter measures address the disease conditions that are most prevalent in Medicare, are among the most expensive to treat, and sensitive to reductions in avoidable hospitalizations by improving management of care in the ambulatory setting.

- Two thirds of Medicare funds are spent on the 20 percent of beneficiaries with five or more chronic diseases. [Source: Alliance for Health Reform, Covering Health Issues] The AQA measures address the diseases most prevalent in the Medicare population with the greatest potential for quality improvements.
- Colorectal cancer screening (one AQA measure): In 2000, only one half of community-dwelling adults aged 65 and older received colorectal screening in the past ten years. Colorectal cancer is the second most frequent cause of cancer death. [Source: Commonwealth Fund's Quality of Health Care for Medicare Beneficiaries: A Chart Book, May 2005]
- Coronary artery diseases (three AQA measures): Coronary heart disease is the number one cause of death among elderly Americans. Prevention of disease "offers the greatest opportunity for reducing the burden of CHD in the United States." Most elderly adults have reported that they had a cholesterol test in the past, but little more than half said they knew they had high cholesterol, less than one third were using cholesterol-lowering medications, and few had achieved control over high cholesterol. [Source: Commonwealth Fund chart book]
- Diabetes management (six AQA measures): Diabetes is associated with increased functional disability and premature death. Diabetes incidence increases with age. Complications include blindness, kidney failure, and cardiovascular disease. Fourteen percent of elderly white males and almost one quarter of elderly black and Hispanic adults report that they have diabetes. Most elderly Americans report that they are receiving recommended tests to monitor their blood sugars and lipids but one quarter did not have an eye exam and three out of ten did not have their feet checked for signs of diabetes complications. [Source: Commonwealth Fund chart book]
- Treatment for depression (two AQA measures): An estimated 2 million elderly Americans, or 6 percent of those over age 65, suffer from depressive illness, and another 5 million, or 15 percent, suffer from depressive symptoms. Late-life depression is associated with increased use of health care and an increased risk of medical illness and suicide. Depressed elderly Americans are less likely than younger Americans to perceive that they need mental health care or receive any specialty mental health care. [Source: Commonwealth Fund chart book]
- Immunization of elderly adults (two AQA measures: influenza and pneumonia): Influenza and pneumonia are the fifth leading causes of death among adults age 65 and older. One third to one half of elderly adults were not immunized in 2003. [Source: Commonwealth Fund chart book]
- The AQA measures target conditions where the evidence suggests there could be substantial decreases in potentially preventable hospitalizations when patients receive timely and appropriate ambulatory care by physicians: congestive heart failure (two AQA measures), bacterial pneumonia (one AQA measure), uncontrolled diabetes and diabetes complications (five AQA measures), lower extremity amputation (one AQA measure) and adult asthma (two AQA measures). [Source: AQA; Commonwealth Fund chart book]
- MedPAC reports that "potentially avoidable admissions are admissions that high-quality ambulatory care has been shown to prevent." MedPAC further states that "rates of potentially avoidable hospitalizations are highest for congestive heart failure" and that "notable, given the amount of emphasis that CMS and others have placed on improving diabetes care, is the decrease in potentially avoidable hospitalizations for beneficiaries with diabetes, both for long- and short- term complications."

- From 2002-2004, MedPAC reported that "potentially avoidable hospitalizations due to high quality ambulatory care" declined by 61 percent for COPD/Asthma, 29 percent for diabetes with long-term complications, and 9 percent for diabetes with short-term complications. [Source: MedPAC, A Data Book, Healthcare Spending and the Medicare program, June 2006]

G. *The program should allocate the performance-based payments to individual physicians on a weighted basis related to performance:*

- *Reporting on high impact measures should receive higher performance payments than lower impact measures;*
- *The weighted performance payments should acknowledge that reporting on a larger number of robust quality measures typically will require a greater commitment of time and resources than reporting on one or two basic measures;*
- *The weighted performance payments should take into account the physician time and practice expenses associated with reporting on such measures;*
- *The weighted performance payments should also provide incentives for physicians who improve on their own performance as well as those who meet defined quality thresholds based on the measures;*
- *The weighted performance payments should allow individual physicians to benefit from reductions in spending in other parts of Medicare attributable to their performance improvement efforts.*

An effective policy of linking payments to performance must provide greater rewards for those physicians who make the greatest commitment to reporting on measures that have the greatest potential to improve quality and achieve savings. Otherwise, the financial incentive will be to report on the fewest measures possible, and those who accept the commitment to report on more than the most basic measures would be penalized because they would be taking on more responsibility and expense without receiving additional performance-based compensation.

Particularly for chronic disease conditions, reporting on measures will require a substantial investment of physician time and resources in implementing the technologies needed to coordinate care effectively, in following up with patients on self-management plans, in organizing care by other health care professionals, and in measuring and reporting quality. Other, more basic, measures will not require a comparable investment of time and resources.

Of the measures approved by the AQA to date, internists might have to report on as many as 24 ambulatory measures as well as several cardiology measures for heart disease, and for a particular patient with multiple chronic conditions, they might have to report on a dozen or more measures for that one encounter. Other physicians will have far fewer measures to report on.

Such differences need to be recognized in how performance-based payments are weighted and allocated by Medicare in order to drive physicians to report on the measures that will have the greatest impact on quality and costs and to avoid creating new inequities in payments that disadvantage internists and other physicians that take care of large numbers of Medicare patients with multiple chronic diseases.

H. *The program should include safeguards to protect patients.*

If implemented incorrectly, pay-for-reporting programs could have unintended but adverse consequences on patients. It is particularly important that the program include safeguards to take into account differences in the "case mix" being seen by a particular physician and in patient populations that may be less compliant because of demographics, culture, or economic factors. Otherwise, physicians who are treating a greater proportion

of sicker or less compliant patients could be being penalized with lower payments. This in turn could create an unacceptable conflict between a physician's ethical and professional commitment to take care of the sickest patients and the financial incentives created by participating in a pay-for-reporting program to avoid seeing sicker or less compliant patients.

Any program that would include public reporting of physician performance based on quality measures must be carefully designed to assure that the information being presented is accurate, useful to patients including those with low levels of reading and health literacy, and uses an open and transparent methodology. Physicians must have the right to review the reports on their performance in advance of release, request changes to correct inaccuracies or misleading information, appeal requested changes that are not initially accepted, and to include their own comments and explanations in any report that is made available to the public.

Conclusion

The College commends Chairman Deal, Chairman Barton, Mr. Brown, Mr. Dingell and the members of the Subcommittee on Health of the Energy and Commerce Committee for holding this important hearing.

We believe that Congress should embrace the opportunity to report legislation this year that will transition dysfunctional Medicare payment policies to a bold new framework that will improve quality and lower costs by aligning incentives with the needs of patients. This transition should:

- lead to repeal of the SGR by a specified date;
- guarantee positive updates so that all physicians receive predictable and fair payments during any transition period;
- allow time for Congress to review alternative approaches to addressing inappropriate volume increases during such a transition;
- increase reimbursement for care provided by primary and principal care physicians;
- create a better process to identify potentially overvalued services;
- implement a pilot test of the patient-centered advanced medical home and other reimbursement changes to facilitate physician-guided care coordination;
- implement incentive-based payments for health information technology to support quality measurement and improvement;
- initiate a voluntary pay-for-reporting program that begins with "high impact" measures that have been approved by the NQF and AQA and that reimburses physicians on a weighted basis related to the number, impact, and commitment of resources associated with the measures being reported; and
- Allow physicians to share in system-wide savings in other parts of Medicare that can be attributed to their participation in performance measurement and improvement.

I began my testimony by discussing why Medicare's payment policies are dysfunctional because they are not aligned with patients' needs.

Congress has the choice of maintaining a deeply flawed reimbursement system that results in fragmented, high volume, over-specialized and inefficient care that fails to produce consistently good quality outcomes for patients. Or it can embrace the opportunity to put Medicare on a pathway to a payment system that encourages and rewards high quality and efficient care *centered on patients' needs*.

The framework proposed by the College will benefit patients by assuring that they have access to a primary or principal care physician who will accept responsibility for working with them to manage their medical conditions. Patients with chronic diseases

will benefit from improved health and fewer complications that often result in avoidable admissions to the hospital. Patients will benefit from receiving care from physicians who are using advances in health information technology to improve care, who are fully committed to ongoing quality improvement and measurement, and who have organized their practices to achieve the best possible outcomes.

Medicare patients deserve the best possible medical care. They also deserve a physician payment system that will help physicians deliver the best care possible. The College looks forward to working with the Subcommittee on legislation to reform physician payment that will help us achieve a vision of reform that is centered on patient's needs.

ACP's Proposed Legislation to Implement a Pilot Test of the Patient-Centered Medical Home

(1) QUALIFIED PATIENT-CENTERED MEDICAL HOME.- The 'qualified patient-centered medical home' (PC-MH) is a physician-directed practice that has voluntarily participated in a qualification process to demonstrate it has the capabilities to achieve improvements in the management and coordination of care of patients with multiple chronic diseases by incorporating attributes of the Chronic Care Model.

(2) CHRONIC CARE MODEL.- The 'chronic care model' is a model that uses health information and other physician practice innovations to improve the management and coordination of care provided to patients with one or more chronic illnesses. Attributes of the model include:

(A) use of health information technology, such as patient registry systems, clinical decision support tools, remote monitoring, and electronic medical record systems to enable the practice to monitor the care provided to patients with chronic disease who have selected the practice as their medical home (eligible patients), to provide care consistent with evidence-based guidelines, to share information with the patient and other health care professionals involved in the patient's care, to track changes in the patient's health status and compliance with recommended treatments and self-management protocols, and to report on evidence-based measures of quality, cost and patient satisfaction measures;

(B) use of e-mail or telephonic consultations to facilitate communication between the practice and the patient on non-urgent health matters;

(C) designation of a personal physician within the practice who has the required expertise and accepts principal responsibility for managing and coordinating the care of the eligible patient;

(D) arrangements with teams of other health professionals, both internal and external to the practice, to facilitate access to the full spectrum of services that the eligible patient requires;

(E) development of a disease self-management plan in partnership with the eligible patient and other health care professionals, such as nurse-educators;

(F) open access, group visits or other scheduling systems to facilitate patient access to the practice;

(G) other process system and technology innovations that are shown to improve care coordination for eligible patients.

(3) CHRONIC CARE REIMBURSEMENT MODEL.- The chronic care reimbursement model is one or more methodologies to reimburse physicians in qualified PC-MH practices based on the value of the services provided by such practices. Such methodologies will be developed in consultation with national organizations representing physicians in primary care practices, health economists, and other experts. Such methodologies shall include, at a minimum—

(A) recognition of the value of physician and clinical staff work associated with patient care that falls outside the face-to-face visit, such as the time and effort spent on educating family caregivers and arranging appropriate follow-up services with other health care professionals, such as nurse educators;

(B) recognition of expenses that the PC-MH practices will incur to acquire and utilize health information technology, such as clinical decision support tools, patient registries and/or electronic medical records;

(C) additional performance-based reimbursement payments based on reporting on evidence-based quality, cost of care, and patient experience measures;

(D) reimbursement for separately identifiable email and telephonic consultations, either as separately-billable services or as part of a global management fee;

(E) recognition of the specific circumstances and expenses associated with physician practices of fewer that five (5) full-time employees (FTEs) in implementing the attributes of the chronic care model and the qualified AMH;

(F) recognition and sharing of savings under part A and C of the medicare program that may result from the qualified PC-MH;

(4) REIMBURSEMENT.- Reimbursement for services in the qualified PC-MH practice may be made through one or more methodologies that are in addition to or in lieu of traditional fee-for-service payments for the services rendered. In developing the recommended chronic care management reimbursement model, the Secretary shall consider the following options or a combination of such options:

(A) care management fees to the personal physician that covers the physician work that falls outside the face-to-face visit;

(B) payment for separately identifiable evaluation and management services;

(C) episode of illness payments; and

(D) per patient per month payments that are adjusted for patient health status.

(5) PERSONAL PHYSICIAN.- A "personal physician' is defined as a physician who practices in a qualified PC-MH and whom the practice has determined has the training to provide first contact, continuous and comprehensive care.

(6) ELIGIBLE BENEFICIARIES.- The term `eligible beneficiaries' are beneficiaries enrolled under part B of the Medicare program whom the Secretary has identified as having one or more chronic health conditions. Eligible beneficiaries will be invited to select a primary care or principal care physician in a qualified PC-MH as their personal physician. The Secretary may offer incentives for eligible beneficiaries to select a physician in a qualified PC-MH, such as a reduced co-payment or other appropriate benefit enhancements as determined by the Secretary.

(7) PATIENT-CENTERED MEDICAL HOME QUALIFICATION.- The PC-MH qualification is a process whereby an interested practice will voluntarily submit information to an objective external private-sector entity. Such entity shall be deemed by the Secretary to make the determination as to whether the practice has the attributes of a qualified PC-MH based on standards the Secretary shall establish.

(8) DEMONSTRATION PROJECT.- The term 'demonstration project' means a demonstration project established under subsection (b)(1).

(9) MEDICARE PROGRAM.- The term `medicare program' means the health benefits program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(b) DEMONSTRATION OF QUALIFIED PATIENT-CENTERED MEDICAL HOME MODEL.—

(1) ESTABLISHMENT.- The Secretary shall establish a demonstration project in accordance with the provisions of this section for the purpose of evaluating the feasibility, cost effectiveness, and impact on patient care of covering the advanced medical home model under the medicare program.

(2) CONSULTATION.- In establishing the demonstration project, the Secretary shall consult with primary care physicians and organizations representing primary care physicians.

(3) PARTICIPATION.- Qualified practices shall participate in the demonstration project on a voluntary basis.

(4) NUMBER AND TYPES OF PRACTICES.- The Secretary shall establish a process to invite a variety and sufficient number of practices nationwide to participate in the demonstration project. Participation must be sufficient to assess the impact of the qualified PC-MH in rural and urban communities, under-served areas, large and small states, and be designed to facilitate and include the participation of physician practices of fewer than five (5) FTEs.

(c) CONDUCT OF DEMONSTRATION PROJECT.—

(1) DEMONSTRATION SITES.- The Secretary shall conduct the demonstration with any qualified PC-MH and eligible beneficiary.

(2) IMPLEMENTATION; DURATION.

(A) IMPLEMENTATION.- The Secretary shall implement the demonstration project under this section no later than June 30, 2007.

(B) DURATION.- The Secretary shall complete the demonstration project by the date that is 3 years after the date on which the demonstration project is implemented.

(d) EVALUATION AND REPORT.—

(1) EVALUATION.- The Secretary shall conduct an evaluation of the demonstration project-

(A) to determine the cost of providing reimbursement for the medical home model concept under the medicare program, and to determine cost offsets;

(B) to determine quality improvement measures such as adherence to evidence-based guidelines and rehospitalization rates;

(C) to determine the satisfaction of eligible beneficiaries participating in the demonstration project and the quality of care received by such beneficiaries; and to determine the satisfaction of participating primary care physicians and their staff;

(D) to evaluate such other matters as the Secretary determines is appropriate.

(2) REPORT.- Not later than the date that is 1 year after the date on which the demonstration project concludes, the Secretary shall submit to Congress a report on the evaluation conducted under paragraph (1) together with such recommendations for legislation or administrative action as the Secretary determines is appropriate.

(e) AMOUNT OF REIMBURSEMENT.- The amount of reimbursement to a qualified PC-MH participating in the demonstration project shall be in a manner determined by the Secretary that takes into account the costs of implementation, additional time by participating physicians, and training associated with implementing this section;

(f) EXEMPTION FROM BUDGET NEUTRALITY UNDER THE PHYSICIAN FEE SCHEDULE.- Any increased expenditures pursuant to this section shall be treated as additional allowed expenditures for purposes of computing any update under section 1848(d).

(g) FINANCIAL RISK.- Practices participating in the demonstration project shall not be required to accept financial risk as a condition of participating in the demonstration project established under this section.

MR. FERGUSON. Thank you, Dr. Kirk. Dr. Schrag, you are recognized for 5 minutes.

DR. SCHRAG. Thank you very much. Good afternoon.

MR. FERGUSON. Just turn your microphone on, please.

DR. SCHRAG. Sorry.

MR. FERGUSON. It is a little button there.

DR. SCHRAG. Good afternoon, Chairman Ferguson, Congressman Allen, other members. I am Deborah Schrag, a medical oncologist at Memorial Sloan-Kettering Cancer Center, and I am here today representing the American Society of Clinical Oncology, or ASCO, the leading medical society for physicians involved in cancer treatment and research.

Quality cancer care is central to ASCO's mission, and we have a number of initiatives that create a strong foundation for measuring quality in oncology. Much of the Society's work in this field is based on our pioneering study, known as the National Initiative on Cancer Care Quality, or NICCQ. This multiyear, multimillion dollar study was prompted by an IOM report that suggested that many cancer patients were not receiving care consistent with best medical evidence.

In response, ASCO worked with Harvard and RAND researchers to review 1,800 medical records of breast and colorectal cancer patients in five major U.S. cities. The study looked at how patients' treatment compared to guidelines and best available evidence. Each patient was also interviewed about his or her own care experience. We found greater adherence to evidence-based medicine than had been expected; 86 percent of breast and 78 percent of colon cancer patients received treatment that was largely consistent with guidelines, but at the same time, we found real targets for improvement, particularly in documentation, communication, and coordination of care.

The study underscored the challenges of cancer care delivery in our highly mobile society, where treatment typically involves many specialists, and is played out over extended periods of time, and across many sites of care. It was often very challenging to locate all of a patient's record to extract the necessary information from those records, and very little information was available in electronic form. Our experience highlighted the need for a cancer treatment summary.

ASCO has taken the lead in developing a template that captures the patient's treatment history and the plan for follow-up. This treatment summary is intended to improve communication among oncologists, their patients, and other healthcare providers, such as those sitting around me at this table. Such coordination is especially important as more patients become survivors, and confront long-term effects of their treatments. We endorse the widespread use of treatment summaries, and also believe that the additional burdens involved in documentation by already busy cancer specialists should be appropriately recognized.

The NICCQ study also generated a set of quality cancer measures, exactly of the type that you asked Dr. McClellan so many questions about earlier, and we are now updating and refining those metrics in

collaboration with the NCCN, a network of specialty cancer centers across the U.S.

ASCO has also developed a program that enables physicians to systematically assess the care they deliver, and compare it to established best practices. The Quality Oncology Practice Initiative is a Web-based reporting system. It was opened to ASCO's membership in January, and already has over 1,000 oncologists voluntarily participating. This is the only oncology-specific measurement program approved by the American Board of Internal Medicine to help physicians maintain board certification.

High-quality care incorporates the patient's unique personal preferences into decision-making. We all know that a well-educated and informed patient is empowered and can get better care. Therefore, a cornerstone of ASCO's mission is to provide patients with clear, informative, timely information about cancer treatment and the latest research.

The underpinning of all of ASCO's quality initiatives remains its evidence-based guidelines. ASCO continues the work of developing, revising, and disseminating these guidelines, which are among the most rigorous in medicine. CMS selected ASCO's guidelines, as well as those from the NCCN, as the basis for its ongoing 2006 Oncology Demonstration project. In this project, physicians provide important information to CMS about the extent of disease, reasons for cancer treatment, and whether that treatment is based on accepted guidelines.

ASCO has worked closely with CMS, and believes that this effort is an important strategy for advancing the quality of cancer care. It is important to note, however, that the data from the demonstration project will be most valuable if it is collected over time, over a number of years. We urge CMS to continue the demonstration project, and we greatly appreciate the committee's support for the 2006 demonstration project, and seek your support in extending it.

Adherence to evidence-based guidelines is important in all fields of medicine in order to achieve the best results for our patients and to foster efficient healthcare delivery. ASCO is firmly committed to continuing its investment and development of validated quality cancer measures, and we look forward to working with our colleagues from other medical disciplines, the Administration, Members of this committee and Congress to ensure that these measures are appropriately incorporated into medical practice.

Thank you very much for your attention.

[The prepared statement of Dr. Deborah Schrag follows:]

PREPARED STATEMENT OF DR. DEBORAH SCHRAG, PAST CHAIR, HEALTH SERVICES COMMITTEE, AMERICAN SOCIETY OF CLINICAL ONCOLOGY

Good morning, I am Deborah Schrag, a medical oncologist and health services researcher at Memorial Sloan-Kettering Cancer Center. Cancer researchers have made enormous strides in discovering the basic biological mechanisms that cause cancer. While treatments are still far from perfect, they are becoming ever more effective. As a health services researcher, my research focuses on evaluating how we perform at actually delivering those treatments to the people who need them. Do we deliver care that improves patient outcomes? Do we do it in a timely and efficient manner? The goal of my research is to define and measure the quality of cancer care in the real world in order to develop strategies for improving health outcomes. I am here today representing the American Society of Clinical Oncology, or ASCO, which is the leading medical professional society for physicians involved in cancer treatment and research.

Quality cancer care is central to ASCO's mission, and ASCO has a multi-faceted approach to improving the quality of cancer care. Oncologists are devoted to achieving the best results for our patients, who depend so much on our judgment and expertise. For this reason, the 1999 Institute of Medicine (IOM) report, "Ensuring Quality Cancer Care," raised concern with ASCO members and leaders. The report concluded that some cancer patients receive less than optimal care, but noted the lack of data available to truly appreciate the extent of the problem. The IOM report called for research to better assess quality of cancer care in the United States.

In response, ASCO undertook a multi-year, multi-million dollar study, the National Initiative on Cancer Care Quality (NICCQ), to quantify the degree to which the actual practice of cancer care matched the evidence-based guidelines for care. With generous support from the Susan G. Komen Breast Cancer Foundation, and research expertise from the Harvard School of Public Health and the Rand Corporation, the NICCQ study evaluated the quality of care received by breast and colorectal cancer patients in five metropolitan areas across the U.S.—Atlanta, Cleveland, Houston, Kansas City and Los Angeles.

In the NICCQ study, professional abstracters received patients' permission and conducted in-depth reviews of every medical record for nearly 1,800 patients with breast and colorectal cancer. Each patient was also surveyed about his or her cancer care experience. The good news from this study was that adherence to evidence-based medicine was higher than previously reported. Eighty-six percent of breast cancer and 78% of colon cancer patients received care that adhered to practice guidelines. The study identified some specific areas where the quality of care could be strengthened, including better documentation of care and optimizing chemotherapy dosing. In response, ASCO has developed a variety of office practice tools and systems to help its members address these issues.

Although the overall NICCQ results were reassuring, the study highlighted just how complex cancer care delivery is and the wide variation in the extent of documentation, particularly for chemotherapy treatment. For instance, we were surprised at the difficulty the researchers had in locating patient records because of the number of cancer specialists seen by each patient. In addition, it was challenging to accurately determine from the multiple records the treatments patients had received. The patients' health information was rarely available in electronic form.

Without clear documentation, NICCQ demonstrated that it was difficult to assess whether patients received appropriate chemotherapy. Further, in this highly mobile society, it is critical for cancer patients, and all their providers, to understand the plan for treatment and the patient's experience in carrying out that plan. The NICCQ study and other quality of care research highlights the value of the chemotherapy "treatment summary" as an effective quality improvement tool. ASCO has played a leadership role

by developing such a treatment summary template for use by treating physicians, patients and their families, and as part of an oncology-specific electronic health record. The treatment summary will provide a brief synopsis of a patient's chemotherapy treatment history and the plan for follow-up care. The treatment summary is intended to improve communication of crucial treatment information between oncologists and their patients and between oncologists and other physicians. As witnessed in the aftermath of hurricane Katrina, when medical records were destroyed or unavailable, it is important for cancer patients to know and understand their care plans. We are partnering with patient advocacy groups and the IOM to ensure this initiative is widely useful. Also, a clear and widely adopted treatment summary and care plan would improve documentation so that the information needed to assess the quality of care is more readily accessible. The additional burden of treatment summary documentation on busy cancer physicians should be appropriately recognized.

The NICCQ measures themselves represent an important and ongoing contribution to improving the quality of care provided to cancer patients. Developing and validating quality measures is challenging and resource-intensive work. As part of the NICCQ study, 61 cancer quality measures were created, specified and validated. To build upon and update this work, ASCO and the National Comprehensive Cancer Network (NCCN) launched a collaboration early this year to select a subset of NICCQ measures that are key indicators of oncology treatment and are directly supported by NCCN guideline recommendations. Content and methodology experts were charged with producing several breast cancer and colorectal cancer quality measures that are appropriate for diverse uses – including accountability for the quality of care. The ASCO/NCCN Quality Measures will be published on both organizations' web sites later this summer.

It is imperative that quality measures undergo the thorough and careful review exemplified by the ASCO-NCCN process before they are used to judge performance. It is also important to note that rapidly evolving cancer treatment standards require quality measures to be updated and monitored for ongoing relevance. ASCO has committed the resources necessary to update and review its quality measures on an ongoing basis.

ASCO has also launched a number of quality-related projects with the common goal of improving patient care. The Quality Oncology Practice Initiative, or "QOPI," was devised by Dr. Joseph Simone and a pilot group of ASCO members practicing in the community. Their vision was of an oncologist-developed and –led quality-improvement initiative offering tools and resources for self-assessment, peer comparison and improvement. QOPI was launched as a pilot in 2002 and has now enrolled almost 150 practices across the country, representing more than 1000 oncologists.

The QOPI quality measures are developed and updated by practicing oncologists and measurement experts. Practices participating in QOPI abstract their medical records twice a year and enter deidentified data for each QOPI measure. Each practice receives reports that enable them to compare their performance with that of their peers. This process of self-scrutiny and evaluation enables participating practices to learn from one another and to identify strengths and weaknesses in their care delivery.

In the first round of QOPI data collection for 2006, more than 9,000 charts were submitted for analysis. As QOPI participation grows so does ASCO's database, making the program increasingly valuable for comparison and benchmarking. We are delighted with the interest and especially the commitment of our members who are voluntarily joining this initiative because they find it valuable and because of their commitment to delivering quality care. We are also proud that the American Board of Internal Medicine has recognized QOPI as the only oncology-specific measurement program approved for use in meeting its new practice performance requirements for maintaining Board certification.

All of ASCO's quality initiatives to improve cancer care promote the practice of evidence-based medicine. For the past 10 year, ASCO's Health Services Committee has

made a crucial contribution with the development of the Society's evidence-based guidelines, which are regarded as the most rigorous in oncology. Oncology is a field of medicine in which the pace of discovery is fast and the complexity of treatment great. Practice guidelines are essential to distilling the vast quantity of clinical data published regarding the care of cancer patients.

ASCO's guidelines focus on treatments or procedures that have an important impact on patient outcomes, represent areas of clinical uncertainty or controversy, or are used inconsistently in practice. They are developed and updated by panels of ASCO member volunteer with content and methodological expertise in disease-specific areas, and patient representatives. ASCO develops office practice tools that make the results of these guidelines relevant for day-to day practice and facilitate adherence the guideline recommendations. ASCO also creates patient guides for each guideline, translating science and recommendations into lay language so that patients can be empowered partners in medical decision making. After completing a multi-layered review process, these evidence-based guidelines, the office practice tools and the patient guides are made freely available on the Society's website.

Beyond these research and practice initiatives, ASCO is pursuing a quality-oriented agenda in the public policy arena by communicating regularly with key stakeholders. One forum for policy development on quality issues is the Cancer Quality Alliance, jointly created by ASCO and one of its patient advocate partners, the National Coalition for Cancer Survivorship, or NCCS. This alliance is the first specialty-specific effort of its kind. It has broad public- and private-sector membership across the cancer community, including CMS officials and representatives of private payers, both of whom have an obvious interest in a robust program of quality cancer care. Other participants include oncology nurses, accrediting bodies, patient advocacy and medical professional organizations, cancer centers, community practices, the IOM, the National Quality Forum and the NCCN. The Cancer Quality Alliance provides a forum for the various stakeholders in cancer care quality to discuss joint initiatives and develop coordinated strategies.

CMS has also taken an important step towards monitoring quality of care delivered to its beneficiaries in its 2006 oncology demonstration project. This demonstration offers a promising foundation for future pay-for-performance programs in Medicare. The 2006 demonstration is structured to determine whether and how oncology providers follow well- established evidence-based guidelines developed by ASCO and NCCN. ASCO has worked with CMS and provided expertise to CMS on an ongoing basis.

While the demonstration project provides a good basis for moving toward pay-for-performance, experts agree that the most useful information will be obtained only by accumulating data over multiple years. The demonstration project provides CMS with a mechanism for collecting clinical data through the claims system – clinical data that are absolutely critical to oncologists in making treatment decisions for cancer patients, and to anyone interested in assessing the appropriateness of cancer care. For the first time CMS has captured the basic information on cancer stage and other disease characteristics that provide both important new insight on patterns of care and a foundation for recognition of quality. As third-party payers and other Alliance members have noted in our Cancer Quality Alliance deliberations, however, such assessment requires multi-year longitudinal data if it is to be a useful guide to future performance measurements. We urge this Committee's support for extension of the current demonstration project for a sufficient period of time to enable meaningful analysis as policy moves toward a pay-for-performance model.

As interest in using quality measures for accountability purposes grows, it becomes more important to ensure these measures are clearly specified and well validated. Failing to do so may lead to adverse consequences. For example, numerous clinical trials demonstrate that patients with colon cancer that has spread to regional lymph nodes

(stage III disease) benefit from a course of chemotherapy after surgery. The clinical trials that form the evidence base for this treatment, however, have included very few patients over the age of 80. While this treatment may be beneficial for all stage III colon cancer patients, the evidence for patients over 80 is not robust and there is great variability of the health status in this group. Implementing a quality measure stating that all patients with stage III colon cancer should receive a course of chemotherapy might encourage over treatment of older patients. Because careful specification is needed to avoid undesirable consequences, ASCO has focused extensively on developing the precise definition of the measures used in our quality initiatives. Additionally, it is imperative to avoid creating systems that make it less desirable to care for especially complex patients with multiple problems for whom adherence to guidelines may be more challenging.

ASCO has the expertise in and a demonstrated commitment to developing and promoting quality measures. We will continue to engage in a variety of activities to define, measure, monitor and improve the quality of cancer care. ASCO is well positioned to provide the expertise, tools, measures and other resources necessary to implement a thoughtful pay-for-performance programs that focus not just on efficiency and cost savings but even more importantly on quality care. We look forward to collaborating with Congress as these initiatives are considered.

MR. FERGUSON. Thank you, Dr. Schrag. Dr. Brush, you are recognized for 5 minutes.

DR. BRUSH. Chairman Ferguson, Congressman Allen, and distinguished members of the subcommittee, thank you for holding this hearing, and offering me the opportunity to speak on behalf of the American College of Cardiology. I am a practicing cardiologist from Norfolk, Virginia, and I chair the ACC's Quality Strategic Directions Committee. I have experience nationally and at the grassroots level in quality improvement and pay-for-performance.

The American College of Cardiology has a long history of setting professional standards for cardiovascular care, through the development of guidelines and performance measures. We have applied those standards through collaborative quality improvement initiatives and pay-for-performance programs. We have developed data standards and a national data registry. We bring to bear a broad experience with quality improvement, and we would like to offer the ACC as a resource to this subcommittee, as it wades through the complexities of developing a pay-for-performance system.

While we are proud of our accomplishments, we are well aware of lingering deficiencies in the quality of cardiovascular care. Current quality problems are largely due to the fractionated and confusing environment in which we practice, and thus, we are determined to find ways to improve our systems of care. Lingering quality lapses and troubling economic projections have led us to discuss new models of reimbursement that pay-for-performance. Current payment models do little to create a business case for the physician practices to invest in systems that will yield better outcomes. Furthermore, projected cuts in physician payments, coupled with rising overhead costs, leave smaller

operating margins and less available funds to invest in long-term system improvements.

Payers are rushing, it seems, towards pay-for-performance. While the ACC supports the concept of pay-for-performance, the rapid movement in this direction is occurring despite little experimental or empirical evidence that pay-for-performance achieves its intended effect in the short or long term. There are more than a hundred pay-for-performance programs in various markets throughout the country, yet there are very few studies that have evaluated these programs. Lacking solid evidence upon which to design new programs, it is imperative that we recognize certain important principles of design that will help ensure success.

Pay-for-performance programs must be based on scientifically validated performance measures that are developed and endorsed by the profession. The ACC has a solid background in developing performance measures, and Medicare would be wise to partner with us and other professional organizations, not only to gain valid measures, but also, to gain widespread buy-in from the practicing community.

We should also recognize that a one size fits all approach would not be wise. Some specialties may be more advanced in quality improvement than others, and should be allowed to pursue more highly developed programs. In addition, we should design programs that engender continuous quality improvement, and avoid programs that attempt to weed out or punish lagging practitioners. Poorly designed payment schemes could exacerbate critical shortages in physicians in certain specialties in geographic areas, and could worsen problems with disparities in care.

We need to design programs that standardize and simplify the data collection process, and we must insist on accurate data collection and valid statistical methods. We should recognize that for all its promise, pay-for-performance may have unintended adverse consequences, and we should accompany any program with a plan for health services research to evaluate the effects of the program. We should focus on incremental steps that CMS can take now to improve quality and outcomes, and on what Congress can do to help build an infrastructure that will help support pay-for-performance systems.

I would like to offer a few modest, yet meaningful suggestions. One simple suggestion comes from our Guidelines Applied in Practice Initiative in Michigan. This initiative sought to improve the care of heart attack and heart failure patients through the use of a tool called a discharge contract. A discharge contract is a disease-specific checklist assigned by the doctor, the nurse, and the patient, and is designed to assure that key processes of care are used reliably. When a discharge

contract is used, Medicare beneficiaries had improved 30 day and 1 year mortality rates and reduced readmission rates. A simple pay-for-performance program could create a financial incentive to use a certified discharge tool that bundles key processes of care into a single process. A special CPT or modifier code could provide that financial incentive.

The most significant quality improvement activities will involve the collection and reporting of clinical data, which are best captured through some type of an electronic health record. To jumpstart the movement toward EHRs, Medicare, as well as other payers, should consider a fee schedule enhancement to practices that document the use of certified EHRs.

We must address the damaging effect of our current tort system on the quality of care. Because of the current malpractice environment, physicians have a strong financial and an even stronger emotional incentive to hide mistakes, missing valuable opportunities to seek ways to improve systems of care.

Finally, we encourage the subcommittee to support increased Federal funding for health services research. We have a talented community of outcomes researchers, including Dr. McClellan, and many others who have the capacity to evaluate the way we deliver healthcare, but these researchers lack adequate funding. Outcomes research provides a reality check on what is working and what is not, and will be invaluable for assessing the effectiveness of pay-for-performance programs.

In closing, I want to emphasize that the American College of Cardiology is committed to assisting this subcommittee and CMS in addressing the challenges ahead. Our mission is to advocate for quality cardiovascular care through the development and application of standards and guidelines. Our core value is to uphold the interest of our patients, and we feel a strong duty to work towards aligning patient systems to assure that our patients have access to high quality care. We are optimistic that together, we can address our current challenges, and we assure you that the ACC is committed to helping move forward.

Thank you.

[The prepared statement of Dr. John Brush follows:]

PREPARED STATEMENT OF DR. JOHN BRUSH, ON BEHALF OF AMERICAN COLLEGE OR CARDIOLOGY

Chairman Deal and Members of the Subcommittee, thank you for holding this hearing today and for affording me the opportunity to discuss efforts by the American College of Cardiology (ACC) that support the provision of high quality care to Medicare patients.

I am board-certified in interventional cardiology, as well as in general cardiology and internal medicine. I am a member of a 19-member private practice cardiology group in Norfolk, Virginia. I am chair of the ACC's Quality Strategic Directions Committee, a

committee that directs and coordinates the ACC's quality efforts. I am also the president of the Virginia ACC Chapter. Nationally and in Virginia, I have had extensive experience in quality improvement initiatives and in the design and implementation of pay for performance programs. I represent the ACC, a 33,000-member organization that is committed to helping Congress address daunting health care challenges. I am honored to give testimony today, and am hopeful that my testimony will facilitate the important work of this Subcommittee.

The U.S. health care system is in the midst of a quality revolution. At a time of spiraling national health care costs, health care providers and payers are struggling with the need to improve the quality of care through systems improvements. At present, medical care consumes 16 percent of the gross domestic product (GDP), and experts project that medical spending will increase to 20 percent by 2015.[1] Undoubtedly the economic burden of cardiac care will continue to rise because of the rising costs of cardiac technological advances[2] and the increasing prevalence of cardiac disease.[3] Our tremendous medical advances have turned once deadly diseases into chronic diseases that create a growing economic burden. Therefore, we can expect that public and private payers will continue to focus on improving both the quality and efficiency of cardiac care.

Current payment models do little to create a business case for physician practices to invest in the systems that will provide reliable, high quality care. Payment is not currently based on performance, except in emerging demonstration projects. Cuts in Medicare physician payments, including cuts in medical imaging payments and those associated with the current sustainable growth rate (SGR) formula, coupled with rising overhead costs leave smaller operating margins and little incentive for physicians to invest in long-term system improvements.

Many practitioners note that high quality does not always pay and sometimes can lead to less pay. Traditional models of payment, such as fee-for-service, pay for inputs of medical care, but do not pay for outcomes, and do not create a solid business case for investing in long-term system improvements that yield better outcomes. Fee-for-service payment may tend to encourage overuse, but other payment models like prospective payment in managed care have their own unintended consequences and may reward under-use. What payers and providers can agree upon is that a medical payment system that consistently encourages and rewards appropriate, high quality care has yet to emerge.

In the words of Avedis Donabedian, "there's lip service to quality…but real commitment is in short supply."[4] The ACC recognizes the importance of inspiring greater focus on improving care delivery systems and supports the concept of paying for performance. However, the ACC believes that physician pay-for-performance programs should support and facilitate the quality improvement process and strengthen the patient-physician relationship rather than solely report performance and outcomes for the purpose of quality assurance.

Programs that support a continuous quality improvement process can serve to unify multiple participants in the health care system, to improve patient care and to realize the full potential of America's health care system. The old quality assurance method sought to "cull out bad apples" and did not engender general improvement. Similarly, poorly

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[1] Borger C, Smith S, Truffer C, et al. Health spending projections through 2015: changes on the horizon. Health Affairs (Millwood) 2006; 25:w61-73.

[2] Lucas FL, DeLorenzo MA, Siewers AE, Wennberg DE. Temporal trends in the utilization of diagnostic testing and treatments for cardiovascular disease in the United States, 2993-2001. Circulation 2006; 113:374-9.

[3] Association AH. Heart Disease and Stroke Statistics – 2005 Update. Dallas, TX: American Heart Association, 2005.

[4] Donabedian, A. A founder of quality assessment encounters a troubled system firsthand. Interview by Fitzhugh Mullan. Health Affairs (Millwood) 2001; 20:137-41.

designed pay-for-performance programs could be divisive and impede a coordinated effort to improve care. Our current quality deficiencies are the result of deficient systems rather than the result of a few bad apples and we should focus our efforts on creating incentives for system improvement.

Today I will demonstrate the ACC's current and ongoing commitment to the development of clinical standards in cardiovascular care and the translation of those standards at the bedside through the adoption of decision support tools and system change. We are confident that our commitment to clinical standards naturally supports the development of progressive models of payment that will align incentives, and thereby facilitate the provision of high quality, appropriate care. You will learn that the ACC has been a leader in the development of clinical guidelines, performance measures, and other quality improvement documents, strategies and tools. The ACC continues to reach out across stakeholder boundaries with the goal of moving those standards of cardiovascular care into practice.

I will also attempt to outline the challenges and complexities associated with instituting a pay-for-performance system, particularly for ambulatory care. We firmly believe that inadequate understanding of these complexities, or bypassing the complexity of performance measurement with an overly simplistic approach, may not only fail to improve patient care, but could have other costly and damaging unintended consequences.

Continuous Quality Improvement: ACC Leading the Way in Cardiovascular Care

The ACC was founded in 1949 as a home where practicing cardiologists can exchange knowledge on the best ways to treat patients with cardiovascular disease. Consistent with the ongoing fulfillment of the ACC's founding mission is the challenge of closing the gap between what is known to be best practices as shown by science and taught in educational courses, and what is applied in everyday practice.

Guideline Development

The ACC was an early promoter of evidence-based medicine and professional standards. Beginning in the early 1980s, the ACC partnered with the American Heart Association (AHA) to develop clinical practice guidelines that would take the best science and interpret it for everyday practice. The ACC is proud to carry the distinction of publishing one of the first clinical practice guidelines. Published in 1994, the Pacemaker Guideline was published in part to proactively respond to the then Health Care Financing Administration's (HCFA) concerns about the costs and benefits of pacemaker implantation.

Guidelines provide the foundation for evidence-based performance measures. It should be noted, however, that the development of guidelines is time consuming and costly to professional medical societies. The average amount of time it takes the ACC to develop and publish a guideline is approximately two years, and once published, those guidelines require periodic updating. It costs the ACC and AHA more than a million dollars a year to support development and updating more than 2,100 recommendations contained in 15 published guidelines. Despite the cost, the ACC views the development of guidelines and performance measures as a core responsibility and a critical function of the organization.

National Measurement and Information Exchange Standards

The ACC has been active in developing and promoting national standardization of performance measures and electronic medical data. The ACC understood from the start of the pay-for-performance movement that a single, evidence-based national standard for measuring improvement would be essential. Beginning in 2000, the ACC partnered with the AHA to develop national performance measurement standards and data standards for

both inpatient and outpatient care based on our guidelines. Together, the ACC and AHA published a methodology for the development of performance measures that outlined criteria to ensure that measures were not only evidence-based but actionable and feasible for quality improvement purposes. To ensure the successful implementation of these measures, the ACC has developed programs such as the National Cardiovascular Data Registry (ACC-NCDR®) and the Guidelines Applied in Practice (GAP) program. To facilitate the development and implementation of performance measures, we have partnered with other national organizations, including the Physician Consortium for Performance Improvement (PCPI), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Centers for Medicare and Medicaid Services (CMS), the Agency for Healthcare Research and Quality (AHRQ), and the Ambulatory Quality Alliance (AQA). These activities have ensured the relevance of measurement standards to cardiologists' daily practice and to the larger stakeholder community, including patients.

Cardiovascular Appropriateness Criteria

Quality improvement efforts cannot ignore the reality that increasing health care costs are imposing fiscal pressures on payers, insurers, employers and patients. Increased demands for health care services, especially expensive diagnostic imaging tests, have led to unsustainable trends in health care economics. The response from the ACC has been the development of clinical appropriateness criteria which not only foster improved quality, but help providers avoid unnecessary tests.

These directives are patient-centric and define "when to do" and "how often to do" a given procedure in the context of scientific evidence, the health care environment, the patient's profile and the physician's judgment. Ultimately, appropriateness criteria can help facilitate reimbursement in a performance measurement-based system.

Development and Adoption of Cardiovascular Performance Measures: A Status Report

Pay-for-performance programs are unlikely to improve patient care without a foundation in valid performance measures. Professional organizations are a trusted source of scientifically valid performance measures and the ACC is a leader in setting professional standards for cardiovascular care. The ACC is committed to continuing the task of developing and field-testing performance measures, a labor-intensive process that can take months or years to complete.

In 1993, the ACC lent support to development by CMS (then HFCA) of some of the earliest national clinical performance measures based on the ACC/AHA Guideline for the Early Management of Patients with Acute Myocardial Infarction. Since then, the ACC has made tremendous strides in the development and adoption of cardiovascular performance measures. For the outpatient setting, the ACC and the AHA, in collaboration with the PCPI, developed measurement sets for patients with coronary artery disease, heart failure, and perioperative care. We are currently working with several other organizations to develop measures for atrial fibrillation, cardiac rehabilitation, primary cardiovascular disease prevention, and peripheral artery disease. For the inpatient setting, the ACC along with the AHA have developed measurement sets for patients with acute myocardial infarction and heart failure.

To date, 16 measures have been endorsed by the National Quality Forum (NQF) and eight measures have been endorsed by the AQA for physician-level measurement for cardiologists.

Putting Cardiovascular Performance Measures into Practice

Through the use of national measurement standards it is possible to bridge the gaps between science and practice. Thanks to ACC, AHA, AHRQ, CMS and JCAHO, the entire United States now has a uniform set of measures that is the standard of care for every physician and every hospital in the country when caring for a patient with an acute myocardial infarction (heart attack).

We cannot ignore the power and importance of such efforts for our practices and for our patients. In a study published last year on the use of the JCAHO core measures (aligned with ACC/AHA measures), the overall rates for four of the measures for acute myocardial infarction *(heart attack)* showed gratifying improvement.[5]

In patients with myocardial infarction, 95 percent received recommended aspirin treatment and 93 percent received recommended treatment with beta blocking agents. Getting those measures right for every patient, every time, truly matters. Research has shown that for every 10 percent increase in adherence to these few, simple measures, there is a commensurate reduction in mortality. We are committed to further improvements in the reliability of care, where every patient gets the appropriate life-saving treatment every time. We have worked with the Institute for Healthcare Improvement and other organizations to improve the reliability of heart care. We are preparing to launch a national campaign that seeks to ensure that patients with heart attacks who require urgent complex care will get that care consistently across the country. Finally, we are committed to updating those measures to remain in step with emerging science and accumulating evidence.

In Virginia, the ACC has worked with the commercial payer, Anthem Blue Cross Blue Shield, to develop two pay-for-performance programs. The first, called Quality-In-Sights® Hospital Incentive Program (QHIP), rewards hospitals for reaching specified quality targets. Forty-two percent of this program involves cardiac care. A second program, called Quality Physician Performance Program (QP3) was recently introduced. This program rewards physicians based on aggregated hospital-wide performance and distributes the rewards to physician groups at each hospital based on a market share calculation. This voluntary program gives physician groups the opportunity for up to an 8 percent across-the-board enhancement in the Anthem fee schedule. Because the program uses aggregated hospital-wide performance data, it overcomes problems with small numbers and difficulties with attribution. Because the rewards are based on shared performance, the program is intended to create incentives for competing physician groups to work together with hospital administration in a cooperative manner to achieve continuous quality improvement.

Is Pay for Performance the Key to Quality?

The key to quality improvement is matching clinical performance to the goals and standards set by the profession. The ACC supports a Medicare payment system that properly aligns incentives, inspiring greater focus on clinical standards and on health care delivery systems that help practitioners reach those standards. However, we need to recognize that the rapid movement toward pay for performance is occurring despite little experimental or empirical evidence that pay for performance achieves its intended effect in the short or long term.[6] While there are as many as 100 existing pay-for-performance programs in different economic markets throughout the country,[7, 8] there are essentially

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[5] Williams, S. C., Schmaltz, S. P., Morton, D. J., Koss, R. G., Loeb, J. M., Quality of care in U.S. hospitals as reflected by standardized measures, 2002-2004, N Eng J Med 2005; 253(3):255-64).

[6] Dudley RA. Pay-for-performance research: how to learn what clinicians and policy makers need to know. JAMA 2005;294:1821-3.

[7] Med-Vantage. Pay for Performance. 2006.

[8] The Leapfrog Group for Patient Safety. Incentive and Reward Compendium. 2006.

no randomized controlled trials demonstrating the effectiveness of these programs and very few reports that analyze existing programs.[9, 10, 11, 12, 13] Paying for performance seems logical, yet without thoughtful design and ongoing evaluation, it may fall short of expectations and could have damaging unintended consequences.

Program Design

Before a performance-based physician payment system is adopted by Medicare, program design must be thoughtfully considered and developed with the input of the physician community. Pay-for-performance programs generally are designed to reward providers for achieving specified levels of clinical performance, as measured by standardized quality indicators. Typically, these programs provide more or less than the standard payment for a particular service using a formula based on measures of structure, process, outcome or cost.

While all pay-for-performance programs are meant to induce change in individual or organizational behavior, specific programs can vary widely. Programs can vary in scope (primary care physicians, specialists, hospitals, clinicians), in the dimensions of performance that are measured, or in the form of payment (straight bonus, enhanced fee schedule, block grant, or indirect payments). Pay-for-performance programs can also vary in how the reward relates to the measurement of performance. A program can reward a provider either for showing a set amount of improvement, or for achieving a threshold of performance. Programs that reward for improvement will stimulate providers at all starting points, but providers who start at high levels of performance may reach a ceiling where the reward will diminish. On the other hand, programs that reward achievement of a threshold level of performance may discourage providers who start at a low level from participating and exacerbate existing disparities in care. Programs may reward for reaching absolute levels of performance, or may reward by grading providers on a curve relative to their peers. Fixed targets and absolute thresholds provide a predictable opportunity for reward, whereas the latter model provides no up front guarantee and can inhibit cooperation, but may provide a competitive environment that creates sustained incentives. Thus, the type of program can have different effects on providers, depending on one's specialty or practice environment. It would be unrealistic to hope for a "one size fits all" design that would simply and easily address all of our current quality and efficiency challenges.

Operational Challenges

The approach of adopting a set of basic, core performance measures that cut across all physicians generally follows the pattern Congress established for hospital payment policy beginning with passage of the Medicare Modernization Act in 2003. The unique challenges to adopting ambulatory pay-for-performance programs were identified through a survey conducted of participants at the ACC's 2005 Medical Directors Institute (MDI), discussions with national quality leaders, and a review of existing literature. The

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[9] Rosenthal MB, Frank RG, Li Z, Epstein AM. Early experience with pay for performance: from concept to practice. JAMA 2005;294:1788-93.

[10] Kouides RW, Bennett NM, Lewis B, Cappuccio JD, Barker WH, LaForce FM. Performance-based physician reimbursement and influenza immunization rates in the elderly. The Primary Care Physicians of Monroe County. Am J Prev Med 1998;14:89-95.

[11] Fairbrother G, Hanson KL, Friedman S, Butts GC. The impact of physician bonuses, enhanced fees, and feedback on childhood immunization coverage rates. Am J Public Health 1999;89:171-5.

[12] Amundson G, Solberg LI, Reed M, Martini EM, Carlson R. Paying for quality improvement: compliance with tobacco cessation guidelines. Jt Comm J Qual Saf 2003;29:59-65.

[13] Roski J, Jeddeloh R, An L, et al. The impact of financial incentives and a patient registry on preventive care quality: increasing provider adherence to evidence-based smoking cessation practice guidelines. Prev Med 2003;36:291-9.

challenges raised focus around the nature of care delivery in the outpatient setting. Unlike the inpatient setting, where patient care can be tracked by a single organization, the ambulatory care setting involves multiple physician groups often lacking a centralized data collection infrastructure. This presents a number of challenges about how to implement performance measurement, especially when it is directed at the individual physician.

The cost of data collection is a major barrier. It is possible that administrative data collection using g-codes can help streamline this process, but this will require pilot testing and careful design. Data collection in the fragmented outpatient care setting raises important concerns regarding the need for data standards and standardized reporting methods.

Using outcomes measures in the outpatient setting (e.g. mortality, or endpoints like blood pressure or cholesterol levels) raises methodological questions about attribution. For example, whose performance is being measured when the performance measure is the blood pressure of patients treated by multiple providers? Will we create incentives for providers to shun difficult or non-adherent patients?

Finally, there are substantial statistical limitations when measuring the performance of an individual physician. We would not judge a baseball player based on a batting average after only a few times at bat, and we should not judge physicians and adjust payments without robust statistical methods that allow us to make the sound judgments. Adjusting payment based on statistical inferences requires accumulated measurement over time, or aggregated measurement of multiple providers to avoid problems of hasty judgments based on small sample sizes.

For all its promise, we should recognize that pay for performance may have unintended adverse consequences. These programs may have detrimental effects on professionalism, intrinsic motivation, cooperation and team building. There may be an incentive to game – that is, to change behavior primarily for the benefit of achieving a reward. Incentives could encourage physicians to narrowly focus on measured tasks, leaving unmeasured but important tasks undone. Providers could tend to shun sicker patients or those perceived as non-compliant and seek patients who will produce a better return. Public awareness of performance may cause sicker patients to choose certain providers, and measurement may not adequately adjust for differences in risk incurred by different providers. Physicians working in underserved areas and treating disadvantaged patients may lack resources to perform at reward levels, which would further widen disparities in performance. We should remain aware of the potential for unintended consequences as we design and implement new models of payment.

Beginning Quality Improvement by Starting with What Works

The challenges to adopting a Medicare physician pay-for-performance system are daunting. Yet, current trends in Medicare growth, if left unchecked, are likely to result in arbitrary cuts in Medicare payments, such as those to imaging services contained in the Deficit Reduction Act, that ultimately will have adverse effects on patient access and quality of care. We caution Congress from attempting to employ a "one size fits all" approach to pay for performance. No matter how well intended the effort, clinicians are unlikely to change their approach to gain rewards – particularly if the rewards are negligible – for actions they do not consider in the best interests of their patients or for which they do not believe they have much influence. Physicians must believe that the measures truly reflect quality of care. Furthermore, collecting data necessary to calculate rewards in both the in-patient and out-patient setting is costly and could be subject to inaccuracies. Administrative or claims data may be easiest to collect, but inaccurate; and clinical data may be a better reflection of actual care, but obtaining data through chart abstraction is costly.

In the absence of widespread health information technology (HIT) adoption to facilitate the collection of clinical data, and in the absence of widespread systems change, there may be modest but meaningful changes that are worth exploring. In the short term, we could begin to focus on specific behaviors, processes and modes of practice. In the ACC's GAP project in Michigan, we introduced a tool called a "discharge contract" which addresses key processes of care at the time of discharge. For hospitalized patients with heart attacks and heart failure, there are about eight processes of care that can prevent subsequent death and readmission, and these processes are currently tracked as "core measures." In our GAP project, we bundled these processes of care in a discharge document or contract, which is signed by the discharging physician, the nurse and the patient. A discharge contract is a disease-specific checklist that provides patients with instructions and a follow-up plan upon discharge. The discharge contract bundles key care processes in a single simple process. Use of this simple tool was associated with a substantial reduction in 30-day and one-year mortality among Medicare beneficiaries with myocardial infarction[14] as well as a reduction in 30-day hospital readmission rates and mortality among Medicare beneficiaries with heart failure.[15] The quality improvement team at Intermountain Health showed similar results using a similar discharge tool.[16]

A CPT code or modifier code could be developed to pay physicians who discharge their patients using a certified discharge contract, giving physicians a financial incentive to use this proven quality improvement tool. Thus, a very simple pay-for-performance program could be developed that creates a financial incentive to use a discharge tool targeted to improve the care of Medicare beneficiaries with heart attacks and heart failure.

As mentioned above, integration of an HIT infrastructure will be absolutely critical to the success of any pay-for-performance program. The ACC thanks Chairman Deal for his leadership on HIT legislation and hopes that Congress will send a bill to the President's desk this year. The reality is that physician practices have been slow to acquire and implement electronic health records (EHRs). Both cost and the current lack of national standards are the most significant barriers to EHR adoption. Physician practices face substantial implementation and maintenance costs without any defined return on investment. CMS and other payers may actually see the return on the investment in EHR because the information systems will help coordinate care and will likely help weed out duplicative tests, thus generating long-term cost savings. As such, it only seems appropriate that the federal government would provide some financial assistance to facilitate more widespread adoption by physician practices. The ACC recommends that HIT legislation include financial incentives for adoption. Medicare, as well as commercial payers, should provide an enhanced fee schedule to providers that can document the use of a certified EHR.

We should recognize the damaging effect of our current tort system on quality of care. Other industries, like aviation and nuclear power, have developed mechanisms to learn from mistakes and near misses. Because of the current malpractice environment, physicians have strong financial and even stronger emotional incentives to hide mistakes, missing valuable opportunities to seek ways to improve systems of care. In Florida, peer review and quality improvement efforts are in serious jeopardy as a result of a recent constitutional amendment that subjects to discovery previously protected peer review proceedings. As a result, my cardiovascular colleagues in Florida say that physicians in

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[14] Eagle, et al. J Am Coll Cardiol 2005;46:1242-8.

[15] Koelling, Todd. Presented at the AHA Scientific Sessions, 2005

[16] Lappe JM, et al. Improvements in one-year cardiovascular clinical outcomes associated with a hospital-based discharge medication program. Annals of Int Med 2004: 141(6): 446-53.

the state are ill-advised to participate in peer-review or other quality improvement efforts at this time.

Finally, we encourage members of this Subcommittee to support federal funding for health services research, such as that being conducted by AHRQ. Outcomes research provides a reality check on what is working and what is not, and will be invaluable for assessing the effectiveness of pay-for-performance programs.

ACC Principles to Guide Physician Pay-for-Performance Programs

Due to the lack of health services research and solid supporting evidence regarding pay-for-performance programs, the ACC has developed principles to guide payers through the development of such programs. (Table 1) The ACC agrees with numerous other professional organizations that pay for performance should be based on valid, scientifically derived measures, should create true and sustainable incentives, and should use methods that are fair and predictable.

Conclusion

National efforts to address health care quality are critically important and the need is immediate. The ACC has invested significant resources to address this issue, including support for education, clinical guidelines, appropriateness criteria, data collection, benchmarking, quality improvement tools and programs, and national standards. Based on our experience, we know that deficiencies in quality and efficiency are not generally the result of uneducated or recalcitrant physicians, but rather the result of misaligned incentives and inadequate systems. The ACC supports the concept of aligning financial incentives with the performance of evidence-based medicine and with improving our care delivery systems. The ACC is committed to working with Congress and with Medicare to design payment models that will ultimately achieve the intended results of improving the health of all Americans. Thank you for allowing us to share our experience in quality improvement.

Table 1. ACCF Pay for Performance Principles

1. Built on established evidence-based performance measures
2. Create a business case for investing in structure, best practices, and tools that can lead to improvement and high quality care
3. Reward process, outcome, improvement and sustained high performance
4. Assign attribution of credit for performance to physicians in ways that are credible and encourage collaboration
5. Favor the use of clinical data over administrative claims data
6. Set targets for performance through a national consensus process
7. Address appropriateness
8. Positive, not punitive
9. Audit performance measure data
10. Establish transparent provider rating methods
11. Not create perverse incentives
12. Invest in outcomes and health services research

For more details on the American College of Cardiology's principles for pay for performance, go to: http://www.acc.org/advocacy/pdfs/ACCFP4PPrinciplesFinal.pdf

MR. FERGUSON. Thank you, Dr. Brush. Dr. Martin.

DR. MARTIN. Good afternoon, Mr. Chairman. I am honored to be here today on behalf of the American Osteopathic Association, the AOA,

and the Nation's 56,000 osteopathic physicians, practicing in all specialties and subspecialties of medicine.

The AOA and our members appreciate the committee's continued efforts to improve the Nation's healthcare system. Reforming the Medicare physician payment formula, and improving the quality of care provided to beneficiaries, are goals that we both share. A top concern of the osteopathic profession remains the ongoing inequities associated with the current Medicare physician payment formula, especially the sustainable growth rate.

We urge Congress to take appropriate steps to ensure that every physician participating in the Medicare program receives a positive 2.8 percent update, as recommended by MedPAC for 2007. The AOA is committed to ensuring that future payment methodologies reflect the quality of care provided, and include incentives to improve health outcomes of patients. We are supportive of programs to allow the reporting and analysis of reliable quality data. Additionally, we support a fair and equitable evaluation process. However, we are concerned that the current Medicare payment formula cannot support the implementation of such a process.

As the debate on quality reporting of pay-for-performance moves forward, the AOA proposes a set of principles to guide your efforts. These include number one, the goal must be improvement in the overall health and outcomes of Medicare beneficiaries. Number two, financing of the program should not be budget neutral. Number three, physicians must remain central to the establishment and development of quality standards. The AOA supports the ability of appropriate outside groups with acknowledged expertise to endorse developed standards that may be used. Number four, the preferential use of clinical data, rather than claims data, in quality evaluation is recommended. Number five, a single set of standards applicable to all physicians may not be optimal. Physicians provide a wide variety of services to Medicare beneficiaries, and a quality reporting program should reflect these differences. Number six, a viable, interoperable health information system is key to the implementation and success of quality improvement and performance-based payment methodologies.

The AOA has taken several steps to ensure that our members are educated, aware, and prepared for new quality reporting programs. The most significant step is the establishment of the Web-based Clinical Assessment Program, known as the CAP, C-A-P. CAP was introduced in 2000 as a program to measure the quality of care in clinical practices in primary care osteopathic residency programs. The goal of CAP is to improve patient outcomes by providing valid and reliable assessments of

current clinical practices, and process sharing of best practices in care delivery.

CAP provides evidence-based measurement sets on eight clinical conditions, including diabetes, coronary artery disease, hypertension, women's health screening, asthma, COPD, childhood immunizations, and low back pain. CAP is able to collect clinical data from multiple residency programs, and provide information regarding performance back to those participating programs. This allows for evaluation of clinical data provided at a single practice site in comparison to other similar practice settings around the region, State, or the Nation.

CAP for residency programs has thus far been quite successful in meeting its initial goals, and has been widely acknowledged as a valuable tool to improve quality in ambulatory care settings. Additionally, CAP is beginning to provide data on quality improvement. In December 2005, CAP became available for physician offices.

In closing, the AOA urges Congress to take steps to eliminate the year-to-year uncertainty that plagues the Medicare physician reimbursement system. The current formula should be eliminated and replaced with a payment system that more accurately reflects the costs of providing care to beneficiaries, and supports the implementation of a quality reporting program. Such activities will ensure that physicians participate in the program, and that it remains robust and provides time for Congress to develop a new payment methodology.

The AOA has worked with the American College of Surgeons to develop a new payment methodology that was reported earlier, and would provide positive annual updates to physicians based upon increase in practice costs, while being conducive to quality improvement and pay-for-performance programs. The proposal is outlined in our written statement also. The AOA also wishes to thank Dr. Burgess for introducing H.R. 5866.

Thank you for the opportunity to testify before this committee.

[The prepared statement of Dr. Paul A. Martin follows:]

PREPARED STATEMENT OF DR. PAUL A. MARTIN, CHIEF EXECUTIVE OFFICER AND PRESIDENT, PROVIDENCE MEDICAL GROUP, INC., ON BEHALF OF AMERICAN OSTEOPATHIC ASSOCIATION

Executive Summary

As a physician organization, we are committed to ensuring that all patients receive the appropriate health care based upon their medical condition and the latest research information and technology. For these reasons, the AOA is supportive of programs aimed at improving the quality of care provided and believe that we have a responsibility to help the Committee and Congress craft such a program. However, we do not, and will not, support programs whose sole goal is to reduce or curb spending on physician services. The goal must be improved health care for beneficiaries, which in the short-term likely will result in increased, not decreased, spending.

The AOA recognized early on the need for quality improvement and the national trend toward quality improvement programs. In response, we took steps to ensure that our members were educated, aware, and prepared for these new programs.

In 2000, building on the hypothesis that some barriers to transforming evidence into practice may begin during physician post-graduate training and that measurement is key to identifying opportunities for incorporation of evidence based measures into practice, the AOA launched the Clinical Assessment Program (CAP). The CAP measures the quality of care in clinical practices in osteopathic residency programs. The goal of the CAP is to improve patient outcomes by providing valid and reliable assessments of current clinical practices and process sharing of best practices in care delivery. The CAP provides evidence-based measurement sets on eight clinical conditions including diabetes, coronary artery disease, hypertension, women's health screening, asthma, COPD, childhood immunizations, and low back pain. Data elements collected by the residency training programs include both demographic and clinical information. CAP has been widely acknowledged as a tool to improve quality in ambulatory care and is beginning to provide data on quality improvement.

In December 2005, the CAP became available for physician offices and offers initial measurement sets on diabetes, coronary artery disease, and women's health screening. The "CAP for Physicians" will measure current clinical practices in the physician office and compare the physician's outcomes measures to their peers and national measures. The AOA looks forward to working with Congress and CMS to explore ways that the CAP may be incorporated into broader quality reporting and quality measurement systems.

The AOA is convinced that the current Medicare payment methodology cannot support the implementation of a quality-reporting or pay-for-performance program. The SGR methodology is broken and, in our opinion, beyond repair. This Committee, the Medicare Payment Advisory Commission, and every physician organization recommends eliminating the formula and replacing it with a payment system that more accurately reflects the costs of providing care to beneficiaries. Steps must be taken to eliminate the year-to-year uncertainty that has plagued the Medicare physician payment formula for the past five years. To this end, **every physician participating in the Medicare program should receive a positive 2.8 percent update in 2007**. This will ensure that participation in the program remains robust. Additionally, this provides time for Congress to develop, adopt, and implement a new payment methodology.

We recognize that Congress faces financial obstacles to accomplishing this goal. However, the costs of not reforming the system may be greater. Physicians cannot afford to have continued reductions in reimbursements. Ultimately, they either will stop participating in the Medicare program or limit the number of beneficiaries they accept into their practices. Either of these scenarios results in decreased access for our growing Medicare population.

Additionally, we believe it is time for Congress to consider changes in the Medicare funding formulas that allow for spending adjustments based upon the financial health of the entire Medicare program. As Congress and CMS establish new quality improvement programs, it is imperative for Medicare to reflect fairly the increased role of physicians and outpatient services as cost savers to the Part A Trust Fund. Quality improvement programs may increase spending in Part B, but very well could result in savings in Part A or Part D. These savings should be credited to physicians through a program between Parts A, B, and D.

As quality reporting and pay-for-performance programs become more prevalent, fundamental issues must be addressed. Some of our top concerns are:

- Quality and pay-for-performance programs must be developed and implemented in a manner that aims to improve the quality of care provided by all physicians. New formulas must provide financial incentives to those who

meet standards and/or demonstrate improvements in the quality of care provided. The system should not punish some physicians to reward others.

- The use of claims data as the sole basis for performance measurement is a concern. Claims data does not reflect severity of illness, practice-mix, and patient non-compliance. These issues and others are important factors that must be considered. Sole reliance on claims data may not indicate accurately the quality of services being provided. We believe that clinical data is a much more accurate indicator of quality care.
- The financial and regulatory burden quality and pay-for-performance programs will have upon physician practices, especially those in rural communities, must be minimized. Physicians, and medicine in general, have one of the highest paperwork burdens anywhere. We want to ensure that new programs do not add to physicians' already excessive regulatory burden.
- Quality and pay-for-performance programs should have some degree of flexibility. The practice of medicine continuously evolves. Today's physicians have knowledge, resources, and technology that didn't exist a decade ago. This rapid discovery of new medical knowledge and technology will transform the "standards of care" over time. It is imperative that the quality reporting and pay-for-performance system have the infrastructure to be modified as advances are made.

Mr. Chairman, my name is Paul Martin. I am a family physician from Dayton, Ohio and currently serve as the Chief Executive Officer and President of the Providence Medical Group, a 41-member independent physician owned and governed multi-specialty physician group in the greater Dayton metropolitan area. I am honored to be here today on behalf of the American Osteopathic Association (AOA) and the nation's 56,000 osteopathic physicians practicing in all specialties and subspecialties of medicine.

The AOA and our members wish to express our appreciation to you and the Committee for your continued efforts to improve the nation's health care system, especially your ongoing efforts to reform the Medicare physician payment formula and improve the quality of care provided by physicians. These are goals that we share. I want to acknowledge and thank Rep. Michael Burgess for introducing the Medicare Physician Payment Reform and Quality Improvement Act of 2006. This legislation is consistent with many AOA policies related to Medicare physician payment, quality reporting, and Medicare financing. We appreciate his efforts to introduce new policy concepts that would eliminate the use of the sustainable growth rate methodology and move physicians toward a more equitable system based upon actual practice cost and reflective of increased quality in care provided. Mr. Chairman, we also applaud your leadership and your willingness to work with Dr. Burgess and other Members of the Committee to advance achievable solutions to this ongoing policy issue.

Since its inception in 1965, a central tenet of the Medicare program has been the physician-patient relationship. Beneficiaries rely upon their physician for access to all other aspects of the Medicare program. Over the past decade, this relationship has become compromised by dramatic reductions in reimbursements, increased regulatory burdens, and escalating practice costs. Given that the number of Medicare beneficiaries is expected to double to 72 million by 2030, now is the time to establish a stable, predictable, and accurate physician payment formula. Such a formula must: reflect the cost of providing care, implement appropriate quality improvement programs that improve the overall health of beneficiaries, and reflect that a larger percentage of health care is being delivered in ambulatory settings versus hospital settings.

Quality Improvement and Pay for Performance

Today's health care consumers—including Medicare beneficiaries—demand the highest quality of care per health care dollar spent. The AOA recognizes that quality improvement in the Medicare program is an important and worthy objective. For over 130 years osteopathic physicians have strived to provide the highest quality care to their millions of patients. Through those years, standards of care and medical practice evolved and changed. Physicians changed their practice patterns to reflect new information, new data, and new technologies.

As a physician organization, we are committed to ensuring that all patients receive the appropriate health care based upon their medical condition and the latest research information and technology. The AOA recognized early on the need for quality improvement and the national trend toward quality improvement programs. In response, we took steps to ensure that our members were educated, aware, and prepared for these new programs.

In 2000, building on the hypothesis that some barriers to transforming evidence into practice may begin during physician post-graduate training and that measurement is key to identifying opportunities for incorporation of evidence based measures into practice, the AOA launched the web-based Clinical Assessment Program (CAP). When the CAP was initially introduced six years ago, it measured the quality of care in clinical practice in osteopathic residency programs. The goal of the CAP is to improve patient outcomes by providing valid and reliable assessments of current clinical practices and process sharing of best practices in care delivery.

The CAP provides evidence-based measurement sets on eight clinical conditions including diabetes, coronary artery disease, hypertension, women's health screening, asthma, COPD, childhood immunizations, and low back pain. Data elements collected by the residency training programs include both demographic and clinical information. CAP has been widely acknowledged as a tool to improve quality in ambulatory care and is beginning to provide data on quality improvement. For example, the percent of diabetics having foot exams performed routinely increased 24% in programs re-measuring as of June 2006. Likewise, in outcome of care measures, the LDL cholesterol levels and diabetic HgbA1c have decreased.

The CAP is able to collect data from multiple clinical programs and provide information regarding performance back to participating residency programs. This allows for evaluation of care provided at a single practice site in comparison to other similar practice settings around the region, state, or nation.

In December 2005, the CAP became available for physician offices offering initial measurement sets on diabetes, coronary artery disease, and womens health screening. The "CAP for Physicians" measures current clinical practices in the physician office and compares the physician's outcome measures to their peers and national measures. The AOA looks forward to working with Congress and CMS to explore ways that the CAP may be incorporated into broader quality reporting and quality measurement systems.

As the national debate on the issues of quality reporting and pay-for-performance began, the AOA established a set of principles to guide our efforts on these important issues. These principles represent "achievable goals" that assist in the development of quality improvement systems while recognizing and rewarding the skill and cost benefits of physician services.

First, the AOA believes that the current Medicare physician payment formula, especially the sustainable growth rate (SGR), is seriously flawed and should be replaced. Additionally, we are convinced that that the current Medicare payment methodology cannot support the implementation of a quality-reporting or pay-for-performance program.

The AOA strongly supports the establishment of a new payment methodology that ensures every physician participating in the Medicare program receives an annual

positive update that reflects increases in the costs of providing care to their patients. Moreover, the AOA is committed to ensuring that any new physician payment methodology reflects the quality of care provided and efforts made to improve the health outcomes of patients. As a result of this commitment, we support the establishment of standards that, once operational, will allow for the reporting and analysis of reliable quality data. Additionally, we support the establishment of a fair and equitable evaluation process that aims to improve the quality of care provided to beneficiaries.

To support this goal, the AOA adopted the following principles:

1. Quality reporting and/or pay-for-performance systems whose primary goal is to improve the health care and health outcomes of the Medicare population must be established. Such programs should not be budget neutral. Appropriate additional resources should support implementation and reward physicians who participate in the programs and demonstrate improvements. The AOA recommends that additional funding be made available through the establishment of bonus-payments.
2. To the extent possible, participation in quality reporting and pay-for-performance programs should be voluntary and phased-in. The AOA acknowledges that failure to participate may decrease eligibility for bonus or incentive-based reimbursements, but feels strongly that physicians must be afforded the opportunity to not participate.
3. Physicians are central to the establishment and development of quality standards. A single set of standards applicable to all physicians is not advisable. Instead, standards should be developed on a specialty-by-specialty basis, applying the appropriate risk adjustments and taking into account patient compliance. Additionally, quality standards should not be established or unnecessarily influenced by public agencies or private special interest groups who could gain by the adoption of certain standards. However, the AOA does support the ability of appropriate outside groups with acknowledged expertise to endorse developed standards that may be used.
4. The exclusive use of claims-based data in quality evaluation is not recommended. Instead, the AOA supports the direct aggregation of clinical data by physicians. Physicians or their designated entity would report this data to the Centers for Medicare and Medicaid Services (CMS) or other payers.
5. Programs must be established that allow physicians to be compensated for providing chronic care management services. Furthermore, the AOA does not support the ability of outside vendors, independent of physicians, to provide such services.

Resource Utilization and Physician Profiling

Over the past few years, Congress, MedPAC and other health policy bodies have placed greater emphasis on controlling the use of "resources" by physicians and other health care providers. The AOA supports, in concept, a systemic evaluation of resource use that measures overuse, misuse, and under use of services within the Medicare program.

Additionally, we do not oppose programs that confidentially share with physicians their resource use as compared to other physicians in similar practice settings. However, any effort to evaluate resource use in the Medicare program must not be motivated only by financial objectives. Instead, the AOA believes that physician utilization programs must be aimed at improving the quality of care provided to our patients. In measuring the performance of physicians the singular use of utilization measures without evaluation of clinical process and outcomes can lead to adverse impact on care delivery. Tracking methods to determine the unintended consequences of reduced utilization on patient safety should be incorporated in any utilization reports developed.

If the intent of the program is to improve the quality of care, then the validity, reliability, sensitivity, and specificity of information intended for private or public reporting must be very high. Comparative utilization information cannot be attained through administrative or claims-based data alone without adequate granulation for risk adjustment.

In an effort to support the establishment of quality improvement programs that stand to benefit the quality of care provided to patients, the AOA adopted the following ten principles that guide our policy on comparative utilization or physician profiling programs:

1. Comparative utilization or physician profiling should be used only to show conformity with evidence-based guidelines.
2. Comparative utilization or physician profiling data should be disclosed only to the physician involved. If comparative utilization or physician profiling data is made public, assurances must be in place that promise rigorous evaluation of the measures to be used and that only measures deemed sensitive and specific to the care being delivered are used.
3. Physicians should be compared to other physicians with similar practice-mix in the same geographical area. Special consideration must be given to osteopathic physicians whose practices mainly focus on the delivery of osteopathic manipulative treatment (OMT). These physicians should be compared with other osteopathic physicians that provide osteopathic manipulative treatment.
4. Utilization measures within the reports should be clearly defined and developed with broad input to avoid adverse consequences. Where possible, utilization measures should be evidenced-based and thoroughly examined by the relevant physician specialty or professional societies.
5. Efforts to encourage efficient use of resources should not interfere with the delivery of appropriate, evidence-based, patient-centered health care. Furthermore, the program should not impact adversely the physician-patient relationship or unduly intrude upon a physician's medical judgment. Additionally, consideration must be given to the potential overuse of resources as a result of the litigious nature of the health care delivery system.
6. Practicing physicians must be involved in the development of utilization measures and the reporting process. Clear channels of input and feedback for physicians must be established throughout the process regarding the impact and potential flaws within the utilization measures and program.
7. All methodologies, including those used to determine case identification and measure definitions, should be transparent and readily available to physicians.
8. Use of appropriate case selection and exclusion criteria for process measures and appropriate risk adjustment for patient case-mix and inclusion of adjustment for patient compliance/wishes in outcome measures, need to be included in any physician specific reports. To ensure statistically significant inferences, only physicians with an appropriate volume of cases should be evaluated. These factors influence clinical or financial outcomes.
9. The utilization measure constructs should be evaluated on a timely basis to reflect validity, reliability and impact on patient care. In addition, all measures should be reviewed in light of evolving evidence to maintain the clinical relevance of all measures.
10. Osteopathic physicians must be represented on any committee, commission, or advisory panel, duly charged with developing measures or standards to be used in this program.

Medicare Payments to Physician

Reform of the Medicare physician payment formula, specifically, the repeal of the sustainable growth rate (SGR) formula, is one of the AOA's top priorities. The SGR formula is unpredictable, inequitable, and fails to account accurately for physician practice costs. We continue to advocate for the establishment of a more equitable, rational, and predictable payment formula that reflects physician cost of providing care.

In 2002, physician payments were cut by 5.4 percent. Thanks to the leadership of this Committee, Congress acted to avert payment cuts in 2003, 2004, 2005, and 2006 replacing projected cuts of approximately 5 percent per year with increases of 1.6 percent in 2003, 1.5 percent in 2004 and 2005, and a freeze at 2005 levels for 2006.

The AOA and our members are appreciative of actions taken over the past four years to avert additional cuts. However, even with these increases physician payments have fallen further behind medical practice costs. Practice costs increases from 2002 through 2006 were about two times the amount of payment increases.

According to the 2006 Medicare Trustees Report, physicians are projected to experience a reimbursement cut of 4.6 percent in 2007 with additional cuts predicted in years 2007 through 2015. Without Congressional intervention, physicians will face a 34 percent reduction in Medicare reimbursements over the next eight years. During this same period, physicians will continue to face increases in their practice costs. If the 2007 cut is realized, Medicare physician payment rates will fall 20 percent below the governments measure of inflation in medical practice costs over the past six years. Since many health care programs, such as TRICARE, Medicaid, and private insurers link their payments to Medicare rates, cuts in other systems will compound the impact of the projected Medicare cuts.

Physicians should be reimbursed in a more predictable and equitable manner, similar to other Medicare providers. Physicians are the only Medicare providers subjected to the flawed SGR formula. Since the SGR is tied to flawed methodologies, it routinely produces negative updates based upon economic factors, not the health care needs of beneficiaries. And, it has never demonstrated the ability to reflect increases in physicians' costs of providing care. Every Medicare provider, except physicians, receives annual positive updates based upon increases in practice costs. Hospitals and other Medicare providers do not face the possibility of "real dollar" cuts—only adjustments in their rates of increase.

It is important to recognize that, in 2007, substantial changes to other components of the Medicare payment formula will shift billions of dollars which will lead to cuts of up to 10 to 12 percent for certain physician services. It is imperative that Congress acts to stabilize the update to the conversion factor in order to bring stability to this volatile system and dampen the impact of payment cuts caused by unrelated policy changes. The non-SGR related changes to physician payment in 2007 include:

Geographic Practice Cost Index (GPCI)

The Medicare Prescription Drug, Modernization and Improvement Act (MMA) (P.L. 108-173) included a three-year floor of 1.0 on all work GPCI adjustments. This provision is set to expire on December 31, 2006. Nationwide, 58 of the 89 physician payment areas have benefited from this provision. If this provision is not extended many physicians, especially those in rural areas, will experience additional cuts. The AOA supports the "Medicare Rural Health Providers Payment Extension Act." (H.R. 5118) introduced by Rep. Greg Walden. We urge the Committee to include the provisions of H.R. 5118 in any legislative package considered this year.

Five-Year Review

Every five years, CMS is required by law to review all work relative value units (RVU) and make needed adjustments. These adjustments must be made in a budget

neutral manner. Changes related to the third five-year review will be implemented on January 1, 2007.

In total, more than $4 billion will be shifted to evaluation and management (E&M) codes, which will be increased by upwards of 35 percent in some instances. The AOA is very supportive of the changes in values for E&M codes. We believe E&M codes have been undervalued historically. The proposed changes are fair and should be implemented.

We do recognize that increases in E&M codes will require decreases in other codes. CMS has proposed a 10 percent decrease in the work RVU's of other codes in the physician fee schedule or an additional five percent cut to the conversion factor as a means of achieving budget neutrality.

Practice Expense

CMS also has announced significant changes to the formulas used to determine the practice expense RVU. These changes also are budget neutral and will shift approximately $4 billion. Again, these increases will require cuts in other areas of the physician fee schedule.

This dramatic shift in the allocation of funding will have a significant impact on many physicians across the country. The AOA is concerned about the impact a reduction in the SGR, along with cuts resulting in the reallocation of funding required by other policy changes, might have upon physicians. While the total impact of the changes will vary by specialty, geographic location, and practice composition; it is clear that physicians specializing in certain specialties may see significant cuts prior to any adjustments to the conversion factor are made as a result of the SGR formula. For these reasons we call upon Congress to ensure that all physicians participating in the Medicare program receive a positive payment update in 2007.

In its 2006 March Report to Congress, MedPAC stated that payments for physicians in 2007 should be increased 2.8 percent. We strongly support this recommendation. Additionally, since 2001, MedPAC has recommended that the flawed SGR formula be replaced. Again, the AOA strongly supports MedPAC's recommendation.

Steps must be taken to eliminate the year-to-year uncertainty that has plagued the Medicare physician payment formula for the past five years. **To this end, every physician participating in the Medicare program should receive a positive 2.8 percent update in 2007** as recommended by MedPAC. This will ensure that participation in the program remains robust. Additionally, this provides time for Congress to develop, adopt, and implement a new payment methodology.

Problems with the Sustainable Growth Rate (SGR) Formula

Concerned that the 1992 fee schedule failed to control Medicare spending, five years later Congress again examined physician payments. As a result, the Balanced Budget Act of 1997 (BBA 97) (Public Law 105-33) established a new mechanism, the sustainable growth rate, to cap payments when utilization increases relative to the growth of gross domestic product (Congressional Budget Office, "Impact of the BBA," June 10, 1999).

This explanation of the SGR not only highlights the objectives of the formula, but also demonstrates the serious flaws that have resulted. The AOA would like to highlight three central problems associated with the current formula—physician administered drugs, the addition of new benefits and coverage decisions, and the economic volatility of the formula.

Utilization of Physician Services—The SGR penalizes physicians with lower payments when utilization exceeds the SGR spending target. However, utilization is often beyond the control of the individual physician or physicians as a whole.

Over the past twenty years, public and private payers successfully moved the delivery of health care away from the hospital into physicians' offices. They did so through a shift in payment policies, coverage decisions, and a move away from acute based care to a more ambulatory based delivery system. This trend continues today. As a result, fewer patients receive care in an inpatient hospital setting. Instead, they rely upon their physicians for more health care services, leading to greater utilization of physician services.

For the past several years, the Centers for Medicare and Medicaid Services (CMS) have failed to account for the numerous policy changes and coverage decisions in the SGR spending targets. With numerous new beneficiary services included in the Medicare Modernization Act (MMA) (P.L. 108-173) and an expected growth in the number of national coverage decisions, utilization is certain to increase over the next decade. The Congressional Budget Office (CBO) cites legislative and administrative program expansions as major contributors to the recent increases in Medicare utilization. The other major contributors were increased enrollment and advances in medical technology.

Physician Administered Drugs—The other major contributor to increased utilization of physician services is the inclusion of the costs of physician-administered drugs in the SGR. Because of the rapidly increasing costs of these drugs, their inclusion greatly affects the amount of actual expenditures and reduces payments for physician services.

Over the past few years, you and the Committee have encouraged the Administration to remove the cost of physician-administered drugs from the formula. The AOA encourages the Committee to continue pressing the Administration on this issue. We do not believe the definition of physician services included in Section 1848 of Title XVIII includes prescription drugs or biological products. Removal of these costs would ease the economic constraints that face Congress and make reform of the physician payment formula more feasible.

Gross Domestic Product—The use of the GDP as a factor in the physician payment formula subjects physicians to the fluctuating national economy. We recognize the important provisions included in the MMA that altered the use of the GDP to a 10-year rolling average versus an annual factor. Again, we appreciate your leadership and insistence that that provision be included in the final legislation.

However, we continue to be concerned that a downturn in the economy will have an adverse impact on the formula. We argue that the health care needs of beneficiaries do not change based upon the economic environment. Physician reimbursements should be based upon the costs of providing health care services to seniors and the disabled, not the ups and downs of the economy.

A New Payment Methodology for Physicians

Several bills aimed at providing both short and long-term solutions to the Medicare physician payment issue have been introduced during the 109th Congress. The AOA supports many of these bills and appreciates the continued efforts of Members of Congress to find achievable solutions to these ongoing policy issues.

The AOA has worked with the American College of Surgeons to develop a new payment methodology that would provide positive annual updates to physicians based upon increases in practice costs, while being conducive to quality improvement and pay-for-performance programs.

The AOA proposes a new payment system that would replace the universal volume target of the current sustainable growth rate (SGR) with a new system, known as the service category growth rate (SCGR), that recognizes the unique nature of different physician services by setting targets for six distinct service categories of physician services. The service categories, which are based on the Berenson-Eggers type-of-service definitions already used by CMS, are: evaluation and management (E&M) services;

major procedures (includes those with 10 or 90 day global service periods) and related anesthesia services; minor procedures and all other services, including anesthesia services not paid under physician fee schedule; imaging services and diagnostic tests; diagnostic laboratory tests; and physician-administered Part B drugs, biologicals, and radiopharmaceuticals.

The SCGR target would be based on the current SGR factors (trends in physician spending, beneficiary enrollment, law and regulations), except that GDP would be eliminated from the formula and be replaced with a statutorily set percentage point growth allowance for each service category. To accommodate already anticipated growth in chronic and preventive services, we estimate that E&M services would require a growth allowance about twice as large as the other service categories (between 4-5 percent for E&M as opposed to 2-3 percent for other services). Like the SGR, spending calculations under the SCGR system would be cumulative. However, the Secretary would be allowed to make adjustments to any of the targets as needed to reflect the impact of major technological changes.

Like the current SGR system, the annual update for a service category would be the Medicare medical economic index (MEI) plus the adjustment factor. But, in no case could the final update vary from the MEI by more or less than 3 percentage points; nor could the update in any year be less than zero. The formula allows for up to one percentage point of the conversion factor for any service category to be set aside for pay-for-performance incentive payments.

Like the SGR, the SCGR would retain a mechanism for restraining growth in spending for physician services. It recognizes the wide range of services that physicians provide to their patients. Unlike the current universal target in the SGR, which penalizes those services with low volume growth at the expense of high volume growth services, the SCGR would provide greater accountability within the Medicare physician payment system by basing reimbursement calculations on targets that are based on a comparison of like services and providing a mechanism to examine those services with high rates of growth while reimbursement for low growth services would not be forced to subsidize these higher growth services. By recognizing the unique nature of different physician services, the SCGR enables Medicare to more easily study the volume growth in different physician services and determine whether or not volume growth is appropriate.

Additionally, the AOA believes the SCGR provides a sound framework for starting a basic value-based purchasing system. Given the diversity of physician services provided to patients, it is difficult to find a set of common performance measures applicable to all physicians. However, development of common performance measures is much easier when comparing similar services.

Beneficiary Access to Care

The continued use of the flawed and unstable sustainable growth rate methodology will result in a loss of physician services for millions of Medicare beneficiaries. Osteopathic physicians from across the country have told the AOA that future cuts will hamper their ability to continue providing services to Medicare beneficiaries.

The AOA surveyed its members on July 14-16, 2006 to analyze their reactions to previous and future payment policies. The AOA asked its members what actions they or their practice would take if the projected cuts in Medicare physician payments were implemented. The results are concerning. Twenty-one percent said they would stop providing services to Medicare beneficiaries. Twenty-six percent said they would stop accepting new Medicare beneficiaries in their practice and thirty-eight percent said they would limit the number of Medicare beneficiaries accepted in their practice.

Many experts concur with these findings. According to a 2005 survey conducted by MedPAC, 25 percent of Medicare beneficiaries reported that they had some problem finding a primary care physician. MedPAC concluded that Medicare beneficiaries *"may*

be experiencing more difficulty accessing primary care physicians in recent years and to a greater degree than privately insured individuals."

While there are some steps that can be taken by physicians to streamline their business operations, they simply cannot afford to have the gap between costs and reimbursements continue to grow at the current dramatic rate. Many osteopathic physicians practice in solo or small group settings. These small businesses have a difficult time absorbing losses. Eventually, the deficit between costs and reimbursements will be too great and physicians will be forced to limit, if not eliminate, services to Medicare beneficiaries.

Additionally, continued cuts limit the ability of physicians to adopt new technologies, such as electronic health records, into their practices.

Health Information Technology

A viable interoperable health information system is key to the implementation and success of quality improvement and performance-based payment methodologies. For these reasons, we support the "Health Information Technology Promotion Act" (H.R. 4157). An interoperable health information system will improve the quality and efficiency of health care.

Our main focus is ensuring that software and hardware used throughout the healthcare system are interoperable. There is no benefit to be found in the utilization of systems unable to communicate with others. Additionally, the AOA believes strongly that systems developed and implemented must not compromise the essential patient-physician relationship. Medical decisions must remain in the hands of physicians and their patients, independent of third-party intrusion.

The AOA remains concerned about the costs of health information systems for individual physicians, especially those in rural communities. According to a 2005 study published in Health Affairs, the average costs of implementing electronic health records was $44,000 per full-time equivalent provider, with ongoing costs of $8,500 per provider per year for maintenance of the system. This is not an insignificant investment. With physicians already facing deep reductions in reimbursements, without financial assistance, many physicians will be prohibited from adopting and implementing new technologies. A July 2006 survey conducted by the AOA demonstrates this concern. According to the survey, 90 percent of osteopathic physicians responding agreed that "decreased reimbursements will hinder their ability to purchase and implement new health information technologies in their practice." While we continue to advocate for financial assistance for these physicians, we appreciate inclusion of provisions in H.R. 4157 that provide safe harbors allowing hospitals and other health care entities to provide health information hardware, software, and training to physicians. This would, in our opinion, facilitate rapid development of health information systems in many communities.

I appreciate the opportunity to testify before the Energy and Commerce Committee Subcommittee on Health. Again, I applaud your continued efforts to assist physicians and their patients. The AOA and our members stand ready to work with you to develop a payment methodology that secures patient access, improves the quality of care provided, and appropriately reimburses physicians for their services. Additionally, we stand ready to assist in the development of new programs that improve quality, streamline the practice of medicine, and make the delivery of health care more efficient and affordable.

Paul A. Martin, D.O.

Paul A. Martin, D.O., a board certified family physician from Dayton, Ohio, is a recognized leader within the medical profession in Ohio and across the nation. He currently serves as the Chief Executive Officer and President of the Providence Medical Group, a 41-member independent physician owned and governed multi-specialty

physician group in the greater Dayton metropolitan area. Dr. Martin oversees the operations of one of the largest multi-physician organizations in southwest Ohio serving urban, suburban, and rural demographic areas. He is deeply knowledgeable about health care financing, including the Medicare and Medicaid programs. He also possesses a strong understanding of the health care delivery system as a whole.

Dr. Martin received his undergraduate degree, Cum Laude, in Biology from the University of Dayton in 1970 and a Masters in Microbiology from the University of Dayton in 1972. He earned his medical degree, Cum Laude, from the Chicago College of Osteopathic Medicine in 1977. He completed his post-graduate training at Grandview/Southview Medical Center in Dayton. Dr. Martin obtained his board certification in family medicine in 1986 from the American Osteopathic Board of Family Physicians and was recertified in 2004. Additionally, he became a Fellow in the American College of Osteopathic Family Physicians in 1997.

Dr. Martin has served in numerous leadership positions throughout his career. He currently serves as a Governor on the American College of Osteopathic Family Physicians Board of Trustees. He is a Past-President of the Ohio Osteopathic Association and the Ohio Chapter of the American College of Osteopathic Family Physicians. He is a former Chief-of-Staff and Chairman of the Physician-Hospital Steering Committee at Grandview/Southview Medical Center in Dayton. Additionally, he is a past member of the Board of Governors for the Chicago College of Osteopathic Medicine, the Board of Trustees for Midwestern University in Chicago, IL, and the Board of Trustees at Grandview/Southview Medical Center in Dayton.

Dr. Martin remains closely tied to academic medicine. He serves as a Clinical Professor at the Ohio University College of Osteopathic Medicine and is a member of the Adjunct Faculty at the University of Dayton.

MR. FERGUSON. Thank you, Dr. Martin.

In case any of you are wondering why Mr. Allen and I look so lonely up here, the Health IT bill, which some of you have referenced, and you are certainly familiar with, is being debated on the floor as we speak. Mr. Allen and I are keeping tabs on it with this little TV right here, so that is why some of the other members of the subcommittee are not here listening to you all. But, I am certain that some of them will be making their way back here as they finish speaking on the Health IT bill, which is being debated on the floor as we are here in this hearing. We appreciate your understanding of that as well.

I am going to recognize myself for 5 minutes for questions. I want to go right down the line, and we will start with Dr. Martin since you had to wait so patiently to go last, you can now go first, but I am looking for a one word answer. I am looking for a yes or a no. If it as at all possible, I want to go right down the line, because I have several other questions I want to get to.

My question is, would you support a pay-for-reporting for 2007?

DR. MARTIN. Yes.

DR. BRUSH. Across the board?

MR. FERGUSON. Yes.

DR. BRUSH. Yes.

DR. SCHRAG. Yes.

DR. KIRK. Yes, we would.

DR. OPELKA. Yes.

DR. RICH. Yes, using clinical data.

DR. HEINE. It depends on the data.

MR. FERGUSON. Would you just turn your mic on? I am sorry.

DR. HEINE. I am sorry. Yes, it depends on the data. There are too many factors to give a yes or no. I am sorry.

DR. WILSON. Yes.

MR. FERGUSON. Okay. Thank you. I appreciate that almost everybody answered with one word. That was pretty good. You would never get that from up here.

Dr. Wilson, would you support, and I recognize you are speaking for the folks that you represent. Dr. Wilson, would you support a pay-for-reporting without a permanent physician fix? What about a year or two of positive updates, without a complete overhaul of the SGR?

DR. WILSON. Thank you, Mr. Chairman, and I assume you are still looking for a yes or no, but--

MR. FERGUSON. No. No, I would like you to elaborate on that.

DR. WILSON. Okay.

MR. FERGUSON. You can expound on that.

DR. WILSON. As I indicated in my testimony, we believe that the increased costs related to reporting are incompatible with the SGR. We believe that continued provision of care for patients is incompatible with continued use of the SGR. There is 37 percent reduction in the last, the coming 9 years, an additional 22 percent cost of living, you are talking about 59 percent. Nine years from now, the dollar I get today, I will get $0.41 on that dollar. It is just not compatible.

So, we believe that these, in a way, are separate issues. We need to revise and reform the payment system. We need to and we will continue, certainly, from the organized medicine standpoint, continue down the road for improved quality. Actually, as you know, we started the Physician Consortium on Quality Improvement in 2000 before a lot of this came on the scene.

MR. FERGUSON. Thank you. As you all know, we don't always get to operate in the world of what we would like to do. Sometimes, we have to operate in the world of what we can do. So, it is interesting for us, and important for us to hear your thoughts, as we try and navigate some of these options, and some of these negotiations that we are involved with.

Dr. Heine, I have a question. We have been talking about pay-for-performance, and we have been talking about pay-for-reporting. Can you, and you specifically talked about this in your testimony, can you explain to me just, as you see it, what is the difference between the two,

and can you talk about the terminology a little bit, and essentially, the value that would be associated with pay-for-performance versus a pay-for-reporting?

DR. HEINE. Well, pay-for-reporting, actually, is what the hospitals are engaged in currently. They actually have to report on certain measures that are set up for them. With regard to pay-for-performance, it is actually performing additional services. So, one is the action, and one is reporting on it. So, that is somewhat of the difference there.

For example, in the hospital, and it is an emergency physician, we have to note whether we give an aspirin for a person who comes in with a heart attack. So, the reporting on that, you are paying for the reporting aspect. The other, you are paying for the act of administering or ordering that aspirin. So, it is a slightly different situation.

The concern that we have, in terms of actually what Dr. Wilson had mentioned, is covering the costs of administering those additional services, and the fact that if you have the SGR currently as it is in place, and you are trying to engage this pay-for-performance or pay-for-reporting. Either one is going to incur additional costs, whether it is just data abstraction or reporting, or it is actual additional services, and then abstraction of that data and reporting. It is on a collision course, so you can have increased volume of services as a result of the initiative for either pay-for-reporting or pay-for-performance, and you are going to have this expenditure cap with the SGR. It just doesn't work. You have to be able to amplify the additional funds that could be present to enable the program to be successful.

MR. FERGUSON. Okay. Rather than go over my time, I am going to recognize Mr. Allen for 5 minutes for questions.

MR. ALLEN. Thank you, Mr. Chairman. I want to second the Chairman's remarks about our colleagues being on the House floor. That IT bill is very important today, and people are there.

Mr. Chairman, if I could just begin and ask you for unanimous consent to put a statement in the record from the Advanced Medical Technology Association.

MR. FERGUSON. Without objection.

[The statement follows:]

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Statement for the Record
The Advanced Medical Technology Association (AdvaMed)

Energy and Commerce Subcommittee on Health
Hearing on "Medicare Physician Payment: How to Build a Payment System that Provides Quality, Efficient Care for Medicare Beneficiaries"

Thursday, July 27, 2006

AdvaMed and its member companies thank the Subcommittee for holding this important hearing on a value-based purchasing program for physicians under Medicare. As leading developers of technologies that improve quality, reduce cost, and increase value, we support efforts to promote quality and value within the health care system.

AdvaMed is the world's largest medical technology association representing manufacturers of medical devices, diagnostic products and medical information systems. AdvaMed's more than 1,300 members and subsidiaries manufacture nearly 90 percent of the $75 billion of health care technology purchased annually in the United States and more than 50 percent of the $175 billion purchased annually around the world.

AdvaMed supports efforts to increase the value of health care, defined as the highest quality services at the best possible price. We support rewarding providers for delivering high quality care and agree that it makes little sense to pay providers the same for high quality and low quality care. In developing a Medicare value-based purchasing program, there should be three essential elements:

- Quality and efficiency measures should be based on recommendations of the relevant specialty society or on a consensus of the peer reviewed literature;
- Quality and efficiency measures should be developed through an open, transparent process, with full opportunity for input by all stakeholders.
- Quality and efficiency measures must be updated frequently through a transparent process that ensures that the measures reflect the most current medical knowledge and do not freeze innovation.

True efficiency is a combination of the highest possible quality with the lowest possible cost. Efficiency measures must be designed so that each measure represents both the outcome of an episode of illness and the cost at which care for that illness is delivered. Providers must not be rewarded for low cost care unless the care is also high quality. Providers who deliver care that is better than the norm must not be penalized because the care may be more costly than average. In the context of efficiency, process measures of quality are not sufficient; outcome measures are needed.

Comments on Current Congressional Proposals

Two bills have been pending before Congress for over a year now specifically create a value-based purchasing program for physicians in Medicare: H.R. 3617, the Medicare Value-Based Purchasing for Physician Services Act of 2005, and S. 1356, the Medicare Value Purchasing Act of 2005. Rep. Burgess has now introduced legislation as well, and we look forward to reviewing his proposal. As the Committee considers a Medicare value-based purchasing program for physicians, we urge you to consider comments that AdvaMed has made on the Record regarding these two pieces of legislation.

H.R. 3617, the *Medicare Value-Based Purchasing for Physicians' Services Act of 2005*, provides incentives and penalties to encourage physician quality and efficiency, which are funded by a one

percentage point holdback in the increase in physician fees that would otherwise be provided. Physicians are to report on quality and efficiency standards during 2007-2008, and the reimbursements are impacted for payments in 2009 and after. The quality and efficiency measures are to ensure fairness by taking into account differences in individual health status, patient compliance with physician orders, and diversity of patient selection. Measures are based on recommendations set by specialty societies and submitted to a consensus-building organization, such as the National Quality Forum. The Secretary would select from organization recommendations and revise the measures periodically. If a sufficient number of recommendations were not provided for a particular specialty, the Secretary could establish standards for that specialty by regulation. The Secretary could set efficiency standards by regulation, regardless of recommendations by the consensus-building organization.

AdvaMed applauds the bill sponsors for recognizing the need to involve relevant medical specialty societies in the establishment of the quality measures in the bill. AdvaMed urges that the same standards be applied to the selection of efficiency measures by the Secretary that are applied to quality standards and that all standards be based on a consensus of the peer-reviewed literature or recommendations of specialty societies.

Section 301 of S. 1356, establishes a comparative utilization system under which physicians are rewarded for the efficiency of the care they provide, as well as quality of care given in comparison to established quality standards. While a process of consultation is included in the provision for establishing quality measures, measures for efficiency are largely left to the discretion of the Secretary. The rewards are funded by withholding one percent of the total amount that would otherwise be paid physicians in 2008, rising to 2 percent by 2012. In 2006 and 2007, physicians are informed of their efficiency on a confidential basis, but no penalties or rewards are applied.

AdvaMed recommends that the procedures for establishing the quality and efficiency measures be more clearly defined in the bill. The procedures should allow for a transparent process, and the Secretary should rely upon recommendations from peer-reviewed literature or the relevant medical specialty societies. Patient protections should be included to prevent against limitations on patient and physician choice of the best treatments or technologies needed for care as well as restrictions against the adoption of new technologies.

As described above, all measures of efficiency must combine both outcome and cost measures, and no provider should be rewarded for low cost care unless the care also results in superior outcomes.

The Importance of Using Expert Recommendations for Promoting Quality

AdvaMed supports the concept of measuring and improving the quality of health care provided under Medicare. We applaud the efforts of Congress and the Administration to develop and implement a progressive and visionary approach to Medicare reimbursement: payment for quality, not just for provision of services.

We particularly support the efforts to assure that clinical quality measures are based on recommendations of physician specialty organizations as mediated by a consensus building organization. Measures that have the solid support of the relevant specialty and subspecialty societies are most likely to be justified by scientific evidence in peer-reviewed literature or professional consensus and to provide an acceptable basis for changing or improving practice norms. We applaud CMS for working with the AMA-convened Physician Consortium for Performance Improvement™ and others to develop quality measures for physician specialties and sub-specialties. A value-based purchasing program should not lead to the government dictating the practice of medicine.

We believe that a value-based program must assure that the measures for physician performance are valid and fair, including requirements that clinical measures be evidence-based and be consistent, valid, practicable and not overly burdensome to collect. We also believe that the using a mix of outcome measures, process measures, and structural measures is the most effective way of achieving quality improvement across the diagnoses and care settings. The use of health information technology provides an immense opportunity to improve quality and reduce costs.

Potential Pitfalls

We have significant concerns about value-based purchasing programs in four areas:

- We are concerned that measures to encourage the efficient delivery of health care may have the unintended consequence of encouraging reduction in needed care, undermining the doctor-patient relationship, limiting access for patients who may be difficult to treat because they are less likely to follow physician orders or are more seriously ill, and inhibiting the adoption of valuable new technology.

- We are concerned that the process for establishing clinical measures of quality and efficiency may allow the Secretary of Health and Human Services (HHS) too much discretion to establish standards that may lack support from medical specialty societies or be inadequately grounded in the medical literature.

- We believe that there needs to be a specific, timely, and transparent process for updating measures of quality in order to avoid freezing medical practice in place, particularly with regard to the adoption of new technology.

- We believe that dissemination of accurate information on the value of health care services. We urge the Congress and the Administration to support transparency about both quality and costs. Patients cannot assess value if they have access to only part of the equation. Moreover, payment information should reflect any variation in the technology used within procedures. Finally, quality and cost information should be disseminated on appropriate evidence-based protocols. A provider may deliver high quality, low cost

"inappropriate" care. Consider a provider who performs high quality, low cost hysterectomies, but performs many more than clinically appropriate. This would not reflect the best value.

Promoting Value While Protecting Quality

A value-based purchasing program may generate conflict between appropriate treatment and lower cost. Our members believe that incentives should encourage providers to deliver high quality care at lower cost. We do not believe it would be appropriate to reward low quality providers simply because they provide low cost care. Care must be taken to assure that a program does not degenerate into incentives to provide the lowest cost care.

When determining value, quality should be measured based on outcome, such as successful treatment, not processes of care. An example of a process measure is whether or not a heart attack patient received aspirin upon arriving at the hospital. Measures related to the process of delivering care would be appropriate to measure quality and improvement, but not to gauge the value of care provided.

AdvaMed is concerned that poorly designed and controlled measures of value, if used for Medicare reimbursement, may put patient health and technological innovation at risk. Caution in developing appropriate incentives for physicians and providers is particularly crucial in light of a study by the RAND Corporation showing that only 50% of patients experiencing common, serious illnesses receive care that meets the accepted standard for quality, and that quality deficiencies were much more commonly the result of undertreatment than of overtreatment. Unless measures of value are based on conformity to standards of care established by peer-reviewed literature or by consensus within the relevant medical specialty, financial incentives to reduce costs could result in unintended consequences, including cuts in necessary as well as unnecessary care.

Inappropriately crafted measures also could put the government in the position of dictating values to physicians and patients. For example, the decision to refer a cancer patient to hospice care rather than pursue additional treatment of the cancer is a decision that should be made based on the wishes of the patient and the advice of the doctor, not on cost.

Measures of cost that focus on short-term costs associated with an episode of treatment could also create a barrier to adoption of technologies that deliver long-term cost savings, including non-health savings such as increased productivity or less time away from work, or improved quality. For example, consider use of an implant for total joint replacement. In this hypothetical scenario one implant lasts longer than another. An appropriate "episode" of care over which to measure benefits and costs may be the lifetime of the patient, or of the implant. The implant that is more costly, and lasts longer, would provide the "best value" if benefits and costs were considered over a period longer than one year, but may not be considered the "best value" if the time period examined is shorter. Inhibiting the adoption of new technology does not serve the goal of a payment system designed to promote quality if such technologies deliver proportionately greater value than older technologies.

We believe that cost of care measures should be crafted to generate savings from three sources:

- Savings that result from improvements in quality, such as reductions in post-operative complications, reductions in medical errors, and reductions in morbidity from improved management of chronic disease.
- Savings from conformity to cost-reducing practices that are demonstrated by peer-reviewed literature or professional consensus to not compromise the quality of care and for which exceptions are allowed based on individual patient circumstances.
- Savings resulting from improvements in administrative processes, such as reduction in duplicative tests, inappropriate use of the emergency room, and utilization of information technology.

Not only will restricting efficiency savings to these sources ensure the integrity of the process by which performance measures are established and protect patients against unjustified reductions in needed services, it still allows the opportunities for large savings. The potential savings from reductions in medical errors and better management of chronic diseases are well-recognized. More widespread use of advanced medical technology can also reduce costs at the same time it improves quality. For example, a study of the use of angioplasty found that the net savings from the procedure was $22,000 per case. Technology can cut the length of hospital stays, substitute less invasive and less costly procedures for surgical interventions, and reduce costs by improving health.

Health information technology offers special opportunities for savings. Studies cited by HHS in its 2004 Health IT Strategic Framework Report suggest the use of electronic health records (EHRs) can reduce laboratory and radiology test ordering by 9 percent to 14 percent, lower ancillary test charges by up to 8 percent, reduce hospital admissions ($16,000 average cost) by 2 percent, and reduce excess medication usage by 11 percent. Two studies have estimated that ambulatory EHRs have the potential to save all payers $78 billion to $112 billion annually. HHS also cites evidence that EHRs have the potential to reduce administrative inefficiency and paperwork.

A 2004 study in Critical Care Medicine found that using remote Intensivists (intensive care specialists) to monitor patients electronically from a remote location as part of an ICU telemedicine program not only improves clinical outcomes, but also enhances hospital financial revenues.[1] Cost savings resulted both from a reduction in the average length of stay in the ICUs (3.63 days vs. 4.35 days) and from a decrease in daily costs.

In addition, picture archiving and communication systems (PACS) enable hospitals, imaging centers and multi-site health care organizations to manage, store and transmit patient medical images such as digital X-ray, MRI and CR images. Combining this kind of technology with a digital patient information system allowed several Boston-area hospitals to save an estimated $1 million annually by, in part, reducing the time spent searching for files and manually admitting patients.[2]

Ensuring Access to Innovation under New Payment Proposals

A value-based purchasing program is meant to reward health care providers for the value of the care they deliver, not just the cost of the care. The value of medical technology should also be taken into account when implementing payment reforms. Value-based purchasing programs should encourage continued innovation in the best ways to provide care, and quality standards should include mechanisms for prompt recognition of new technologies. Without such language, medical care could be frozen in place and present an additional barrier to the timely adoption of new technology. A provider who is rewarded for providing a beta-blocker to every patient who suffers a heart attack – a performance standard used for hospitals under a CMS demonstration program – faces a disincentive to adopt a new alternative drug or technology, even if it offers better value than the beta-blocker.

To provide for periodic updates to measures, we recommend that a value-based purchasing program include provisions modeled on the current coverage determination process and including the following elements:

- **Measures should be updated frequently to reflect technological advances**. The program should provide for updates at least annually, just as the Secretary now updates the DRG system on an annual basis.

- **Local carriers should be generally free to recognize new technology as meeting a process measure prior to the updating of any national standards, as is the case for coverage decisions made under Medicare.** Since new technologies have a development period in which they diffuse (and are continually improved), failure to allow local carriers to recognize a new technology could have a devastating effect on innovation.

- **There should be mechanisms for an individual provider or manufacturer to seek recognition of an alternative process measure based on technological advances.** Evidence could include information presented to either FDA as part of the approval process or CMS or other payers as part of their coverage determination processes.

- **Effective new technologies, such as physician interpretation of data from remote monitoring devices, should be recognized in the standard payment mechanisms in conjunction with pay-for-performance incentives.**

Conclusion

Again, we thank the Subcommittee for holding this hearing today on Medicare payments for physicians. As you consider legislation in this area, AdvaMed urges you to consider our comments on value-based purchasing for physicians. It is important to promote the value of health care while considering quality. Equally important is ensuring access to innovative clinically appropriate technology when developing a value-based purchasing program in Medicare. We look forward to working with the Subcommittee as the issue moves forward in Congress.

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[1] Breslow MJ, Rosenfeld BA, Doerfler M, Burke G et al. Effect of a multiple-site intensive care unit telemedicine program on clinical and economic outcomes: An alternative paradigm for Intensivist staffing. Crit Care Med 2004;32:31-38.
[2] Networking Health: Prescriptions for the Internet, Institute of Medicine, National Academy of Sciences, p. 81, 2000.

MR. ALLEN. I think what I would like to do is begin with Dr. Rich.

I wanted to focus on two different things, process measures and outcome measures, and basically my understanding is that process measures are things like checking blood pressure, washing your hands, giving the right medication. Outcomes measures measure what happens to a patient--mortality, infections, and conditions, and how the condition progresses or doesn't.

My understanding is many physicians' groups are concerned that by only measuring processes, we will increase costs, but not improve patient care or save money. And I wondered if you could address that particular topic, and the impact of how we design these different measures, the impact of that on spending of the Medicare program.

DR. RICH. Sure. I think that there are some process measures that have good links to quality and are demonstrated to have such, and that would be, for instance, using an artery for coronary artery bypass grafting. There is clear improvement in mortality. But most of the process measures that are being proposed out there really represent an expansion of physician services, an expansion of testing that do not have direct links to quality improvement, and therefore, can lead to expansion of volume of physician services.

Outcomes measures, on the other hand, really pull together not only process and the measurement, but acting on the measurement to improve the eventual outcome for the patient. Reflecting on it from a cardiac surgical standpoint, an outcome measure requires an entire team to impact and change, and it is much like the comment Dr. Opelka had about the teams working together and improved outcomes.

Process measures, you can individualize to a physician, so he has control, but you will race past the most important level in the healthcare system, and that is the system of care, where you can gain improvements in quality and costs.

MR. ALLEN. While we have you all here, I would like to know if there is any divergence of opinion on that point among anyone on the panel. Yes, Dr. Brush.

DR. BRUSH. Well, process measures and outcomes measures have advantages and disadvantages. The process measures is an action that a physician can take, and it is immediately actionable. It is within the physician's grasp and control, and it is appealing as a measure to track. Generally, the ones that are considered valid are the ones that are associated, through research, with specific outcomes. We have processes in cardiology, such as beta blocker use, or use of drugs called ACE inhibitors in certain subgroups that are shown to reduce mortality over the long run. So, those process measures are very important, and they are very nice, because they are actionable. Case mix and case severity and type of thing doesn't enter into it.

On the other hand, outcomes measures are very appealing, because they are a composite of a lot of things that go into care. They are very appealing, but they can be potentially affected by severity of the case. We need to have risk adjustment, and risk adjustment sometimes is a very tricky thing. Both of them have advantages and disadvantages.

MR. ALLEN. Thank you. Dr. Schrag.

DR. SCHRAG. Yeah, I think the field of cancer medicine provides a great example of how outcomes measures can be tricky and slippery. So, they work quite well in thoracic surgery, where you can look at what a patient's mortality is after they undergo a high risk operation. We have to be careful. If in cancer medicine we choose mortality as an outcome, when there are chronic, complex diseases that play out over a long period of time, we all know that it is not just how long a patient lives. But how well a patient lives, how they want to live, and what sorts of disabilities and compromises; what sort of choices people want to make.

So, not that outcome measures aren't important, but they have to be carefully vetted. They have to be complemented with process measures and structural measures, and we haven't talked about structural measures. Those are really measures of the infrastructure available to a practice. So, we really need all of the above.

MR. ALLEN. Fine. Yes, Dr. Heine.

DR. HEINE. Just one quick thing and that is with regard, for example, the case that I presented. When you talk about outcomes measures, you are always subject to the compliance of the patient, and that is one thing that you don't have control over.

MR. ALLEN. Good. Thank you. Well, Mr. Chairman, I notice my time has expired, too, and so why don't I yield back for the moment, anyway.

MR. FERGUSON. Fair enough. Dr. Burgess is here. Dr. Burgess, it is nice to have you here. We know you were on the floor with the Health IT bill. Your name has been used many times in your absence, I can assure you only in the most positive way.

MR. BURGESS. I will need to see a copy of the record.

MR. FERGUSON. Yes. Well, we will be sure to provide that for you. But Dr. Burgess, you are recognized for 5 minutes for questions.

MR. BURGESS. Thank you, Mr. Chairman, and thank you for understanding about my absence. I am going to assume that you are talking about the bill that was recently introduced, H.R. 5866. Dr. Heine, are you familiar with, at least a first read-through or look at that bill?

DR. HEINE. Well, we understand that it is an important and positive step forward, but we have to get into the details. The Alliance is carefully reviewing the piece of legislation, but we are grateful to your leadership on that.

MR. BURGESS. Do you have an opinion as to what direction, I mean, obviously, a piece of legislation is written, and then, it has got to go through the subcommittee process, the committee process, probably massaged several times before it actually gets to a state where it is at the floor.

Are you aware of any changes that you would like to see made in the language of the bill, and recognizing that it is just a starting point, a framework that we can build around, hopefully this year, to get something done?

DR. HEINE. We, unfortunately, have not come to that progression of events yet. We will certainly be in touch with your office when we come to those opinions, and we appreciate the opportunity to comment.

MR. BURGESS. Let me just ask a general question of the panel, anyone who wishes to answer it. If no one feels that they can comment, that is okay, as well. But the bill is introduced, H.R. 5866, and I am actually submitting this question to Dr. McClellan in writing. The bill is designed to pay doctors in Medicare with a more stable and predictable system than currently exists. One of the problems, of course, with the SGR is every year, you come up against that angst, am I going to get cut this year, and then, looking out over the horizon, am I going to get 26.9 percent over the next 5 years if Congress doesn't do something.

So, in order to provide a more stable and predictable system, is it possible to balance value to the taxpayer and to the beneficiary within the Medicare program, while ensuring doctors are paid fairly? Is it even doable? Is this something that you think, in your opinion, has an option

of ever succeeding, or will we just constantly be left with a series of last minute fixes to make certain that everyone doesn't walk off the job? And anyone who feels--yes. Please, Dr. Kirk.

DR. KIRK. Yes. We certainly strongly support what you are talking about, in terms of having some sort of mechanism to replace the SGR that is reliable and consistently gives positive updates, whatever those are. I think it is very hard for a physician, and the majority of the physicians we represent are in small group practices or solo practices, to plan ahead to buy HIT or commit to that without even knowing what their reimbursement is going to be the next year, or knowing there is a very high risk for it.

We don't know the exact solution to that. We would like to see a commitment this year to phase out or do away with SGR over as long as 5 years, to replace it by something that at least guarantees positive updates. I know MedPAC has been charged, in March of 2007, to coming up with options that might replace that. I don't know exactly what they are, but we strongly believe that we need something that consistently can help physicians to plan ahead for caring for these patients.

MR. BURGESS. Thank you. Yes, sir.

DR. OPELKA. Congressman, from the College of Surgeons, our viewpoint is to bring forward these six service categories for growth rate, to try and use these as instruments to recognize where we need growth, where we need to stay flat, where we need to suppress utilization in terms of our volume, and to link that into our quality initiatives as well.

MR. BURGESS. And that is an admirable goal, but it does become a little more complicated, and I hope you have been able to see here in your time this morning, we don't do complicated all that well. We are simple and straight and to the point, some days.

DR. WILSON. Dr. Burgess.

MR. BURGESS. Yes, sir.

DR. WILSON. Right here to your right.

MR. BURGESS. Yes, sir.

DR. WILSON. I would, again, say what we have all said when you were out of the room, and that is we appreciate your bill. We appreciate particularly the fact that you moved from SGR, which we think is not sustainable, to the Medical Economic Index. We look forward to working with you on that. I think we would hope it is the Medical Economic Index, period, and we want to talk about that.

MR. BURGESS. Sure.

DR. WILSON. We also feel that the quality reporting, there are administrative costs associated with that and that it would be important

for physicians to be able to receive those. The balanced billing, we are in support of. And I guess--

MR. BURGESS. I am glad you brought up the cost of the administrative costs, because we just absolutely blow past that almost every time we have a chance to think about it, and the Health IT bill that we are doing on the floor today, one of the flaws is the cost associated with a small office going out and getting that type of equipment. I am trying to get some relaxation of the Stark laws, where if a hospital or another healthcare facility is willing to partner with a small office, to bring them into the computer age, that that would be permissible.

Mr. Chairman, just before I finish up, I want to ask just a philosophical question, and anyone who wants to respond in writing, you heard me ask Dr. McClellan or say to Dr. McClellan we have not been able to get from CMS or from MedPAC any sense of what the savings would be if we put some sense into our medical justice system. And I would just ask if the panel, if anyone on the panel wishes to respond to the committee in writing about that, I would be very anxious to hear your views on that as well.

Thank you. I will yield back.

MR. FERGUSON. Thank you, Dr. Burgess. The distinguished gentleman from Illinois, Mr. Shimkus, is recognized for 5 minutes for questions.

MR. SHIMKUS. Thank you, Mr. Chairman.

The question I asked to Dr. McClellan, and you are all probably even better prepared to answer, based upon your professional associations and memberships and stuff. What do you hear out there from the physicians on the problem with getting to a point, and how are they coping with their operating budget shortfall, because of the lower payments, and the struggle of deciding to continue to provide care, and anyone. Is that Dr. Martin, do you want to start?

DR. MARTIN. Yeah, let me start. Whether you are a group physician, a solo practitioner, or you are a rural physician, you have always got to look at the bottom line. Margins are getting thinner and thinner, whether you look at the hospital level or you look at the physician level, margins are thin. As physicians predicted into the future, they have to look at what is going to be their income or their revenue stream when they look into that future.

Physicians know that they need to move into an electronic medical record. The health information technology is the way to go. As President of a medical group in the Ohio area, one of the things we had to look at is are we going to participate without an electronic medical record. The idea that was brought forward from our Board of Trustees was the fact that we want that electronic medical record, so that the

aggregation of data for these payment-for-performance systems is much easier. The actual dollar value that will bring to our group we don't know yet. As Dr. Burgess was, or Congressman Burgess was bringing up, we don't know the value of that.

We know it will be there, so what we have done as a group is we have contacted our Ohio QIO group. We are working with the QIO group to evaluate our 21 practice sites. Once we evaluate our practice sites for health information technology, we will go forward in 2007, and implement this. We are very concerned if we face a 4.6 percent decrease in our payments, because not only does that affect our Medicare payments, but that will also affect other third party carriers whose payments are based on the Medicare system.

So, all of these things are essentially a set of dominos that are starting to fall, but we in fact want to look for that particular area of getting into health technology, and once we have got that, we feel we can sail. It will be a lot easier to aggregate that data that is needed for those payment-for-performance systems, and we would look for a thank you or a pat on the back for being involved with those payment-for-performance systems.

Thank you.

MR. SHIMKUS. Yeah, and Dr. Burgess just leaned over, and Dr. Burgess, do you want to--I will yield you some time.

MR. BURGESS. Oh, just the point that we also forget up here, all too often, is we cut your reimbursement rate on January 1, and many of the private insurers have already got those new fee schedules already drawn up the previous November, and are ready to enact them when your doors open on January 3.

MR. SHIMKUS. Anyone--well, we will go right down.

DR. BRUSH. Yes, Congressman.

Your question is, what is happening out in the real world, at the ground level, between doctors and patients as the payments decrease. I think that already, we are seeing patients that can't get primary care physicians. Primary care physicians are shunning complicated elderly patients. They take more time.

Like any business, a practice is going to try to cut their costs as their revenues and their operating margins decrease, and what are the costs? The costs for a doctor is time, so you cut back on time. You may cut back on the time it takes to make a good decision, or spend time with compassionate care of patients. I really fear that further cuts will really affect the way that care is delivered on a one on one basis in this country.

What is happening with the sustainable growth rate is really, really going to have a true effect on every doctor and patient. I think on the

ground level, at the grassroots level, you are already starting to see very, very serious alterations in the way patients receive their care.

MR. SHIMKUS. Yeah, and my time is running out. Has everybody from the panel, is there any disagreement with what has been said, or anything in addition that you want to add? All right, well, if the Chairman--I am going to run out of time, but if the Chairman will allow me to finish the panel, then I will just run out my time with the answers to the question. And we will start from left to the right, whoever wants to go. Is that--

DR. SCHRAG. An example specific to cancer. One of the things that happen when small community practices start to choke under declining reimbursement is that patients migrate towards larger centers, such as the one I practice at, Memorial Sloan-Kettering Cancer Center. Where just because we are larger, we are better able to absorb the costs, and we don't suffer as much short term.

But that means that we end up seeing patients, often elderly, who live in New Jersey, who travel a long distance into Manhattan, fighting traffic. We should be busy developing the next generation of treatments, and engaged in research, not treating people who really could be well cared for by their community oncologists in New Jersey. Those providers are choking.

That is just the kind of domino series of steps that occur that we are seeing.

MR. SHIMKUS. And let me just add to that, as a Member who represents 30 counties in Southern Illinois, access to care, and the having to travel is really a challenge for a lot of especially the elderly. And if they are going to get a son or a daughter, that is usually a day away from the work, and it just compounds the problems.

Dr. Kirk.

DR. KIRK. I think one thing to add to everything that has been said. At least in primary care general internal medicine, like I do, or family practice, we find that there is nobody going into those odd disciplines at this point in time, and reimbursement is one of the issues. Students now are graduating from medical school with over $150,000 in debt. It is like having a mortgage without having a home. They know what people make, and it can't help but figure in, even the most altruistic, into what they decide to do.

We are really worried about the pipeline. People my age, who are 10 to 15 years out of their training, 20 percent of them are no longer practicing general internal medicine, because they haven't been able to make it. So, we do worry about who is going to take care of us as we get older.

DR. OPELKA. In the area of surgery, just a couple examples; one is the emergency trauma call situation. It is becoming increasingly more challenged across the country to get proper call coverage in our various emergency rooms and surgical areas. Another area that is becoming increasingly more concerning is breast disease and breast care, where the reimbursements that had covered for radiologists to perform mammography, and for breast surgeons to uniquely specialize in the care of these women's diseases. It has actually gotten to the point where it is almost unsustainable to get proper, timely screening, mammography, and then proper referral to an expert in breast disease. In many communities, it is just not available.

DR. RICH. Speaking from our professional society, the punitive declines in reimbursements that we have seen have really put our specialty in a crisis, and in a crisis from the standpoint of the workforce. Our current workforce is aging, and our attrition rate is accelerating. Many people are leaving early, retiring early, and finding other professions, because the business model no longer works for cardiac surgery often.

Even more frightening, this is the third year in a row where we have not been able to fill our training positions with general surgery residents who want to be cardiac surgeons. Fifty percent of our positions are left unfilled. You put the two together, you have an expanding elderly population, an expanding Medicare beneficiary base, and no place to go for cardiac surgical care. You will have severe access problems in the next 5 to 7 years.

DR. HEINE. On the access problems, speaking as an emergency physician really, I mean, this is where we see it. We have patients coming in who are far more senior, more complex, chronic illness, patients who have to board in the emergency departments, stay overnight in the emergency department, because there are no beds upstairs, since the patients who are already admitted are so sick that they need to stay in the hospital.

There is no access that way, so even though patients may not be able to see their physicians in the community, because they are leaving the community practices that they have, that ultimately translates into exacerbation of ED crowding, and that is one of the things we are really, we are very concerned about with regard to access.

DR. WILSON. As you hear, we all have anecdotes that we can share with you, and I think the observation would be that 10 years ago, we would not be telling you these stories. Now, the GAO report, which you have looked at recently, suggests maybe there is a 7 to 10 percent challenge, in terms of finding physicians. If you are in the 7 to 10 percent, it is your whole world, but that allows me just to say that what

we have not had the big crunch yet. That is the 5 percent cuts as far as the eye can see, and we have great concerns that things will get remarkably worse, unless those are corrected. Thank you.

MR. FERGUSON. Thank all of you for being here today. We appreciate your insights as we work through these issues, and we will certainly look forward to turning to you for your expertise in the future.

This hearing is now adjourned.

[Whereupon, at 2:05 p.m., the subcommittee was adjourned.]

RESPONSE FOR THE RECORD OF MARK MILLER, EXECUTIVE DIRECTOR, MEDICARE PAYMENT ADVISORY COMMISSION

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Glenn M. Hackbarth, J.D., Chairman
Robert D. Reischauer, Ph.D., Vice Chairman
Mark E. Miller, Ph.D., Executive Director

September 18, 2006

The Honorable Anna G. Eshoo
Subcommittee on Health
House Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515

Re: Medicare physician payment

Dear Congressman Eshoo:

This letter is in response to the questions you sent us on September 5th. Answers to your questions are as follows:

1. Is MedPAC aware of any instances in which beneficiaries are not able to access care, or in which physicians are refusing to treat Medicare beneficiaries?

Through a beneficiary survey that MedPAC sponsors and our analysis of other survey data, MedPAC has found that for the last several years, a consistently large majority of Medicare beneficiaries have reported no major problems accessing physicians. A relatively small share, however, has reported major problems finding a new physician. The U.S. Government Accountability Office (GAO) and CMS have published similar findings. (Reports are cited below.) These studies have identified circumstances that make it more likely for a beneficiary to report major problems accessing physicians. These circumstances include traveling to a new area, having a low income, having a disability, and being in poor health.

See "Medicare Physician Services: Use of Services Increasing Nationwide and Relatively Few Beneficiaries Report Major Access Problems" (GAO 2006); and "Results from the 2003 and 2004 Targeted Beneficiary Surveys on Access to Physician Services Among Medicare Beneficiaries" (CMS 2005).

2. In California there are 10 counties underpaid by up to 10%. In my district, Santa Cruz County physicians are underpaid by 10%. According to CMS, Santa Cruz County has similar cost factors with neighboring Santa Clara County, yet Santa Cruz physicians are paid 25% less. Santa Cruz County is facing a major physician shortage, and as of June 1st of this year, physicians are no longer accepting new Medicare patients. Is MedPAC aware of the scope of this problem, and can you provide any detail as to how serious this crisis is?

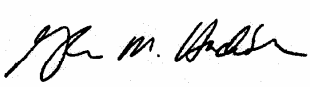
The average among counties of the difference between payments and local costs of care is 2.2 percent. However, keep in mind some counties have payments above costs and the others have payments below costs. In counties that are underpaid (payments below costs), large differences are not common. Twenty-nine counties, out of 3077 counties (less than 1 percent of all counties), are underpaid more than 10 percent.

3. Does MedPAC have a recommendation for addressing this issue?

At this time, we do not have a recommendation addressing this issue.

If we can be of further assistance, please do not hesitate to contact MedPAC's Executive Director Mark Miller at (202) 220-3700.

Sincerely,



Glenn M. Hackbarth, J.D.
Chairman

CC: The Honorable Nathan Deal

SUBMISSION FOR THE RECORD OF ORIN F. GUIDRY, M.D., PRESIDENT, AMERICAN SOCIETY OF ANESTHESIOLOGISTS

Statement of Orin F. Guidry, M.D.
President, American Society of Anesthesiologists

For the Record of the Hearing Before the

Subcommittee on Health of the House Energy and Commerce Committee

July 25 and 27, 2006

As President of the American Society of Anesthesiologists (ASA) and on behalf of its 41,000 physician members, I would like to thank Chairman Deal for his leadership on issues related to Medicare physician payments and holding this hearing. ASA applauds all efforts by the committee and Congress as a whole to address this important topic, and we appreciate the opportunity to make our voices heard in this discussion. We would like to offer comments on two facets of Medicare payment for physicians: value-based purchasing and the repeal of the Sustainable Growth Rate (SGR) formula, as well as touch on the urgent need to save our anesthesiology residency programs.

The notion of a "Pay-for-Performance" system has been a pervasive topic during recent deliberations within CMS and Congress about innovative methods for updating payments to physicians. As the recognized leaders in patient safety, anesthesiologists have made great strides in improving the quality of patient care, as noted by the Wall Street Journal, Institute of Medicine (IoM), and the Agency for Healthcare Research and Quality (AHRQ). We remain committed to continuing our efforts to further improve patient safety and ensure quality.

Over the past year in particular, ASA has stepped up its work toward the development of a workable set of performance measures (see attached chart). As part of this effort, ASA members participate in key organizations with a role in physician quality improvement, including the Surgical Care Improvement Project, the Surgical Quality Alliance, the Ambulatory Quality Alliance, National Quality Forum, and others. To ensure the development of a fair, fully-functional set of quality performance measures across the breadth of medicine, we are committed to working with the AMA and other specialties to define such metrics.

ASA plays a key role in the AMA Physician Consortium for Performance Improvement (PCPI). Indeed, ASA has been working with the Consortium since its inception, and ASA member Ronald A. Gabel, M.D. was recently elected to the Consortium's executive committee.

In the summer of 2005 ASA collaborated with CMS, at its request, to develop a starter set of performance standards specifically related to anesthesia care. Despite our good-faith efforts to address the Agency's purely technical concerns, none of the proposed measures relating to anesthesiology was adopted in a form usable by anesthesiologists when the Physician Voluntary Reporting Program (PVRP) was finalized by CMS. However, ASA continued to forge ahead and as such, recently moved measures in coordination with the Surgical Quality Alliance, focusing on the administration of perioperative antibiotics through the Consortium's Perioperative Workgroup. This measure, which is just one of many ASA is working on, is

currently undergoing a comment process, and we anticipate continuing to work on this and additional measures through the Consortium process. Undoubtedly, the medical specialty of anesthesiology is fully engaged in meeting the challenge of establishing performance measures in response to the national agenda requiring them.

Value-based purchasing has the undeniable potential to improve health care, if implemented slowly, carefully and fairly. Recently discussed proposals have many strengths but they will entail new expenses for medical practices. There are many rate-limiting steps in the path to full acceptance of any measure, as ASA determined in working on the PVRP.

Moving forward, we emphasize that a performance-based system must be linked to positive updates to the Medicare Physician Fee Schedule. It is absolutely essential that any payment changes are based on changes in medical practice cost inflation. We cannot overemphasize the importance of the replacement of the SGR with an MEI adjustment for physicians in general and anesthesiologists in particular.

Anesthesiologists receive far lower relative payments from Medicare than do all other specialties. The 2005 Medicare conversion factor for anesthesia services is $17.76 -- $1.51 lower, in absolute dollars, than it was 14 years ago. If the SGR is not repealed, the 4.6% reduction that will take effect on January 1, 2007, will bring Medicare payments for our specialty down to 88% of their 1991 levels and less than 35% of typical private rates. We urge Congress to redouble its efforts to avoid further cuts to physicians under the current SGR system, which is simply unsustainable in construct.

ASA thanks Chairman Deal and the Subcommittee members for considering a sensible structure for value-based purchasing tied to urgently needed SGR reform. We look forward to working with you on the next steps toward the repeal of the SGR and the establishment of a new Medicare payment system containing effective incentives for improving the quality of health care of beneficiaries.

Updating physician payments is particularly urgent for anesthesiology in light of the CMS proposed practice expense methodology and work value changes that would amount to a 10% cut in Medicare payments to anesthesiologists over the next four years. Further, an unresolved 50% Medicare payment penalty for teaching anesthesiologists is significantly harming anesthesiology residency programs throughout the country and would further harm such programs if SGR and other Medicare cuts are not averted. As we have previously done, we draw the Committee's specific attention to the need to advance legislation before the House, H.R. 5246 or H.R. 5348, that would restore full Medicare reimbursement starting in 2007 to our anesthesiology residency training programs in teaching hospitals.

ASA is grateful for the Committee's willingness to consider payment issues as a whole and the intricate concerns that must be weighed throughout the process. Above all, ASA remains committed to working with Congress and CMS to update physician payments in a way that ensures high quality care for all Americans. We appreciate your kind consideration of our comments.

American Society of Anesthesiologists (ASA) Development of Quality Performance Measures

as of July 14, 2006

	INTERNAL PRODUCTION				STAGES OF APPROVAL			MEDICARE ADOPTION
	MEASURE	ASA Development Status	Partners	Approved by ASA	AMA Consortium (PCPI)	NCQA	NQF (ASA Joined April 2006)	PVRP (CMS)
1	Timely Administration of Antibiotic Prophylaxis							
2	Normothermia				Submitted January 2006			
3	Chronic Pain				Submitted January 2006			
4	Ventilator-Associated Pneumonia		Under SCCM review	Awaiting approval	Submitted January 2006			
5	Prevention of Catheter-Related Bloodstream Infection		Under SCCM review	Awaiting approval	Submitted January 2006			
6	Patient Satisfaction	In progress	In progress: SQA, SAMBA					
7	Preoperative Assessment for Obstructive Sleep Apnea	Practice Guideline published in *Anesthesiology* May 2006						
8	Obstetrical Anesthesia	1999 Practice Guideline being updated						

AAPM—American Academy of Pain Medicine
ASRA-PM—American Society of Regional Anesthesia and Pain Medicine
ISIS—International Spinal Injection Society
NASS—North American Spine Society
SAMBA—Society for Ambulatory Anesthesia
SCCM—Society for Critical Care Medicine
SQA—Surgical Quality Alliance