

**USING INNOVATION TO REFORM MEDICARE
PHYSICIAN PAYMENT**

HEARING
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON ENERGY AND
COMMERCE
HOUSE OF REPRESENTATIVES
ONE HUNDRED TWELFTH CONGRESS
SECOND SESSION

—————
JULY 18, 2012
—————

Serial No. 112-167



Printed for the use of the Committee on Energy and Commerce
energycommerce.house.gov

—————
U.S. GOVERNMENT PRINTING OFFICE

87-750 PDF

WASHINGTON : 2014

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512-1800; DC area (202) 512-1800
Fax: (202) 512-2104 Mail: Stop IDCC, Washington, DC 20402-0001

COMMITTEE ON ENERGY AND COMMERCE

FRED UPTON, Michigan

Chairman

JOE BARTON, Texas <i>Chairman Emeritus</i>	HENRY A. WAXMAN, California <i>Ranking Member</i>
CLIFF STEARNS, Florida	JOHN D. DINGELL, Michigan <i>Chairman Emeritus</i>
ED WHITFIELD, Kentucky	EDWARD J. MARKEY, Massachusetts
JOHN SHIMKUS, Illinois	EDOLPHUS TOWNS, New York
JOSEPH R. PITTS, Pennsylvania	FRANK PALLONE, Jr., New Jersey
MARY BONO MACK, California	BOBBY L. RUSH, Illinois
GREG WALDEN, Oregon	ANNA G. ESHOO, California
LEE TERRY, Nebraska	ELIOT L. ENGEL, New York
MIKE ROGERS, Michigan	GENE GREEN, Texas
SUE WILKINS MYRICK, North Carolina <i>Vice Chairman</i>	DIANA DEGETTE, Colorado
JOHN SULLIVAN, Oklahoma	LOIS CAPPS, California
TIM MURPHY, Pennsylvania	MICHAEL F. DOYLE, Pennsylvania
MICHAEL C. BURGESS, Texas	JANICE D. SCHAKOWSKY, Illinois
MARSHA BLACKBURN, Tennessee	CHARLES A. GONZALEZ, Texas
BRIAN P. BILBRAY, California	TAMMY BALDWIN, Wisconsin
CHARLES F. BASS, New Hampshire	MIKE ROSS, Arkansas
PHIL GINGREY, Georgia	JIM MATHESON, Utah
STEVE SCALISE, Louisiana	G.K. BUTTERFIELD, North Carolina
ROBERT E. LATTA, Ohio	JOHN BARROW, Georgia
CATHY McMORRIS RODGERS, Washington	DORIS O. MATSUI, California
GREGG HARPER, Mississippi	DONNA M. CHRISTENSEN, Virgin Islands
LEONARD LANCE, New Jersey	KATHY CASTOR, Florida
BILL CASSIDY, Louisiana	JOHN P. SARBANES, Maryland
BRETT GUTHRIE, Kentucky	
PETE OLSON, Texas	
DAVID B. MCKINLEY, West Virginia	
CORY GARDNER, Colorado	
MIKE POMPEO, Kansas	
ADAM KINZINGER, Illinois	
H. MORGAN GRIFFITH, Virginia	

SUBCOMMITTEE ON HEALTH

JOSEPH R. PITTS, Pennsylvania

Chairman

MICHAEL C. BURGESS, Texas <i>Vice Chairman</i>	FRANK PALLONE, Jr., New Jersey <i>Ranking Member</i>
ED WHITFIELD, Kentucky	JOHN D. DINGELL, Michigan
JOHN SHIMKUS, Illinois	EDOLPHUS TOWNS, New York
MIKE ROGERS, Michigan	ELIOT L. ENGEL, New York
SUE WILKINS MYRICK, North Carolina	LOIS CAPPS, California
TIM MURPHY, Pennsylvania	JANICE D. SCHAKOWSKY, Illinois
MARSHA BLACKBURN, Tennessee	CHARLES A. GONZALEZ, Texas
PHIL GINGREY, Georgia	TAMMY BALDWIN, Wisconsin
ROBERT E. LATTA, Ohio	MIKE ROSS, Arkansas
CATHY McMORRIS RODGERS, Washington	JIM MATHESON, Utah
LEONARD LANCE, New Jersey	HENRY A. WAXMAN, California (<i>ex officio</i>)
BILL CASSIDY, Louisiana	
BRETT GUTHRIE, Kentucky	
JOE BARTON, Texas	
FRED UPTON, Michigan (<i>ex officio</i>)	

C O N T E N T S

	Page
Hon. Joseph R. Pitts, a Representative in Congress from the Commonwealth of Pennsylvania, opening statement	1
Prepared statement	3
Hon. Michael C. Burgess, a Representative in Congress from the State of Texas, opening statement	4
Hon. Frank Pallone, Jr., a Representative in Congress from the State of New Jersey, opening statement	5
Hon. Phil Gingrey, a Representative in Congress from the State of Georgia, opening statement	6
Hon. Henry A. Waxman, a Representative in Congress from the State of California, opening statement	7
Hon. John D. Dingell, a Representative in Congress from the State of Michigan, opening statement	8
Hon. Fred Upton, a Representative in Congress from the State of Michigan, prepared statement	136
WITNESSES	
Scott P. Serota, President and Chief Executive Officer, Blue Cross and Blue Shield Association	9
Prepared statement	12
Bruce Nash, Senior Vice President and Chief Medical Officer, Capital District Physicians' Health Plan	36
Prepared statement	38
David L. Bronson, President, American College of Physicians	42
Prepared statement	45
David B. Hoyt, Executive Director, American College of Surgeons	72
Prepared statement	74
Kavita Patel, Fellow, Engelberg Center for Health Care Reform, The Brookings Institution	87
Prepared statement	89
SUBMITTED MATERIAL	
Statement, dated July 18, 2012, of Garrison Bliss, President, Qliance Medical Group, submitted by Mr. Pitts	102
Letters of March 30, 2011, from Ms. Sebelius to Mr. Pallone and Mr. Waxman, submitted by Mr. Pallone	131

USING INNOVATION TO REFORM MEDICARE PHYSICIAN PAYMENT

WEDNESDAY, JULY 18, 2012

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

The subcommittee met, pursuant to call, at 10:02 a.m., in room 2123 of the Rayburn House Office Building, Hon. Joe Pitts (chairman of the subcommittee) presiding.

Members present: Representatives Pitts, Burgess, Shimkus, Rogers, Murphy, Blackburn, Gingrey, Latta, McMorris Rodgers, Lance, Cassidy, Guthrie, Pallone, Dingell, Towns, Engel, Schakowsky, Christensen, and Waxman (ex officio).

Staff present: Julie Goon, Health Policy Advisor; Debbie Keller, Press Secretary; Ryan Long, Chief Counsel, Health; Katie Novaria, Legislative Clerk; John O'Shea, Professional Staff Member, Health; Andrew Powaleny, Deputy Press Secretary; Chris Sarley, Policy Coordinator, Environment and Economy; Heidi Stirrup, Health Policy Coordinator; Phil Barnett, Democratic Staff Director; Alli Corr, Democratic Policy Analyst; Amy Hall, Democratic Senior Professional Staff Member; Karen Lightfoot, Democratic Communications Director and Senior Policy Advisor; Karen Nelson, Democratic Deputy Committee Staff Director for Health; and Roger Sherman, Democratic Chief Counsel.

Mr. PITTS. The subcommittee will come to order. Chair recognizes himself for an opening statement.

OPENING STATEMENT OF HON. JOSEPH R. PITTS, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

There is no disagreement that the current Medicare physician reimbursement system, the Sustainable Growth Rate, or SGR, is broken. Time and again, Congress has had to override scheduled cuts in physician reimbursement to avert disaster, and we will have to do it again before the end of this year. Absent congressional actions, physicians will face a 27 percent cut starting January 1, 2013.

There is also no disagreement that the SGR needs to be replaced with something that actually is sustainable, and reimburses for outcomes and quality instead of just volume of services.

The focus of today's hearing is not the well-documented deficiencies of the current system, it is about the future. What should the new physician payment system look like, and what can we

learn from the private sector's experience in this area that may serve as a roadmap for reform? What has been tried and failed, and what has worked?

Our witnesses today are here to share with us the innovative payment systems and care delivery models they have experimented with, and their outcomes. I want to thank all of them for their testimony.

So thank you. I yield the remainder of my time to the vice chairman of the subcommittee, Dr. Burgess.

[The prepared statement of Mr. Pitts follows:]

**Opening Statement of the Honorable Joe Pitts
Subcommittee on Health
Hearing on “Using Innovation to Reform Medicare Physician Payment”
July 18, 2012**

(As Prepared for Delivery)

There is no disagreement that the current Medicare physician reimbursement system, the Sustainable Growth Rate or SGR, is broken.

Time and again, Congress has had to override scheduled cuts in physician reimbursement to avert disaster.

And, we will have to do it again before the end of this year. Absent Congressional action, physicians will face a 27 percent cut starting January 1, 2013.

There is also no disagreement that the SGR needs to be replaced with something that actually is “sustainable” and reimburses for outcomes and quality, instead of just volume of services.

The focus of today’s hearing is not the well-documented deficiencies of the current system, it is about the future.

What should the new physician payment system look like? And, what can we learn from the private sector’s experience in this area that may serve as a road map for reform? What has been tried and failed? What has worked?

Our witnesses today are here to share with us the innovative payment systems and care delivery models they have experimented with and their outcomes.

I thank all of them for their testimony.

**OPENING STATEMENT OF HON. MICHAEL C. BURGESS, A
REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS**

Mr. BURGESS. I thank the chairman for the recognition. It has been a very interesting congressional term. We are now 18 months into it. I think this term I have seen more work done on this problem than I have at any other time that I have been in Congress, but we are still pretty far away from the goal that we expect to achieve. Everyone on both sides of the aisle accepts the premise of the SGR has got to go. The conversation about actual innovative replacements that providers in the future—and really, I do want to ensure, my vision is that people will have options, that they will not see a “one size fits all” that we think is best for their practice, but they will actually be able to choose the option that is best for their practice. But in the meantime, we have got to sketch out the means by which to ensure that Medicare beneficiaries can continue to see their physicians.

We have been in the process of testing models for years. The witnesses at the table also have been in the process of developing models for some time, and we expect that they are going to have some interesting ideas to share with the committee, and look forward to that.

But we have got a cut coming in just a few months, and a lot of uncertainty as we face elections, while we face expiration of existing tax policy, we have the payroll tax holiday ending, we face unemployment insurance needing to be extended, and oh yes, who can forget all the collegiality that existed in this body a year ago with the discussion of the debt limit? We are likely to face that again, but this time, without all of the good feeling that we all had last August.

We could have taken this problem and moved it a little farther away from December, recognizing that December is going to be such an uncomfortable month for so many reasons. I had—many members of this committee had asked for a 2-year extension in December of last year. A 2-year extension passed without a lot of other things attached to it so that it would be sure to pass. In fact, we could probably do it on suspension on a Monday afternoon. But I didn't get that. We didn't get that. You didn't get that. And as a consequence, we got a 1-year extension or what ended up being a 1-year extension that expires in the middle of this fiscal holocaust at the end of the year.

So all I would suggest is we know that we are not likely to end up doing something that will provide that long-term relief and long-term replacement for the Sustainable Growth Rate by December 31. I wish we could, but I have been here long enough to know that that is a goal that is going to be difficult to achieve. But what I would like to suggest is this month, before the August recess, the House of Representatives could pass yet an additional extension to give us that 2 years that we asked for in December of last year so that we have time to fully vet and evaluate the proposals that are before us. The committee staff has done a good job in developing some of these ideas. It is now up to us to take them to doctors across the country and get their feedback so we get the best possible policy. So I will be introducing that legislation later today or this week to extend the SGR for an additional year.

Mr. Chairman, I thank you for the recognition. I will yield back to you the time.

Mr. PITTS. The chair thanks the gentleman and now recognizes the ranking member of the subcommittee, Mr. Pallone, for 5 minutes for an opening statement.

OPENING STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PALLONE. Thank you, Mr. Chairman. Let me associate myself with the remarks of Dr. Burgess. Of course, I don't know how he is paying for the 2-year extension, so I won't associate myself with that until I see what the pay-for is. But I think that what he said overall is very true. I think we have to be very honest with the physician community. We all agree that the SGR needs to be replaced, but you know, the question is is there political will to do that, and whether or not it can be done effectively by the end of the year with all these other problems that need to be addressed out there? It is very questionable. I don't have any doubt that this committee and the members of this committee would like to accomplish that, but I don't know whether or not the House or the GOP leadership, you know, would be willing to put it on the agenda for a long-term fix.

I want to, though, go beyond what Dr. Burgess said and say that I also think we have to be very careful that when we talk about pay-fors, because pay-fors, it is not only a question of the new formula, but also the pay-for. I think we have to be very careful. We need a pay-for that is big. I have always suggested the overseas contingency operation fund, or the PEACE dividend, as it is called, for the pay-for, because we need a large amount of money. I think that this idea of constantly picking at other providers, whether it is hospitals or nursing homes, home health care providers, is not the way. It bothers me many times when I hear other physicians say, "Well, you know, we can take it from other parts of the health care system." I don't see that. And I would also warn my GOP colleagues that I certainly will not support, and I think it is useless politically, to try to take the money away from the Affordable Care Act. You know, I don't want to say for sure, but so many times the answer has been, "Oh, you know, let us get rid of the prevention fund, let us get rid of the community health centers, let us get rid of, you know, the subsidies or the tax credits that would make premiums more affordable for certain incomes." That is not the answer. I think that the health care system is in crisis, and the other providers have the same problems. And so for us to suggest that we are going to, you know, go after the ACA or other providers I think is really a huge mistake.

So the question remains, how do we fix it? I don't think there is a "one size fits all" approach. Any new payment system should rely on improved outcomes, quality, safety, and efficiency. In addition, while there must be fee-for-service within the future payment system, we must stop rewarding doctors for volumes of services. Primary care must be strengthened and given special consideration, and a new system must better encourage coordinated care while incentivizing prevention and wellness within the patient.

Now, there are a number of innovative programs that are currently underway across the country. We will hear today from two private payer plans that are learning and building on successes from such initiatives as pay-for-performance, patient-centered medical homes, bundle payments, and of course, arrangements with accountable care organizations. Many of these initiatives recognize the local needs of their marketplaces, which is something worthy of consideration moving forward. Local markets have different needs, and while one payment model may work in New Jersey, it doesn't necessarily work in Montana.

While we are eager to hear from the private sector, we mustn't forget about the delivery system reforms already underway in the public sector. The Center for Medicare and Medicaid Innovation created by the Affordable Care Act gives CMS the ability to pursue many similar demonstration programs in both Medicare and Medicaid. Currently they are testing a few new models, including ACOs in the patient-centered medical homes. The ACA also strengthens incentives for reporting on quality measures for physicians. Meanwhile, in 2011, Medicare began paying a 10 percent incentive payment of primary care physicians for primary care services nationwide.

So together, the public and private sectors can and should work together to get the health care system on a better path to sustainability. I look forward to hearing today about the exciting work being done in this field. I want to thank our witnesses. I want to especially note the American College of Surgeons who have taken a leading role on conceptualizing a new proposal to replace the SGR, which they are going to talk about today.

And again, Mr. Chairman, I think this is a very important hearing. I appreciate your having it. This committee has worked effectively on dealing with the—with PDUFA and other things on a bipartisan basis. I think we can do the same here.

I am sorry, I guess I am out of time.

Mr. PITTS. The chair thanks the gentleman. I now recognize the gentleman from Georgia, Dr. Gingrey, for 5 minutes for opening statement.

OPENING STATEMENT OF HON. PHIL GINGREY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA

Mr. GINGREY. Mr. Chairman, I won't take the entire 5 minutes, but thank you for recognizing me.

The Sustainable Growth Rate we all know is broken and none of us support it, and it must, must go. Therefore, I look forward to the testimony of those here today, our witnesses, on what payment models might be used to replace SGR.

I do want to mention one thing. House Republican physicians worked very closely with the House leadership last year to put forward a multi-year SGR patch. I think my colleague as I walked in, Dr. Burgess, was talking about that. It wasn't the full repeal that I wanted, but it ensured some level of stability for physicians and our patients. Ultimately we couldn't get the Senate on board and it failed, as you all know.

Now we find ourselves facing SGR cuts again in January of what, 27.4 percent if something is not done. I urge this Congress

to put partisan and election politics aside, and let us work together to get rid of SGR once and for all.

I don't agree with my colleague from New Jersey, the ranking member of the Health Subcommittee, in regard to the pay-fors, and that—but I do agree with him that that is a huge problem, how we are going to pay for the cliff. The last figure I saw of that cliff to bring the baseline back down to zero was something of the magnitude of \$300 billion, but that OCO money we talked about and that got kicked around by the Super Committee, overseas contingency operation, honestly from my perspective, it really looks like funny money, very much like funny money. You can't convince me that it isn't. I agree with Mr. Pallone and his concerns, of course, about goring—oxing the gore or goring the ox or whatever of other providers within the Medicare program. Every one of them are concerned about cutbacks and taking money out of—whether it is home health care or hospice or whatever. I agree with him on that point, but I am not for OCO money.

I will just conclude by saying that myself and the GOP Doctors Caucus, my colleagues, 21 of us, will be working with leadership again in the House, and also with our Democratic colleagues, because there is no way to get this done in a one-party, Majority party effort. This has got to be done in a bipartisan way. And indeed, the House can't fix the problem alone. It has to be bicameral.

So Mr. Chairman, thank you for calling the hearing together today. This hearing is hugely important. We can all work together—we have to get this done, and I am looking forward to this expert panel of witnesses.

I yield back, Mr. Chairman.

Mr. PITTS. Is there anyone else seeking time on this side of the aisle?

If not, the chair thanks the gentleman and recognizes the ranking member of the full committee, Mr. Waxman, for 5 minutes for opening statement.

OPENING STATEMENT OF HON. HENRY A. WAXMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. WAXMAN. Thank you very much, Mr. Chairman. I would like to start by acknowledging and welcoming the bipartisan interest in transforming the Medicare physician payment system from one that focuses on rewarding volume to one that focuses on rewarding quality and outcomes.

While Congress has yet to come to a bipartisan agreement on how to accomplish the shared goal of repealing and replacing the flawed Sustainable Growth Rate, SGR, mechanism, there seems to be bipartisan agreement that it should be done. We must find a way to end the unsustainable system of cuts that loom over our physicians every year. The uncertainty created by the current system serves no one well: the physicians who have no stability in payments, the beneficiaries who worry about access to their doctors, and even Congress. Even more encouraging is a bipartisan agreement that delivery system reforms, many of which were included in the Affordable Care Act, hold promise in a post-SGR world. We must work towards a new way of paying for care for

both physicians and other providers that encourages integrated care, improving care for individuals, improving care for populations, and reducing costs.

Right now, the way we pay for care doesn't always support these goals. The Affordable Care Act makes major strides to improve the way Medicare deals with physicians and other providers. Some of the new care models supported by the ACA include Accountable Care Organizations, bundled payments, medical homes, and initiatives that boost primary care and encourage paying for value and outcomes, not volume. As we will hear today, the private sector is exploring these avenues as well.

I yearn for the day when the Republicans knew how to handle this problem. They simply extended the SGR payments and didn't pay for it. They didn't do a lot of things to pay for what they charged to the taxpayers of the United States towards the Medicare prescription drug benefit, SGR, didn't pay for it. Now they want to be sure that every way to pay for this is airtight. Well, it is a new day where Republicans are giving us their fiscal responsibility side of things. We need to work together. Our goal should be to enact a permanent repeal to the existing flawed physician payment system this year. Let us do it this year. We had chances to do it, as Mr. Burgess pointed out, but we couldn't get the Republican leadership, his Republican leadership, to go along with what he and we wanted. So it is time for the Republican leadership to recognize this is a problem that we ought to resolve, not just, well, I guess, not just kick it down the road, but I guess we would be satisfied just for that for a couple years.

But we got to get on with the job of doing what is responsible. I want to yield the balance of my time to Mr. Dingell.

OPENING STATEMENT OF HON. JOHN D. DINGELL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. DINGELL. Mr. Chairman, I thank the gentleman from California for his kindness to me. I have a splendid statement. I ask unanimous consent that the fullness of it be inserted in the record.

Mr. PITTS. Without objection, so ordered.

Mr. DINGELL. I commend my colleagues on the Republican side for their desire to keep Medicare fiscally solvent to address the SGR problem, and to see to it that we fix the concerns of the medical profession in seeing to it that they are properly compensated. Their complaint is a real and a valid one, and it is a thing to which we should pay heed.

As any good physician will tell you, we need to cure the underlying problem, not to just treat the symptoms, and the patchwork job that we have done in addressing these problems over the years has done nothing but to create a growing and painful problem, which gets worse and worse as time passes. So curing the matter for once and all with proper attention from this committee, as we have done in the past and in a bipartisan fashion, is the way out of this thicket.

I commend my colleagues on both sides of this, and I look forward to working with them towards that very important end.

Thank you, Mr. Chairman.

Mr. PITTS. Chair thanks the gentleman, and now will introduce today's panel. First, Mr. Scott Serota is President and Chief Executive Officer of Blue Cross Blue Shield Association. Second, Dr. Bruce Nash is Senior Vice President and Chief Medical Officer of the Capital District Physicians' Health Plan. Thirdly, Dr. David Bronson is President of the American College of Physicians; then Dr. David Hoyt is the Executive Director of the American College of Surgeons; and finally, Dr. Kavita Patel is the Managing Director for Clinical Transformation and Delivery at the Engelberg Center for Health Care Reform at the Brookings Institution.

Your written testimony will be made matter of the record. We ask that you summarize in 5 minutes. Mr. Serota, you are recognized for 5 minutes for your opening statement.

STATEMENTS OF SCOTT P. SEROTA, PRESIDENT AND CHIEF EXECUTIVE OFFICER, BLUE CROSS AND BLUE SHIELD ASSOCIATION; BRUCE NASH, SENIOR VICE PRESIDENT AND CHIEF MEDICAL OFFICER, CAPITAL DISTRICT PHYSICIANS' HEALTH PLAN; DAVID L. BRONSON, PRESIDENT, AMERICAN COLLEGE OF PHYSICIANS; DAVID B. HOYT, EXECUTIVE DIRECTOR, AMERICAN COLLEGE OF SURGEONS; AND KAVITA PATEL, FELLOW, ENGELBERG CENTER FOR HEALTH CARE REFORM, THE BROOKINGS INSTITUTION

STATEMENT OF SCOTT P. SEROTA

Mr. SEROTA. Thank you, Mr. Chairman.

Mr. PITTS. Poke that button there.

Mr. SEROTA. Sorry about that. I will try again.

Thank you, Chairman Pitts, Ranking Member Pallone, and members of the Health Subcommittee for inviting me here to testify today. I am Scott Serota, President and Chief Executive Officer of the Blue Cross Blue Shield Association, which represents 38 independent community-based Blue Cross Blue Shield companies that collectively provide health care coverage for 100 million Americans. I commend the subcommittee for convening today's hearing.

Blue Plans are leading efforts in their communities to implement payment, benefit, and delivery system reforms that will improve quality and reign in costs. We believe that Medicare cannot only learn from, but also should align with these successful initiatives.

Today, I would like to focus on three interrelated strategies. First, Blue Plans are changing payment incentives by putting place models that move away from fee-for-service and link reimbursement to quality and outcomes. The goal is to promote patient-centered care that pays for desired outcomes, rather than the number or intensity of service. These payment innovations include pay-for-performance initiatives, bundle payment arrangements in more than 32 States, arrangements with accountable care organizations in 29 States, and patient-centered medical homes, with Blue Plans collectively supporting the Nation's largest network of medical homes in 39 States. These models are driving substantial improvements in care quality, while taking avoidable costs out of the system. For example, CareFirst Blue Cross Blue Shield's Medical Home Initiative includes 3,600 primary care physicians and nurse practitioners caring for one million members. Preliminary 2011 re-

sults indicate that 60 percent of the eligible primary care panels earned outcome incentive awards, which are based on a combination of savings achieved and quality points. Among these panels, costs were 4.2 percent less than expected. In Pennsylvania, Highmark Blue Cross Blue Shield's Quality Blue pay-for-performance program has prevented 42 wrong-side surgeries, reduced hospital-acquired infections, raised breast cancer screening rates nine points above the national average, all while saving \$57 million over 4 years.

Our second strategy is to partner with clinicians to give them individualized support to be successful under new payment and care delivery models. This includes sharing data about a patient's full continuum of care, helping improve the way care is delivered, enhancing care coordination, and providing powerful health IT capabilities.

For example, a powerful way to improve the quality of care for beneficiaries with chronic illness is to enhance care coordination. Horizon Blue Cross Blue Shield of New Jersey has partnered with Duke and Rutgers Universities to train at least 200 nurses as practiced-based population care coordinators in medical homes and other settings. This first of its kind nurse training curriculum recognizes the workforce enhancement necessary to enable a statewide expansion of medical homes.

None of these innovations would succeed without our third strategy, engaging patients. This includes providing information on cost and quality to help patients make informed decisions about their care, tiered benefit designs that encourage patients to seek care from high quality providers, and tools for members to improve their health and wellness. For example, Blue Cross Blue Shield Association's national consumer cost tool lets members obtain information on estimated costs for more than 100 of the most commonly billed elective procedures for hospitals, ambulatory surgery centers, and freestanding radiology centers in nearly every U.S. zip code. In addition, Blue Plans are using health informatics from a database of claims data for more than 110 million individuals nationwide collected over a 7-year history. The analytics capability made possible by Blue Health Intelligence, or BHI, are resulting in healthier lives and more affordable access to safe and effective care. For example, BHI collaborated with Independence BlueCross in Pennsylvania to determine the best-performing facilities in bariatric surgery. Looking at 3 years of data, BHI analyzed potentially avoidable complications at 214 facilities and identified Pennsylvania's Crozer-Chester Medical Center as having an extraordinarily low complication rate for bariatric surgery, just four-hundredths of a percent compared to the nationwide average of 6.7 percent. We designated Crozer as a best-in-class provider in this specialty under the Blue Distinction Initiative, which encourages patients to seek care from high-quality providers.

Achieving a high-quality, affordable care system will require a multi-faceted approach, using all the strategies that I have outlined. Sustaining and building on these successes will require a continuously evolving approach of fine-tuning strategies and implementing new ones. We believe a compelling opportunity exists to accelerate Medicare's adoption of these private sector initiatives.

Payment approaches and technical assistance must be adapted to fit local delivery system conditions, which vary widely. This assumes patients can meet practices where they are, rather than attempting to overlay a one size fits all solution that may not be workable. The time is right to accelerate the pace of reform for Medicare, and we are pleased that Blue Plans are participating in pilots to test these approaches, and urge successful approaches be expanded rapidly beyond pilot markets.

I appreciate the opportunity, Mr. Chairman. Thank you very much.

[The prepared statement of Mr. Serota follows:]



**Summary of Testimony by Scott P. Serota
President and Chief Executive Officer
Regarding “Health Care Payment and Delivery System Innovations”**

*Subcommittee on Health, Energy and Commerce Committee; U.S. House of Representatives
Hearing on: “Using Innovation to Reform Medicare Physician Payment”
July 18, 2012*

The Blue Cross and Blue Shield Association (“BCBSA”) – a national federation representing the 38 independent, community-based, and locally operated Blue Cross and Blue Shield companies (“Plans”) that collectively provide health care coverage for 100 million members, one in three Americans in every U.S. ZIP code – is pleased to testify on private sector payment and delivery system innovations that hold lessons for Medicare.

Overview of Testimony

BCBSA believes transforming our health care system involves three interrelated strategies:

- First, change payment incentives, by putting in place innovative payment models that move away from fee-for-service – which rewards volume – and link reimbursement to quality and outcomes.
- Second, partner with clinicians, by giving them individualized support – such as access to data on patients’ full continuum of care, and help improving the processes by which care is delivered – they need to be successful under new payment and care delivery models.
- Third, engage patients, by providing consumers with wellness incentives, transparency tools so they understand the quality and costs of services, and information on how to keep healthy and manage chronic conditions.

In addition to providing an overview of the core principles that Plans believe should underlie any payment and care delivery innovation – such as putting quality and safety first – the testimony provides examples of how Blue Cross and Blue Shield Plans are implementing the three inter-connected strategies above to improve quality and reduce costs today.

This includes results from such initiatives as pay-for-performance, patient-centered medical homes, bundled/episode-based payments, and arrangements with accountable care organizations.

Lessons Learned

Sustaining and building on early successes will require a continuously evolving approach, as well as strong alignment between the public and private sectors. Based on Plans’ experience in their local markets, BCBSA believes Medicare should:

- Take a multi-faceted approach using the strategies above.
- Recognize the importance of local flexibility in adapting payment approaches and technical assistance to fit local delivery system conditions.
- Accelerate Medicare’s adoption of private sector innovations, capitalizing on the substantial and growing body of private sector experience, and expand successful initiatives rapidly beyond pilot markets.



**BlueCross BlueShield
Association**

**An Association of Independent
Blue Cross and Blue Shield Plans**

1310 G Street, N.W.
Washington, D.C. 20005
202.626.4780
Fax 202.626.4833

Testimony

Before the

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

on

Health Care Payment and Delivery System Innovations

Presented by:

**Scott P. Serota
President and Chief Executive Officer**

July 18, 2012

INTRODUCTION

Thank you Chairman Pitts, Ranking Member Pallone, and members of the Health Subcommittee for inviting me to testify today on private sector payment and delivery system innovations that hold lessons for Medicare. I am Scott Serota, President and Chief Executive Officer of the Blue Cross and Blue Shield Association ("BCBSA") – a national federation representing the 38 independent, community-based, and locally operated Blue Cross and Blue Shield companies ("Plans") that collectively provide health care coverage for 100 million members, one in three Americans in every U.S. ZIP code.

As we all know, the country needs to be more aggressive in getting health costs under control and assuring patients receive the highest quality care. U.S. health care spending exceeds \$2.5 trillion annually. However, with studies estimating that 30 cents of every health care dollar goes to care that is ineffective or redundant (Fisher and Wennberg, 2003), many of those dollars are not well spent.

Blue Plans are leading efforts in communities nationwide to achieve value-based health care, implementing payment, benefit, and delivery reforms that are showing excellent results in improving quality and reining in costs. Because Plans serve members in all 50 states and U.S. territories, yet are community-based and locally operated, they are implementing similar strategies on a broad scale across the country while customizing their approaches to meet local market needs. Plans also are building on their results to expand successful initiatives. BCBSA is working with all Blue Plans to facilitate the sharing of best practices.

We believe Medicare can not only learn from but should align with these private sector initiatives.

OVERVIEW OF TESTIMONY

Achieving value-based health care ultimately depends on successfully implementing three interrelated strategies:

- First, change payment incentives, by putting in place innovative payment models that move away from fee-for-service – which rewards volume – and link reimbursement to quality and outcomes.
- Second, partner with clinicians, by giving them the individualized support they need to be successful under new payment and care delivery models. This includes real-time information on their practices, their peers, and their patients; hands-on technical assistance and practice coaching on redesigning workflows and adopting best practices; and tools such as embedded nurse care managers and health information technologies (“IT”) that enhance practices’ ability to coordinate care.
- Third, engage patients, by providing consumers with wellness incentives, transparency tools so they understand the quality and costs of services, and information on how to keep healthy and manage chronic conditions.

Changing payments alone will not transform care if clinicians lack the means to identify and implement best practices. Giving clinicians sophisticated information systems and IT tools will not optimize health value if incentives are not realigned to favor outcomes, not volume. Neither changing payments nor partnering with clinicians will achieve its full potential if patients are not engaged in helping to manage their own health and care.

My testimony focuses on:

- 1) The core principles that Plans believe should underlie any payment and care delivery innovation.
- 2) Examples of how Plans are implementing these strategies to improve quality and reduce costs today.
- 3) Some lessons learned from Plans’ experience that can help Medicare.

CORE PRINCIPLES FOR PAYMENT AND CARE DELIVERY INNOVATION

When implementing strategies to achieve value-based health care, Plans adhere to four core principles:

- **First, put quality and safety first.** The health and safety of Plans' members demands that new payment incentives are not premised on cost savings alone. Thus, as Plans move away from fee-for-service reimbursement, they build quality assessment and goals into new payment models.
- **Second, partner with the local provider community.** This means taking a market-specific – not a one-size-fits-all – approach to designing new payment and delivery reforms. Thus, Plans calibrate incentives and individualized support to reflect local provider practices, and they account for providers' readiness to move toward value-based care.
- **Third, measure quality and safety rigorously.** This means using metrics based on nationally accepted quality measures or physician specialty societies' own evidence-based guidelines. Thus, Plans not only achieve credibility with physicians and other providers – because new incentive programs reflect evidence-based care goals that have been carefully vetted by physicians themselves or a multi-stakeholder, consensus-based entity, such as the National Quality Forum – they also minimize the burden on providers that can stem from disparate measures.
- **Fourth, be transparent.** Payment and delivery reforms are far more likely to succeed if they are transparent to providers. Thus, the methodologies and measures that Plans use to assess providers' performance, Plans' scoring approaches, and other mechanics are made available to those affected, not created or administered in a "black box."

Adhering to these principles has helped Plans achieve success, in no small part by minimizing complexity and uncertainty for physicians and other clinicians. Aligning public and private efforts would reduce complexity and uncertainty even further.

EXAMPLES OF BLUE INNOVATIONS

I would like to share examples of how Plans are implementing the three interrelated strategies I mentioned earlier, showcasing various innovative initiatives to change payment incentives, to partner with clinicians, and to engage patients.

Initiatives to Change Payment Incentives

There is widespread consensus that we need to move away from a fee-for-service payment system – which drives up costs by paying for more services, even if they are unnecessary or redundant – and toward payment models that reward better quality, and move us toward a value-based health care system.

Plans' payment innovations range from pay-for-performance, to patient-centered medical homes ("PCMHs"), to bundled/episode-based payments, to arrangements with accountable care organizations ("ACOs"). These initiatives exist along a continuum and may share features with one another. For example, an ACO might comprise multiple, interconnected PCMHs, and for certain procedures the ACO might receive bundled payments. However, for the sake of clarity, I will focus on these innovations separately.

Pay-for-Performance

Plans have implemented pay-for-performance initiatives using nationally accepted quality measures so that payment is aligned with what we know works, such as assuring all patients with diabetes receive recommended tests and treatments, or adhering to hospital infection

prevention best practices that can dramatically reduce infections, re-admissions, and other costly complications.

Experience shows that to truly motivate practice change, incentives must be substantial, often in the range of 10 to 15 percent for physicians. This must be coupled with efforts to help providers redesign their practices, examples of which I shall discuss in the next section.

Results indicate that aligned incentives drive substantial improvements in care quality while taking avoidable costs out of the system. For example:

- Highmark Blue Cross and Blue Shield's (PA) QualityBLUE incentive program involves 81 local hospitals and two-thirds of Highmark's network primary care providers ("PCPs") in a decade-long effort to align payment with high-quality care and improved outcomes. QualityBLUE also provides technical assistance to PCPs and hospitals to support the use of best-practices in patient safety and care coordination.

In addition to preventing 42 wrong-site surgeries and reducing hospital-acquired infections, during the past four years Highmark has achieved up to \$57 million in savings. 2011 quality results also include breast cancer screening rates nine percentage points above the national average, and practice-based electronic health record ("EHR") adoption rates 11 percentage points higher than the national rate.

Highmark plans to expand the QualityBLUE program to select specialists next year and already is sharing cost and quality performance data with cardiologists in its network to guide improvement.

Other Plans also have worked to expand their pay-for-performance initiatives to specialties including cardiology, obstetrics and gynecology, anesthesia, and orthopedics.

Patient-Centered Medical Homes

Collectively, Blue Plans support the nation's largest network of medical homes with initiatives in 39 states, the District of Columbia, and Puerto Rico, covering millions of members. Plans also are partnering with other payers, including CMS, on multi-payer models that align incentives for providers to transform care delivery.

In a medical home, the patient and primary care practice are at the center of care, and patients have a continuing relationship with a PCP and care team that assures care is comprehensive, proactive, and coordinated. This reinforces primary care's critical role in helping patients get the care they need, when they need it, with greater efficiency, less redundancy, and fewer return trips to the hospital or physician's office – and it encourages teamwork and coordination across all of the clinicians involved in caring for a patient.

Examples range from statewide programs, as in Maryland and Michigan, which are among the nation's largest PCMHs, to targeted pilots as in New Jersey that are undergoing rapid expansion:

- CareFirst BlueCross BlueShield's (Maryland, the District of Columbia, and portions of Northern Virginia) PCMH initiative includes 3,600 primary care providers and nurse practitioners caring for 1 million CareFirst members and is specially tailored so small practices can participate. The Plan helps providers group together into "virtual" panels of five to 15 providers each, which allows for accurate quality and financial measurement, facilitates around-the-clock access for patients, and creates provider "peer-review" of each other's performance. The model includes an immediate double-digit increase in the primary care fee schedule and new payments for "care plans" for chronically ill members. Participating providers also are eligible for additional fee increases based on performance.

Preliminary 2011 results indicate that 60 percent of eligible primary care panels earned Outcome Incentive Awards, which are based on a combination of savings achieved by a particular panel against projected 2011 total care costs for CareFirst members, as well as the attainment of quality points based on care quality measures. Among these panels, costs were 4.2 percent less than expected.

- Blue Cross Blue Shield of Michigan's statewide PCMH program involves 780 practices and 3,000 physicians designated as medical-home PCPs caring for 850,000 patients. PCMH-designated practices work toward implementing key capabilities including using a patient registry, expanding access to after-hours care, and implementing processes for following up on test results. Under the program, PCMHs can earn at least a 10 percent increase in office visit fees for the extra time involved in optimally managing patient health. Physicians also receive additional fee-for-service payments for chronic illness care management services.

Results include a 22 percent lower hospital admission rate for conditions that could have been managed through better primary and outpatient care; a 10 percent lower use of emergency department services; and an eight percent lower use of radiology services. The Plan is also working with CMS, the State of Michigan, and other private payers as part of the Multi-Payer Advanced Primary Care Demonstration, which uses the Plan's PCMH model as a foundation for statewide, multi-payer implementation.

- Horizon Blue Cross and Blue Shield of New Jersey is spearheading a PCMH program – developed collaboratively with the New Jersey Academy of Family Physicians – involving 145 primary care practices and over 500 physicians throughout the state. Horizon provides upfront and ongoing support to redesign primary care, including: an enhanced fee schedule; a monthly per-member fee supporting care coordination, care

plan development, and other patient engagement activities; financial support for a population care coordinator at the practice site who proactively manages patient care; and an opportunity to earn additional incentives based on quality, patient experience, and utilization metrics.

Preliminary results comparing 2011 quality and cost trends between 24,000 Horizon members participating in the medical home program and members not in the program indicate that patients within the program are benefiting, and costs are lower. For example, PCMH patients had an eight percent higher rate in improved diabetes control (HbA1c); six percent higher rate in breast cancer screening; and six percent higher rate in cervical cancer screening, as well as a 10 percent lower cost of care (per member per month); 26 percent lower rate in emergency room visits; 25 percent lower rate in hospital readmissions; 21 percent lower rate in hospital inpatient admissions; and five percent higher rate in the use of generic prescriptions.

Bundled/Episode-Based Payments

Another strategy for encouraging teamwork and coordination across all of the clinicians involved in patients' care is to pay for "episodes" or "bundles" of clinically related services. Bundling initiatives are now underway by Plans in 32 states – and growing – for a range of procedures ranging from hip and knee replacements to localized prostate cancer treatment to coronary artery bypass grafting. To implement episode-based/bundled payment arrangements, Plans have worked extensively with local provider partners to define services – down to the code level – that comprise the bundle, as well as the episode duration.

For example, Horizon Blue Cross and Blue Shield of New Jersey is piloting a bundling initiative for hip and knee replacements with eight orthopedic practices. Francois DeBrantes, a pioneer

in promoting new payment incentives, says the pilot “is the broadest one that any health plan has attempted to date. . . the broadest in terms of its scope in the country.”

Because of the complexities involved in paying surgeons a bundled fee for hip or knee replacement, the Plan is taking a phased approach to allow for a transition period before bundled payments take full effect and foster provider involvement in the development and validation of the episode-based approach. Working closely with the practices, the Plan gathered data on hundreds of joint replacement cases, used analytical tools to estimate how much the episode might be expected to cost, and then compared those projections with actual experience. These data will allow the Plan to take into account the severity of the case when it eventually sets the budget for an episode of care.

Horizon is holding monthly meetings with participating surgeons to discuss selecting robust quality measures and setting expectations for transparent Plan-provider data exchange as well as data validity. Next, the Plan will transition to a year-long orthopedics pay-for-performance initiative to incentivize the groups to improve quality and efficiency.

This will culminate in full implementation of bundled payments for total hip and knee replacements – capturing related care up to 30 days pre- and 90 days post-surgery – once the Plan and providers have gained experience with performance measurement and value-based reimbursement. Physicians then will share in any savings, although only if stringent quality benchmarks are met.

Such rigorous quality measurement – chosen with input from provider partners, and built into the payment model as a condition of shareable savings – plays a central role across Plan bundling initiatives. Metrics typically address patient safety, potentially avoidable complications, clinical processes (e.g, adherence to best patient care practices) and outcomes, and patient experience. A number of Plans also use patient-reported functional status measures to assess patient-centered outcomes, such as return to normal activity.

Plans are seeing promising early results. For example, under a bundled payment arrangement between Blue Cross and Blue Shield of North Carolina and Gastonia, N.C.-based CaroMont Health, there has been a reduction in potentially avoidable complications for total knee replacements yielding an average per-episode savings of 10 percent.

While most currently implemented bundled payments are anchored by an inpatient procedure, Plans are exploring strategies for bundling payments for outpatient-oriented services, such as a year's worth of care for a patient with diabetes. This would expand the application of bundling considerably, and help change incentives for high-cost, high-opportunity clinical areas, such as chronic disease management.

Accountable Care Organizations

ACOs represent another major vehicle for transforming payment to encourage teamwork, coordination, and the move to value-based health care. Often built on a strong foundation of PCMHs that coordinate patient care, ACOs take responsibility for the overall quality and costs of a defined patient population. These arrangements are now underway by Plans and local provider partners in 29 states and the District of Columbia, including several on a statewide basis.

Plans' ACO-type contracts include a variety of models ranging from hospital-centered ACOs to those involving networks of independent physician practices. Reciprocal risk often is an important element of promoting systems change in these arrangements because, although a bonus-only model may yield incremental improvements in quality and cost, it cannot begin to have the power to reshape practice patterns as effectively as a system that also puts providers at risk for losses.

Successful Blue ACO-type arrangements include:

- Blue Cross and Blue Shield of Massachusetts's ("BCBSMA") Alternative Quality Contract ("AQC") – launched in 2009 – is an innovative global payment model that is on track to reduce medical expense trend by half in five years while substantially improving care quality. The AQC gives providers a population-based global budget that is adjusted annually for health status and inflation, combined with substantial performance incentives tied to nationally accepted quality measures. To help providers improve, the Plan shares efficiency and quality data monthly and partners with providers on performance improvement. The Plan now covers 79 percent of its HMO members under AQC agreements, up from 39 percent in 2008.

According to an independent analysis by Harvard Medical School researchers appearing in the August 2012 edition of *Health Affairs*, providers' participation in the contract over two years led to cost savings and quality improvement that steepened in the AQC's second year. For example, AQC groups achieved overall savings of 2.8 percent over two years (1.9 percent in year 1 and 3.3 percent in year 2) compared to spending in nonparticipating groups, driven by shifting procedures, imaging, and tests to facilities with lower fees, as well as reducing utilization among some groups. Quality of care also improved compared to nonparticipants, with chronic care management, adult preventive care, and pediatric care within AQC groups improving more in year 2 than in year 1.

- Blue Shield of California in 2010 partnered with Dignity Health (formerly Catholic Healthcare West) – which operates four Sacramento-area hospitals – and Hill Physicians Medical Group to launch an ACO serving 41,500 CalPERS members. The ACO promised to hold costs flat, with the Plan, physicians, and hospital system sharing in potential savings of exceeding that goal, as well as absorbing the difference if the target was not met. Blue Shield played a major role in assuring providers' success by

sharing timely clinical and case management information and identifying members going outside the ACO for care.

Results include a 15 percent decrease in hospital readmissions; a 15 percent decrease in inpatient hospital stays; a 50 percent decrease in inpatient stays of 20 days or more; a half-day reduction in the average patient length of stay; and an estimated \$15.5 million in overall health care cost savings. The Plan has replicated the ACO model in several additional counties and now covers more than 100,000 members under ACO arrangements.

- Blue Cross and Blue Shield of Illinois ("BCBSIL") in January 2011 entered a three-year agreement with the 10-hospital Advocate Health Care system under which Advocate significantly limited annual rate increases in return for Advocate having the opportunity to share in savings resulting from care improvements. The contract applies to 420,000 BCBSIL PPO and HMO members who receive care from Advocate and its 2,700 affiliated physicians, who predominately are in small, independent practices. The Plan supports Advocate's care improvement efforts through monthly performance feedback on quality, costs, and utilization. The Plan also shares updated lists of the BCBSIL attributed members and their care patterns, including concurrent (daily) communication of attributed members who have been hospitalized, enabling Advocate to proactively manage patients' care. Shareable savings are measured by Advocate's performance compared with other BCBSIL network providers. In order to receive payments for savings created, Advocate needs to meet a series of specified quality, service, and safety parameters, which must show continuous improvement. Additionally, Advocate faces downside risk if costs are higher than the average network medical cost trend, as well as penalties if there are declines in the quality, service, and safety parameters.

In the first three quarters, the ACO has seen a 4.6 percent decrease in costs versus the market benchmark, with improved clinical outcomes such as lower admission rates.

Initiatives to Partner with Clinicians

To realize value-based health care, realigning incentives is necessary but not sufficient without Plans giving clinicians the individualized support they need to be successful. Plans partner with physicians and other providers by (1) sharing data about a patient's full continuum of care; (2) helping to improve the processes by which care is delivered; (3) enhancing care coordination; and (4) providing powerful health IT capabilities. I have already alluded to some of these efforts, and I would now like to give you more specific examples.

(1) Sharing Data

Experience has proven the importance of robust, actionable data-sharing between Plans and providers, especially since provider organizations are likely to vary widely in their ability to capture and analyze data independently.

For example, as part of its AQC contracts discussed earlier, BCBSMA distributes practice pattern variation analyses ("PPVA") to physician groups emphasizing unexplained variations in practice patterns that are clinically and financially important. In 2009 and 2010, BCBSMA provided PPVA reports twice a year on more than a dozen conditions across multiple specialties and subspecialties noting physician-specific information on practice tendencies, and allowing comparison to all other physicians within that specialty. The reports allow medical groups and individual clinicians to drill down to patient-level detail in order to truly engage with the information and attempt to understand the underlying reasons for differences in practice patterns.

This value-added data-sharing is augmented with hands-on technical assistance discussed below. Plan-generated data and analytics, for instance, often are foundational to guiding Plan-provider discussions – via e-mail, phone, and at monthly in-person meetings – regarding actionable strategies for improving performance.

(2) Improving Health Care Processes

Making data available in the context of realigned incentives encourages clinicians to identify best practices. However, constraints on time, staffing, and expertise may hold some back without additional coaching and management support that Plans can provide.

For example, as part of its QualityBLUE incentive program, Highmark provides forums for providers to obtain feedback and share best practices, and dedicates consultative resources that provide on-site program guidance. To support QualityBLUE hospital partners, Highmark has formed teams of professionals that include medical technology experts, registered nurses, Certified Infection Control Professionals, speech pathologists, Registered Health Information Administrators, and Certified Professional Healthcare Quality experts, including medical directors, who provide consultative support to hospitals' quality teams and lead an annual "Best Practice Forum."

To support physicians, Highmark has formed the Clinical Quality Consultants (CQCs), a dedicated staff that includes a medical director and clinical pharmacy consultants to provide consultative quality improvement support, education, and training to participating practices. CQC teams evaluate physicians' operations to determine process improvement opportunities, provide feedback and recommendations to improve clinical quality and office operations, and help create and execute work plans; they also provide methods for conducting patient outreach and assistance for identifying opportunities for electronic reminders and alerts.

In 2011, CQCs supported 993 primary care practices, 62 percent of those participating in QualityBLUE. As a result of CQC coaching and support, QualityBLUE participating practices continually improve quality scores. Additionally, CQC-supported practices achieved statistically significant clinical outcomes compared to non-CQC-supported practices on metrics including acute pharyngitis testing, adolescent well care, well child care (3-6 years of age), cervical cancer screening, annual cholesterol screening, and diabetes management.

(3) Enhancing Care Coordination

Plans have learned that a powerful way to improve the quality of care for members with chronic illnesses is to enhance practices' care coordination capabilities. For example, CareFirst contracts with registered nurse Local Care Coordinators that partner with PCMH practices to help assure patient follow-through on the provider-directed care plan.

Nurse-led teams can include privately practicing allied professionals such as home care agencies, hospital affiliated care coordinators, and other community-based providers (e.g., pharmacists, therapists, and mental health professionals) specifically assigned and available to work with each PCMH to aid in the completion and implementation of care plans for chronically ill members.

The Local Care Coordinator helps coordinate patients' care transitions – such as following up on specialist referrals, assuring coordination after hospital discharge or an ER visit, and conducting medication reconciliation with the appropriate pharmacist. In addition, the Local Care Coordinator works closely with the PCP, including making office visits to discuss patients' care plans, and provides regular web-based updates to a record available to the entire care team.

Recognizing the potential impediments to a PCMH-based approach caused by personnel shortages, Horizon Blue Cross and Blue Shield of New Jersey has gone to the next level by partnering with Duke and Rutgers Universities to train at least 200 nurses over the next two

years to be practice-based population care coordinators in PCMHs and other settings. The first-of-its-kind nurse training curriculum recognizes the workforce enhancement necessary to enable a state-wide expansion of PCMHs and includes modules on complex patient management, care coordination, patient communication strategies, and disease registry and EHR use.

(4) Providing Health IT

Plans are helping providers adopt and make powerful use of health IT tools such as electronic prescribing and EHRs.

For example, since 2005, Blue Cross and Blue Shield of Rhode Island ("BCBSRI") has been implementing programs to assist and encourage PCPs to adopt multifunctional EHR systems in their offices. The Plan currently offers two EHR Incentive Programs, including enhanced reimbursement to providers who have met Stage 1 criteria under CMS's Medicare and Medicaid EHR Incentive Program for the "meaningful use" of certified EHRs.

Additionally, the Plan provides incentives for EHR adoption through its current PCMH initiative, which also includes bonus payments based on mutually agreed-upon quality measures ranging from immunization rates to blood pressure control. To date, nearly 500 PCPs have participated in the BCBSRI EHR Incentive Programs. All of these providers have fully implemented EHRs in their practices.

Blue Cross and Blue Shield of North Dakota has created a statewide health information and care coordination technology platform with embedded decision support that is available to the 80 percent of primary care providers in the state who are in the Plan's PCMH initiative (MediQhome).

Providers send their electronic patient data, such as progress notes, procedure reports, lab test results, and discharge summaries, to the Plan's technology platform (run by MDdatacor) on a daily or weekly basis through a secure internet connection. MDdatacor quantifies the data and

creates reports for physician practices that identify potential gaps in care and opportunities to improve adherence to best practices.

Initiatives to Engage Patients

Because none of these innovations would succeed without patient engagement, Plans are prioritizing new transparency tools that help patients make informed decisions about the relative quality and efficiency of network providers; creating tiered benefit designs that encourage patients to seek care from high-quality providers; and providing members with tools and resources to improve their health and wellness.

Transparency Tools

The Blue System engages consumers with actionable data and tools that enable them to make the most informed decisions for their health care needs.

- BCBSA's online National Consumer Cost Tool, available to all Plans, lets members obtain information on total estimated costs – and soon an estimate of out-of-pocket liability – for 100+ of the most commonly billed elective procedures for hospitals, ambulatory surgery centers, and free-standing radiology centers in nearly every U.S. ZIP code.
- The Physician Quality Measurement program displays physician performance measures to assist members in selecting a provider. Through the Blue National Doctor and Hospital Finder, members view physicians' performance and local comparison scores for a core set of National Quality Forum-endorsed HEDIS® Physician Quality of Care measures.
- The Blue Physician Recognition Program identifies physicians, groups, or practices who have demonstrated their commitment to delivering quality and patient-centered care by

currently participating in national, regional, or local quality improvement or recognition programs such as the National Committee for Quality Assurance PCMH recognition program.

- BCBSA's Patient Review of Physicians is a member tool for reading and writing reviews of physicians and professional providers nationwide based on a standard methodology.
- Plans offer personal health records ("PHRs") to their members. BCBSA recently collaborated with several professional specialty societies to roll out an informational tool showing consumers how they can use PHRs to store vital health information in one convenient and secure place, empowering them to take a more active role in coordinating their own care.

Tiered Benefit Designs

Plans are working to tier physicians and facilities based on a transparent, statistically rigorous methodology incorporating *both* quality and cost metrics so members have incentives to seek out those providing the best care.

Tiering is a key driver of consumer engagement – especially when paired with robust transparency tools – because this gives consumers tools and incentives for seeking high-quality, affordable care while sensitizing them to the cost of care.

In a typical benefit arrangement, Plans place providers into two or three benefit tiers based on how they score on nationally accepted quality benchmarks and costs. Members' cost sharing is based on the tier status of the provider they see, which encourages members to consider the quality and cost of their provider each time they get care.

This also harnesses consumer behavior to encourage providers to move toward greater value. For example, some Plans' tiered networks evaluate providers' rates of potentially avoidable complications; achieving higher performance can qualify providers for a more favorable tier.

Good data is essential to tiering. Plans are able to take advantage of industry-leading health informatics from Blue Health Intelligence ("BHI"), which accesses a database of claims data from more than 110 million individuals nationwide, collected over seven years.

For example, BHI collaborated with Independence Blue Cross (PA) to determine the best-performing facilities in bariatric surgery. Looking at three years of data, BHI analyzed potentially avoidable complications at 214 facilities, identifying the rate, cost, and type of complications associated with the bariatric surgery episodes of care. BHI identified that southeastern Pennsylvania's Crozer-Chester Medical Center has a truly extraordinarily low complication rate for bariatric surgery – just 0.04 percent compared to a nationwide average of 6.7 percent – designating Crozer as a best-in-class provider in this specialty.

The analytics enabled by resources like BHI help to transform the health care system by delivering data-driven information about health care trends and best practices, resulting in healthier lives and affordable access to safe and effective care.

Blue Distinction Centers for Specialty Care®

BCBSA's Blue Distinction Centers ("BDCs") for Specialty Care® is a national initiative that empowers and encourages consumers to seek out the best providers for their needs. BDCs are facilities recognized by Plans for distinguished care in bariatric surgery, cardiac care, complex and rare cancers, knee and hip replacement, spine surgery, or transplants. The designation process considers total value measures (quality metrics established in collaboration with expert clinicians and leading professional organizations, cost, and access). Plans may use benefit differentials to incent members' use of BDCs. Research shows that BDCs outperform their

peers on quality (e.g., 21 percent lower readmission rate for cardiac bypass procedures for a BDC vs. non-BDC).

Health and Wellness

Plans are committed to helping members lead healthier lives. To do this, they are using a dual strategy: keep people healthy to prevent the onset of disease, and effectively coordinate care for those with chronic conditions.

Both of these approaches rely on empowering patients with information and tools to support healthier lifestyles, which is crucial to curbing health care cost growth. Both also involve helping people understand that they play a vital role in their own health care.

Examples include:

- Blue Cross and Blue Shield of Hawaii supports self-monitoring of blood glucose (SMBG) to help address gaps in diabetes care. It launched an educational program to promote regular monitoring that increased SMBG compliance 58.1 percent to 67.8 percent among Medicare members, and 67.5 percent to 75.6 percent among commercial members.
- Louisiana 2 Step is Blue Cross and Blue Shield of Louisiana's flagship free health and wellness program available to both members and non-members. Participants have access to an interactive website featuring healthy food recommendations, activity and walking logs, weight tracker, calorie counter, and personal virtual coach.
- Blue Cross and Blue Shield of Kansas City's A Healthier You is emblematic of many Plan workplace wellness programs that engage employees in positive behavior change to improve their health status and avoid the impact of chronic disease. A mix of

incentive programs, lifestyle coaching, and webinar and onsite health education classes have reduced the medical trend by more than 30 percent.

- Blue Cross of Idaho Health Service provides one-on-one nurse health coaching and outreach to members who visit the ER or receive inpatient services due to congestive heart failure. By using a team-based and patient-centered approach, the program helps ensure that members take the correct medications and receive the necessary screenings and follow-up care. The Plan gives biometric monitoring equipment to high-risk members with congestive heart failure, enabling them to report their conditions from home. The program collectively achieved more than \$1 million in medical claims cost savings in a single year while empowering patients to take a more active role in managing their own health.

LESSONS LEARNED

I would like to conclude with some lessons learned from Plans' experience that can inform efforts to transform Medicare. BCBSA believes there is a compelling opportunity to accelerate Medicare's adoption of private-sector innovations, which would not only help transform Medicare's payment approach, but also align public and private initiatives so providers have a clear set of incentives for providing high-quality, affordable care.

Chief among our lessons learned is that no single reform will, by itself, transform the health care system. Achieving tomorrow's value-based health care system will require a multi-faceted approach using all of the strategies I've outlined: changing payment incentives, partnering with clinicians to transform care, and engaging patients.

Second, while wide-scale implementation is imperative, we must not lose sight of the importance of local flexibility – built on a foundation of core, cross-cutting principles such as

being collaborative and transparent with providers. Provider configurations and readiness to transform vary widely across the country, and require that payment approaches and technical assistance be adapted to fit local delivery system conditions. This assures that payers can meet practices "where they are," rather than attempting to overlay a one-size-fits-all solution that may not be workable locally.

Finally, the time is ripe to accelerate the pace of reform for Medicare. We now have a substantial and growing body of private-sector experience with innovations such as PCMHs that support wide-scale implementation in both public and private programs. We are pleased that Plans are participating in CMS pilots to test varying approaches to fostering PCMH-like care delivery models and urge that successful approaches be expanded rapidly beyond pilot markets.

As you can see, Plans have a full slate of initiatives underway that have lessons for Medicare. However, sustaining and building on these early successes will require a continuously evolving approach of fine-tuning existing strategies while implementing new ones. We cannot do it alone. A collaborative approach is imperative, and we need the government aligning with what works in the private sector to really move the needle.

I appreciate the opportunity to share Blue Plans' innovations today and look forward to your questions.

Mr. PITTS. Chair thanks the gentleman. I now recognize Dr. Nash for 5 minutes for an opening statement.

STATEMENT OF BRUCE NASH

Mr. NASH. Good morning. My name is Bruce Nash, and I am the Chief Medical Officer of Capital District Physicians' Health Plan, which is based in Albany, New York. CDPHP, as we are known, is a not-for-profit physician-sponsored network model plan with close to 400,000 members who live in the 24 counties in upstate New York. We are the capital district's largest provider of managed commercial Medicare and Medicaid products. I also serve as the Chairman of the Medical Directors' Council for the Alliance of Community Health Plans, or ACHP, whose members include 22 of the Nation's leading non-profit regional health plans, who share our commitment to the Triple Aim, a concept created by the Institute for Health Care Improvement, that is improving the patient's experience of care, improving the health of populations, and reducing the per-capita cost of care.

CDPHP was founded by the physicians of the Albany County Medical Society 28 years ago, and to this day is governed by a board whose majority are practicing physicians who are elected by their peers. Our board chair is also required to be a practicing physician. As a consequence, we have enjoyed a close relationship with our provider community, enabling us to deploy market-leading initiatives that improve the care delivery for our members, despite not directly employing any of the clinicians. This has led to us being recognized as a top-ranked health plan in the State and the Nation for our member satisfaction and quality metrics.

Four years ago, our board emerged from a strategic planning session with a directive for management to address the impending primary care crisis. It was noted that our local medical school was no longer graduating significant numbers of new physicians who were choosing primary care as a career. While the causes for this were multiple, we chose to focus on improving a primary care physicians' income potential. It was clear that for this to be accomplished it would have to be funded by changing the way physicians practice with more effective and efficient care as a result. This began the program that we later labeled our Enhanced Primary Care program, or EPC.

We began with an initial pilot of three practices, and over a 2-year period of time were able to demonstrate an improvement in 14 of 18 specific quality metrics; a 15 percent reduction in hospital utilization; a 9 percent reduction in emergency department usage; a 7 percent reduction in the use of advanced imaging. All of this resulted in an \$8-per-member-per-month savings in total health care costs.

On the strength of these early data, CDPHP expanded its EPC program by establishing training programs for selected practices lasting 12 months and requiring significant commitment of time and effort from the practices as they learned the basics of Enhanced Primary Care. We currently have 75 such practices, representing 384 providers and almost 100,000 of our members. We are now launching our next cohort which will add an additional 70 practices.

While much of what I have described is common to many successful patient-centered medical home initiatives nationally, we believe our unique contribution to this effort has been the creation and deployment of a novel reimbursement methodology. This model involves a risk-adjusted global payment for all services that the physician provides, in conjunction with a significant bonus based upon the elements of the Triple Aim, the patient's experience of care, the quality, and the cost efficiency. It creates an opportunity for a physician to enhance his or her reimbursement by an average of 40 percent.

Our base payment is a unique global payment to the practice for each of their patients. This is driven by a severity factor that was developed for our use by the scientists associated with Verisk Health, Inc., a global analytics firm. This severity score predicts the amount a primary care physician should be paid for a specific patient based upon the diagnoses of that patient. This score is then multiplied by a conversion factor to determine the payment for that given patient based upon their plan type, that is, Commercial, Medicare, or Medicaid, and we pay this to the practice on a monthly basis.

We still pay fee-for-service for a small subset of physician services, about 15 percent. These payments represent things that we would like to incent the primary care physicians to do in their office as opposed to referring to a specialist, such as minor skin biopsies, or for the acquisition cost of things like immunizations.

The bonus or pay-for-performance aspect of the model is focused on the Triple Aim. We measure the satisfaction of the practice's patients to determine bonus eligibility for the practice. Currently we utilize HEDIS metrics to measure the quality of care delivery. A weighted average of 18 distinct metrics creates a quality score for the practice. Our efficiency metric is an output of our Impact Intelligence software, which accomplishes the required risk adjustment across the total cost of care. The annual bonus payment to a practice is determined in a manner that has been described as a "tournament" system, simply said, practices need to perform better than other practices in the network to achieve their optimal payout.

Our initial data for the EPC program was based on a population of only 12,000 members. We are fortunate that the Commonwealth Fund has provided a grant to an external evaluator, Dr. David Bates of the Brigham and Women's Hospital, to evaluate our 2012 experience. These data will become available in the latter half of 2013.

CDPHP has also been active in the development of alternative reimbursement models for certain specialist and hospital partners. While we have yet to develop the experience that we have with the EPC program, we firmly believe that all components of the delivery system need to engage with us in payment models that align financial incentives with the needs of our communities.

Thank you for inviting me to be here today, and I look forward to your questions.

[The prepared statement of Mr. Nash follows:]

Written Testimony for Committee on Energy and Commerce, U.S. House of Representatives

July 18, 2012 - 10 A.M.

Bruce Nash, M.D., M.B.A.

Senior Vice President and Chief Medical Officer

Capital District Physicians' Health Plan, Inc.

Albany, NY

Good morning. My name is Bruce Nash and I am the Chief Medical Officer of Capital District Physicians' Health Plan which is based in Albany, New York. CDPHP, as we are known, is a not-for-profit, physician-sponsored, network model health plan with close to 400,000 members who live in 24 counties in upstate New York. We are the Capital District's largest provider of managed Commercial, Medicare, and Medicaid products. I also serve as the chairman of the Medical Directors' Council for the Alliance of Community Health Plans (ACHP) – whose members include 22 of the nation's leading non-profit, regional health plans, who share our commitment to the Triple Aim –working to enhance our members' experience of health care while improving their health and keeping it affordable.

CDPHP was founded by the physicians of the Albany County Medical Society 28 years ago and to this day is governed by a Board whose majority are practicing physicians who are elected by their peers. Our Board chair is also required to be a practicing physician. As a consequence, we have enjoyed a close relationship with our provider community, enabling us to deploy market-leading initiatives that improve care delivery for our members, despite not directly employing any of the clinicians. This has led to us being recognized as a top-ranked health plan, in the state and the nation, for our member satisfaction and quality metrics.

Four years ago, our Board emerged from a strategic planning session with a directive for management to address the impending primary care crisis. It was noted that our local medical school was no longer graduating significant numbers of new physicians who were choosing primary care as a career. While the causes for this were multiple, we chose to focus on improving a primary care physicians' income potential. It was clear that for this to be accomplished it would have to be funded by changing the way physicians practice with more effective, efficient care as a result. This began the program that we later labeled our Enhanced Primary Care program or EPC.

Over the ensuing years, CDPHP invested over \$10 million assisting practices with transformation to this patient-centered medical home model of care, the acquisition of electronic medical records, and their achievement of meaningful use. CDPHP also deployed on a selective basis its nurse care managers, pharmacists, and behavioral workers directly in EPC practices.

We began with an initial pilot of three practices, and over a two-year period of time were able to demonstrate an improvement in 14 of 18 specific quality metrics; a 15% reduction in hospital utilization; a 9% reduction in emergency department usage; and a 7% reduction in the use of advanced imaging¹. All of this resulted in an \$8 per member per month savings in total health care costs.

On the strength of these early data, CDPHP expanded its EPC program by establishing training programs for selected practices lasting 12 months and requiring significant commitment of time and effort as they learned the basics of Enhanced Primary Care. We currently have 75

¹ The utilization reductions all reached statistical significance at $p < .1$ level.

such practices, representing 384 providers and almost 100,000 members. We are now launching our next cohort which will add an additional 70 practices to the program.

While much of what I have described is common to many successful patient-centered medical home initiatives nationally, we believe our unique contribution to this effort has been the creation and deployment of a novel reimbursement methodology.

This model involves a risk-adjusted global payment for all services that the physician provides, in conjunction with a significant bonus focused upon elements of the Triple Aim. The combination of these two creates an opportunity for a physician to enhance his or her reimbursement by an average of 40%. A fundamental characteristic of the model is that it provides higher rewards specifically for better care of the sicker patients who consume the greatest amount of our health care dollars.

Our base payment is a unique global payment to the practice for each of their patients. This is driven by a severity factor that was developed for our use by the scientists associated with Verisk Health, Inc.² This severity score predicts the amount a primary care physician should be paid for a specific patient based upon the diagnoses of that patient. This score is then multiplied by a conversion factor to determine the payment for that given patient based upon their plan type – i.e. Commercial, Medicare, or Medicaid. We pay this to the practice on a monthly basis.

We still pay fee-for-service for a small subset of physician services (15%). These payments represent things that we would like to incent the primary care physicians to do in their office as opposed to referring to a specialist (e.g., minor skin biopsies) or for the acquisition cost of things like immunizations.

² Ash, Arlene S., Ellis, Randall P. Risk Adjusted Payment and Performance Assessment For Primary Care. Medical Care 50(8) August 2012. 643-6653. DOI: 10.1097/MLR.0b013e3182549c74

The bonus or pay-for-performance aspect of the model is focused on the Triple Aim. We measure the satisfaction of the practice's patients to determine bonus eligibility. Currently we utilize HEDIS³ metrics to measure the quality of care delivery. A weighted average of 18 distinct metrics creates a quality score for the practice. Our efficiency metric is an output of our Impact Intelligence software which accomplishes the required risk adjustment across the total cost of care.

The annual bonus payout to a practice is determined in a manner that has been described as a "tournament" system – simply said, practices need to perform better than other practices in the network to achieve their optimal payout.

Our initial data for the EPC program was based on a population of only 12,000 members. We are fortunate that the Commonwealth Fund has provided a grant to an external evaluator, Dr. David Bates of the Brigham and Women's Hospital, to evaluate our 2012 experience. These data will become available in the latter half of 2013.

CDPHP has also been active in the development of alternative reimbursement models for certain specialist and hospital partners. While we have yet to develop the experience that we have with the EPC program, we firmly believe that all components of the delivery system need to engage with us in payment models that align financial incentives with the needs of our communities.

³ HEDIS – Healthcare Effectiveness Data and Information Set: a set of standardized performance measures on health plan quality and service

Mr. PITTS. Chair thanks the gentleman, and now recognizes Dr. Bronson for 5 minutes for opening statement.

STATEMENT OF DAVID L. BRONSON

Mr. BRONSON. Good morning. I am David Bronson, President of the American College of Physicians, the Nation's largest medical specialty organization, representing 133,000 internal medicine specialists who care for patients in primary and comprehensive care settings, internal medicine subspecialists, and medical students who are considering a career in internal medicine. I reside near Cleveland, Ohio. I am Board-certified in internal medicine and practice at the Cleveland Clinic on the downtown campus. I am also President of Cleveland Clinic Regional Hospitals, and a Professor of Medicine at the Cleveland Clinic Lerner College of Medicine of Case Western Reserve University. Thank you very much for allowing us to share our perspective.

This morning, instead of rehashing all of the reasons why the SGR must be repealed, I will focus on the innovative solutions being championed by ACP and others—others at the table, I might add—within the medical profession.

First, ACP recommends that the patient-centered medical home model of care be supported for broad Medicare adoption. Patient-centered medical home is an approach to providing comprehensive primary care in a setting that focuses on the relationships between patients, their primary care physician, and other health care professionals. This care is characterized by the following features: a personal physician for each patient, physician-directed medical practice where the personal physician leads a team of individuals trained to provide comprehensive care, and a place where the treatment team can assist the patient in meeting their specific health care needs. The patient-centered medical home practices provide increased access to care to prevent avoidable emergency room and hospital use, processes to facilitate care coordination amongst all physicians, and address chronic illnesses present within the Medicare population, including patient self-management education. These, and other features of the medical home, contribute to the increasing quality of care and reducing avoidable costs to patients and health systems.

Patient-centered medical homes use quality management tools such as registries and outcomes reporting to proactively manage the health care of a whole practice's population. There is an extensive and growing body of evidence on the medical home's effectiveness in improving outcomes and lowering costs. To cite just one example, in Genesee County, Michigan, the Genesee Health Plan in collaboration with local physicians and hospitals formed the Genesys HealthWorks. This model, which is built upon a strong, redesigned primary care infrastructure, has demonstrated both significant cost savings and improved quality.

Many large insurers, including United Health, WellPoint, CareFirst, and Blue Cross Blue Shield affiliates, are in the process of scaling up their efforts in the medical home to thousands of primary care physician practices in tens of millions of ruralities across the country. In my practice at the Cleveland Clinic, all the primary

care practice physicians taking care of adults are certified by the NCQA at the highest level as medical homes.

In the public sector, CMS Innovations Center is in the process of enrolling practices in its Comprehensive Primary Care Initiative. Primary care practices enrolled in this initiative will receive new public and private funding for primary care not included—primary care functions not included in the fee-for-service payments and will have the opportunity to share net savings generated through the program. Fifty-four commercial and State insurers are joining with Medicare and support approximately 500 participating practices in seven markets.

The bottom line is that the medical home is no longer just an interesting concept, but a reality for millions of Americans and thousands of practices. The commercial insurers are driving these innovations in many markets. This can also become a reality for Medicare patients.

To accomplish this, Congress needs to accelerate Medicare's adoption of the medical home model by providing higher payments to physician practices that have achieved recognition by deemed private sector accreditation bodies consistent with the standards to be developed by the Secretary. In a subsequent stage, performance metrics could be added and incorporated into the Medicare payment policies.

By supporting the PCMH, Medicare will accelerate the national adoption of this innovative approach to improving the health care system. The goal should be to promptly implement the payment policies to steadily grow physician and patient participation in medical homes over the next several years.

Second, Congress should enact payment policies to accelerate the adoption of the related medical home neighborhood. This concept is essential to the ultimate success of the medical home. It recognizes that specialty and subspecialty practices and others that provide treatment to the patient be recognized and provided with incentives to work together in a collaborative manner. With the patient-centered home neighborhood program, primary care physicians and specialists work together to proactively reduce duplication, enhance quality, and reduce preventable hospitalizations.

Specifically, ACP proposes that Congress help increase non-primary care specialists' participation in the medical home neighborhood project by offering higher payment levels for those services. In my practice, PCPs and cardiologists specializing in heart failure have developed coordinated early intervention programs that have improved quality and reduced preventable admissions, and saved health care dollars.

Third, Congress should establish Medicare incentives to physicians to incorporate evidence-based guidelines in national specialty societies and to share decision-making with the patients. We think that is a vital step that is important to get there.

And finally, ACP believes that additional steps should be taken now to help physicians to move toward models aligned with value for patients, as well as awarding those who have taken leadership and risk in participating in new models, like medical homes and ACOs. Even as new models are being more thoroughly developed

and pilot tested, physicians could get higher updates for demonstrating they successfully participated in such programs.

In conclusion, ACP believes that for the first time in many years, we can begin to see a vision for a better future where the SGR no longer endangers access to care, Medicare recognizes and supports the value of primary and coordinated care, and where every person who is enrolled in Medicare has access to a highly-functioning primary care practice through certified medical homes and other promising care coordination models. The current system disincentivizes the use of modern practice approaches that are proven to improve quality, prevent hospitalization, and save lives.

Thank you for your time, and I am pleased to answer questions.
[The prepared statement of Mr. Bronson follows:]

Brief Summary of Written Testimony
 Hearing before the House Energy & Commerce Subcommittee on Health
 “Using Innovation to Reform Medicare Physician Payment”
 Dr. David Bronson, MD, FACP
 President, American College of Physicians
 July 18, 2012

ACP recommends that the Patient-Centered Medical Home model be scaled up for broad Medicare adoption.

A Patient-Centered Medical Home is an approach to providing comprehensive primary care in a setting that focuses on the relationships between patients, their primary care physician, and other health professionals involved in their care. This care is characterized by the following features: a personal physician for each patient; a physician-directed medical practice, where the personal physician leads a team of individuals trained to provide comprehensive care; whole person-orientation, where the treatment team directly assists the patient in meeting their specific health care needs.

There is an extensive and growing body of evidence on the medical home’s effectiveness in improving outcomes and lowering costs. To cite just one example, in Genesee County, Michigan, the Genesee Health Plan, in collaboration with local physicians and hospitals, formed Genesys HealthWorks. This model, which is **built on a strong, redesigned primary care infrastructure, has demonstrated significant cost savings.**

Congress should accelerate Medicare adoption of the medical home model by providing higher payments to physician practices that have achieved recognition by a deemed private sector accreditation body consistent with standards to be developed by the Secretary. At a subsequent stage, medical home performance metrics could be added and incorporated into Medicare payment policies.

Congress should enact payment policies to accelerate adoption of the related Medical Home *Neighborhood* model.

The concept of a “medical neighborhood” is essential to the ultimate success of the medical home. It recognizes that specialty and subspecialty practices, hospitals, and other healthcare professionals and entities that provide treatment to the patient need to be recognized and provided with incentives—both non-financial and financial—for engaging in patient-centered practices that complement and support the efforts of the PCMH to provide high quality, efficient, coordinated care.

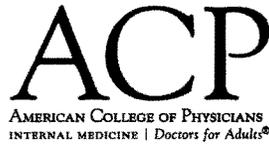
ACP proposes that Congress help increase non-primary care specialists’ participation in the medical home neighborhood model by offering higher Medicare payments to practices that have achieved neighborhood recognition through the NCQA or other private sector accreditation programs, consistent with standards to be developed by the Secretary.

Congress should establish Medicare incentives for physicians to incorporate evidence-based guidelines from national medical specialty societies into shared decision-making with their patients.

ACP’s *High Value, Cost-Conscious Care Initiative*, which includes clinical, public policy, and educational components, was designed to help physicians and patients understand the benefits, harms, and costs of an intervention and whether it provides good value, as well as to slow the unsustainable rate of health care cost increases while preserving high-value, high-quality care.

Programs like this initiative could be incorporated into Medicare payment policies by: (1) reimbursing physicians appropriately for spending time with patients to engage them in shared decision-making based on the recommendations from this initiative and similar efforts by other specialty societies and (2) developing a way to recognize, with higher payments, physicians who can demonstrate that they are incorporating such programs into their practices and engagement with their patients.

Finally, ACP believes that additional steps could be taken now to help physicians move toward models aligned with value to patients, as well as rewarding those who have taken the leadership and risk of participating in new models like medical homes and Accountable Care Organizations. ACP will highlight several key principles for developing a transitional value-based payment program.



Statement for the Record

American College of Physicians

Hearing before the House Energy & Commerce Subcommittee on Health

“Using Innovation to Reform Medicare Physician Payment”

July 18, 2012

The American College of Physicians (ACP) applauds Chairman Pitts and Ranking Member Pallone for holding this hearing and for the committee’s bipartisan efforts in trying to develop a solution to Medicare’s physician payment system, which has been a burden on physician practices for over a decade. We share your view that Medicare is in need of a new system that “reduces spending, pays physicians fairly, and pays for services according to their value to the beneficiary.” In that spirit, ACP’s statement will focus primarily on new value-based payment and delivery system models that we envision as the most promising in any post-SGR environment, and the kinds of structural and reporting capabilities, payment incentives, and measurement systems needed for them to work. We likewise will outline what we see as the preferred legislative pathway to these new models.

My name is David L. Bronson. I am President of the American College of Physicians, the nation’s largest medical specialty organization, representing 133,000 internal medicine physicians who specialize in primary and comprehensive care of adolescents and adults, internal medicine subspecialists, and medical students who are considering a career in internal medicine. I reside in Cleveland, OH, and am board-certified in internal medicine and practice at the Cleveland Clinic. I am also President of the Cleveland Clinic Regional Hospitals and a professor of medicine at the Cleveland Clinic Lerner College of Medicine of Case Western Reserve University.

Our testimony offers the following for the Subcommittee’s consideration:

1. We explain why it is imperative that the SGR be repealed and replaced with a framework to align payment incentives with the value of care provided to beneficiaries.
2. We explain why a payment system that recognizes the value of well-delivered primary care is essential to improving outcomes and lowering the costs of care.
3. We identify specific payment and delivery models that we believe have progressed enough that they can be scaled up into the broader Medicare program in the near-term future, as well as other promising models that should be evaluated on a broader scale and if shown to be effective, broadly implemented throughout the Medicare program as part of a permanent alternative to the SGR.
4. We propose improvements that can be made in the existing Medicare fee schedule to create incentives for coordinated, patient-centered care.
5. We offer our preferred legislative framework to eliminate the SGR and advance to better payment and delivery models.
6. We offer a set of specific principles to develop a transitional program to create incentives for physicians to begin incorporating value-based payment (VBP) initiatives into their practices, as a step toward full implementation of new payment and delivery models.

REFORMING THE SUSTAINABLE GROWTH RATE (SGR)

Medicare's SGR formula is fatally flawed and should be replaced with a framework that creates stable and positive updates for all physician services; provides incentives for primary, preventive and coordinated care; accelerates development and testing of new models developed with physicians input; and establishes a transition to the most effective new payment models.

The unworkable SGR formula determines the annual payment updates to physicians for the services they provide under the Medicare and TRICARE programs. (TRICARE, the health insurance program for military families, uses the same flawed SGR formula as Medicare.) Every year since 2001, the SGR has resulted in annual scheduled

payment cuts that jeopardize access to care for our nation's Medicare beneficiaries and military families. The scheduled cuts also act as a barrier to physicians investing in health information systems and in acquiring other practice capabilities to improve the value of care provided to patients. While Congress typically enacts short-term "patches" to avert payment reductions, its repeated inability to agree on a permanent solution has resulted in a ballooning of the budget cost of SGR repeal – from \$40 billion only a few years ago to almost \$300 billion today to an estimated \$600 billion by 2016. If Congress does not intervene, the estimated cut scheduled for Jan. 1, 2013 is nearly 30 percent.

Congress should eliminate the physician payment cuts scheduled for Jan. 1; the SGR should be repealed this year and physician payments should be transformed from a system that incentivizes volume to one that preserves and promotes the patient-physician relationship and rewards high-quality and efficient care. It should also recognize and address the on-going undervaluation of primary care, preventive and care coordination services – which have led to a projected shortage of 44,000 primary care physicians for adults by the end of this decade.

THE VALUE OF PRIMARY AND COORDINATED CARE

Research both in this country and globally reflects that the foundation of an effective and efficient health care system is a robust primary care work. Care delivered in areas in which there is a sufficient number of primary care physicians and other related health care professionals is of higher quality and lower cost. The need to ensure a sufficient primary care workforce becomes more important with recognition of our rapidly aging population characterized by multiple chronic conditions.

The demand for primary care in the United States is expected to grow at a rapid rate while the nation's supply of primary care physicians for adults is dwindling and interest by U.S. medical school graduates in pursuing careers in primary care specialties is steadily declining. Primary care physicians provide 52 percent of all ambulatory care visits, 80 percent of patient visits for hypertension, and 69 percent of visits for both chronic obstructive pulmonary disease and diabetes, yet they comprise only one-third of the U.S. physician workforce, and if current

trends continue, fewer than one out of five physicians will be in an adult primary care specialty. There are over **100 studies that show primary care is associated with better outcomes and lower costs of care** (http://www.acponline.org/advocacy/where_we_stand/policy/primary_shortage.pdf).

Medicare and delivery system reform should have as explicit goals increasing recognition of the value of primary care in improving outcomes and lowering costs; creating incentives for well-organized, team-based, coordinated, accountable and patient-centered primary care (Patient-Centered Medical Homes); and creating incentives for more physicians to go into internal medicine and other primary care disciplines.

Congress should also recognize that internal medicine subspecialists provide a substantial amount of primary and principal care in the United States as well as being key members of the team in providing coordinated care to patients, working hand-in-glove with the patient's primary care specialists. Their contributions should be recognized in any new payment system, and specifically, Medicare should improve payments for undervalued evaluation and management and care coordination services, whether provided by a primary care specialist or an internal medicine subspecialist physician within their range of expertise. And, as discussed later in this testimony, incentives should be created for medical specialists to link seamlessly with Patient-Centered Medical Home practices—a concept called the Patient-Centered Medical Home Neighborhood (PCMH-N).

SPECIFIC PAYMENT AND DELIVERY REFORMS THAT CAN SERVE AS THE BASIS FOR A NEW MEDICARE PAYMENT SYSTEM

1. Patient-Centered Medical Home (PCMH)

ACP has joined with other physician organizations in advancing new models of payment and delivery that are centered on patients' needs, including working with the Centers for Medicare and Medicaid Services (CMS),

private payers, business, and consumer groups to broadly test the PCMH model, which already is showing success in improving outcomes and reducing costs.

The PCMH is an approach to providing comprehensive primary care in a setting that focuses on the relationships between patients, their primary care physician, and other health professionals involved in their care. Key attributes of the PCMH promote health care delivery for all patients through all stages of life. This care is characterized by the following features: a personal physician for each patient; a physician-directed medical practice, where the personal physician leads a team of individuals trained to provide comprehensive care; whole person-orientation, where the treatment team directly assists the patient in meeting their specific health care needs; care coordinated across all elements of the complex health care system; quality and safety; and enhanced access to care. Several accreditation groups have developed accreditation or recognition programs that can be used in determining if a practice provides care that is consistent with these expected features. And an increasing number of payers and physicians are engaged in PCMH initiatives throughout the country.

PCMH in the Public Sector

In its first year the CMS Innovation Center (CMMI), established by the Affordable Care Act (ACA), has introduced 16 initiatives, involving over 50,000 health care clinicians. CMMI's initial efforts have focused on improving patient safety, promoting care coordination, investing in primary care transformation, creating bundled payment models, and addressing the needs of dual-eligibles. One critical program of the CMMI is the Comprehensive Primary Care Initiative (CPCI), which is a collaboration between private and public payers and primary care practices to support patient centered primary care. The CPCI is modeled on the PCMH and PCMH-Neighborhood concepts, championed by ACP and other national membership organizations representing physicians and other clinicians and supported by thousands of business, consumer, and payer groups represented in the Patient-Centered Primary Care Collaborative (PCPCC). In this initiative, primary care practices will receive new, public and private funding for primary care functions not included in the fee-for-service payments and will have the opportunity to share net savings generated through the program. Forty-four commercial and

State insurers are joining with Medicare to support comprehensive primary care, provided that selected practices demonstrate capabilities aligned with the PCMH model. If successful, CMS has the authority to expand the program throughout Medicare, potentially leading to a sustainable new payment and delivery model for primary care.

On April 11, 2012 CMS announced the first seven market areas—and on June 6, 2012, CMS named the 45 commercial, federal and State insurers in those seven markets that have committed to work with CMS on this project. These include:

- Arkansas: Statewide (4 payers)
- Colorado: Statewide (9 payers)
- New Jersey: Statewide (5 payers)
- New York: Capital District-Hudson Valley Region (6 payers)
- Ohio and Kentucky: Cincinnati-Dayton Region (10 payers)
- Oklahoma: Greater Tulsa Region (3 payers)
- Oregon: Statewide (7 payers)

ACP has reached out to all of our Chapters in these states and regions to help spread the word about the importance of this initiative and encourage our members to apply by the July 20, 2012 deadline.

PCMH in the Private Sector

There has also been a significant amount of private sector payer activity in area of the PCMH, including test projects or roll-outs of the model in nearly all 50 states. For example:

- In Michigan, Blue Cross Blue Shield of Michigan's (BCBSM) Physician Group Incentive Program (PGIP) was established in 2004 as a collaborative partnership between BCBSM and physician organizations across the state, with the goal of optimizing patient care and transforming the state's health care delivery system. Then, in 2007, in the wake of the growing interest in the PCMH model, and in response to PGIP clinician requests for more direction and structure, BCBSM collaborated with clinicians to develop a set of 12 PCMH Initiatives.¹
- In Genesee County, Michigan, the Genesee Health Plan, in collaboration with local physicians and hospitals, formed Genesys HealthWorks and has implemented a model **built on a strong, redesigned primary care infrastructure and has demonstrated significant cost savings.**²
- In the Hudson Valley area of New York, the THINC P4P-Medical Home project brings together multiple health plans that service the Hudson Valley region. Using standardized measures agreed upon by clinicians and payers, the project is providing performance incentives from multiple payers to the participating clinicians.³
- Colorado is the site of a multi-payer, multi-state PCMH pilot that includes multiple participants at both the local and national levels. The PCMH model is being tested in 16 family medicine and internal medicine practices selected from across the Colorado Front Range, as well as practices in Cincinnati, Ohio. The pilot is being evaluated by the Harvard School of Public Health to determine the effect on quality, cost trends, and satisfaction for patients and their health care team.⁴ ACP has been actively involved in this pilot, including serving on the steering committee.

In addition to these pilot programs, a number of large insurers have announced their intent to roll the PCMH model out more widely. For instance, in January 2012, Wellpoint, a private insurer covering 34 million Americans with a network of 100,000 primary care doctors, publicly announced its decision to invest in the

¹ Share, David. From Partisanship to Partnership: The Payor-Provider Partnership Path to Practice Transformation. Testimony before the House Ways and Means Committee, Health Subcommittee. February 2012. Available at: http://waysandmeans.house.gov/UploadedFiles/Share_Testimony_FinalHE27.pdf.

² Genesys HealthWorks Health Navigator in the Patient-Centered Medical Home. Available at: <http://www.pcpc.net/content/genesys-healthworks-health-navigator-patient-centered-medical-home>.

³ Hudson Valley P4P-Medical Home Project. Available at: <http://www.pcpc.net/content/hudson-valley-p4p-medical-home-project>.

⁴ The Colorado Multi-Payer, Multi-State Patient-Centered Medical Home Project. Available at: <http://www.pcpc.net/content/colorado-multi-payer-multi-state-patient-centered-medical-home-pilot>.

medical home model across its entire network. Aetna, another large private health plan insuring more than 18 million Americans with a network of 55,000 primary care doctors, also recently announced a PCMH program roll-out in Connecticut and New Jersey, with expectations to expand the program nationally in 2012. And, building on a large medical home pilot project already underway, UnitedHealthcare, insuring 34 million Americans, announced in February 2012 an expansion of its value-based payment model, affecting between 50 percent and 70 percent of its customers. Numerous Blue Cross Blue Shield (BCBS) plans across the U.S. have been leaders in their respective marketplace, with over 4 million BCBS members in 39 states currently participating in some version of a PCMH initiative. For example, Care First, the BCBS affiliate in the Maryland/DC area, has implemented the PCMH model within over 75 percent of its participating primary care practices.

These private insurers have made the decision to roll the PCMH model out based on their experience to date with pilot programs, as well as the substantial evidence that health systems with a strong primary care foundation deliver higher-quality, lower-cost care overall and greater equity in health outcomes.⁵ Taking this a step further, research also shows that patient-centered primary care is best delivered in a medical home.⁶ Although peer-reviewed academic studies evaluating the medical home model in its full implementation are still limited^{7,8,9} there is much to be learned from the numerous PCMH evaluations that have considered individual components of the PCMH model in specific settings, including a recent Institute of Medicine report that evaluated methods of care for those who are chronically ill.¹⁰ One compelling indication of the value of PCMHs in improving outcomes and lowering costs is the simple fact that so many large, private sector payers have embraced the PCMH model,

⁵ Johns Hopkins Bloomberg School of Public Health. Publications of the bureau of primary health care and primary care policy center. (2012). Available at: <http://www.jhsph.edu/pcpe/publications.html>.

⁶ Commonwealth Fund (2012, March 12). Patient-Centered Coordinated Care. Program Description. http://www.commonwealthfund.org/-/media/Files/Programs/2012/Program%20PDFs/2011_PatientCentered_Coord_Care_with_caption.pdf

⁷ Peikes, D., Genevro, J., Scholle, S. H., Torda, P. (2011, Feb). The patient-centered medical home: Strategies to put patients at the center of primary care. Agency for Healthcare Research and Quality. AHRQ No. 11-0029. Rockville, MD. Retrieved from http://www.pcmh.ahrq.gov/portal/server.pt/community/pcmh_home/1483/pcmh_tools_resources_patient-centered_v2.

⁸ Jaén C. R., Ferrer R. L., Miller W. L., Palmer R. F., Wood R., Davila M., et al. (2010, May 1). Patient outcomes at 26 months in the patient-centered medical home national demonstration project. *Ann Fam Med*, 8(1 Suppl):S57–S67; S92.

⁹ Reid, R. J., Coleman, K., Johnson, E. A., Fishman, P. A., Hsu, C., Soman, M. P., Trescott, C. E., et al. (2010, Mar) The group health medical home at year two: cost savings, higher patient satisfaction, and less burnout for providers. *Health Affairs*, 29(5):835–43.

¹⁰ Institute of Medicine. (2012). *Living well with chronic illness: A public health call to action*. Washington, DC: National Academy Press.

scaling it up to make PCMHs widely available to their subscribers, with many of them are reporting substantial costs savings as a result.

Scaling Up the PCMH Model

ACP believes that the PCMH model has advanced enough that it could be scaled up for widespread implementation throughout Medicare in the immediate future. The growing amount of experience in both the public and private sectors on how to organize care around PCMHs, the thousands of physician practices that already achieved certification or accreditation as a PCMH, and the growing amount of data on its effectiveness in improving care and lowering costs, makes it a logical model to scale up to the broader Medicare program. **This could be done, for instance, by providing higher Medicare payments to physician practices that have achieved recognition by a deemed private sector accreditation body.** At a subsequent stage, PCMH performance metric could be added and incorporated into Medicare payment policies.

At the same time, ACP recognizes that there are challenges to the PCMH model. Some of these include:

- The need for care coordination across settings and the continuum of patient care. ACP has taken a leadership role in helping to address this challenge through our work on the development of the PCMH-Neighborhood model, which is discussed below.
- Related to the issue of care coordination is the lack of real- or near-time data being provided to practices on their patients, which makes it extremely challenging for them to provide proactive, patient-centered care. This is exacerbated by the lack of effective data and information sharing across sites of care. ACP has been deeply involved in the national policy issues surrounding the use of health information technology to facilitate effective clinical data sharing—including the EHR Incentive Program as initiated with the HITECH act. In our most recent comments on the notice of proposed rulemaking from both

CMS¹¹ and ONC¹² on Stage 2 Meaningful Use, we highlighted our support of the government's vision to use EHRs and health IT to improve care, but believe that more needs to be done to align the measures across all of the initiatives currently underway including CMS PQRS and e-prescribing programs. While CMS has made strides in aligning the measures, at a high level the technical requirements in each of the programs are different enough that dual processes must be undertaken. We are also concerned about the approach that CMS has taken when structuring the penalty phases of the EHR Incentive Programs, e-Prescribing Incentive Program, and Physician Quality Reporting System (PQRS) by requiring that the activity to avoid the penalty must be completed in the prior year or even two years in advance of the legislated deadline. As a result, CMS has effectively moved up the legislated deadline beyond what the market can bear. More about ACP's effort to facilitate the adoption of health IT will be addressed below.

- Practices that are trying to transform and that are actively engaging in or pursuing PCMH recognition/accreditation, meaningful use for their electronic health records, e-prescribing, etc. also struggle when they do not receive timely payments from their payers for these activities.
- Finally, in many cases practices are transforming to provide services to their patients in line with the PCMH model, but are only paid to do so for a subset of their patient population (e.g., Wellpoint and Aetna are paying them a per member per month payment for their beneficiaries, but they are not receiving payment from CMS for their Medicare patients). This issue is being addressed in some areas of the country, particularly those that were selected to participate in the CPCi, discussed above, but many other practices across the country are not being "made whole" in terms of payment for the work they are doing.

The Role of the PCMH in a Post-SGR Environment

Given all of the federal, state, and private sector activity described above, as well as ongoing efforts to address the challenges that have been discussed, it is reasonable to expect that the PCMH model will be ready to be a part of a

¹¹ These comments can be found at: http://www.acponline.org/advocacy/where_we_stand/health_information_technology/cms_nprm.pdf.

¹² These comments can be found at: http://www.acponline.org/advocacy/where_we_stand/health_information_technology/onc_nprm.pdf.

new, value-based health care payment and delivery system. Under this model, practices that provide comprehensive primary care to their patients will be:

- Paid differently, including:
 - A periodic (e.g., monthly, quarterly) care management fee to allow them to strengthen their capacity to provide comprehensive, patient-centered care. This fee could go toward additional staffing, infrastructure, health information technology, and/or otherwise uncompensated physician and staff time.
 - A potentially revised, improved, and/or expanded set of fee-for-service evaluation and management codes that better incorporate physician and staff non-face-to-face time when providing care management and care coordination services.
 - Shared savings based upon improved quality of care and better patient outcomes.
- Organized differently, in order to:
 - Deliver proactive, timely preventive care to their patients.
 - Provide 24/7 access to their patients through online interactive tools, data, and information.
 - Actively engage patients, their families, and their caregivers in their health care.
 - Provide comprehensive care management services to their patients, particularly those with high health care needs (e.g., multiple chronic conditions).
 - Coordinate care across their patients' medical neighborhoods by acting as the first point of contact and working collaboratively with the team of clinicians involved in their patients' care.
- Measured differently, via measures that are focused on:
 - Delivery of patient-centered care, which could be determined by recognition from a national "patient-centered medical home" program such as the Accreditation Association for Ambulatory Health (AAAH), the Joint Commission, NCQA, URAC, or a state-based accreditation program; and/or by criteria developed by the Secretary of HHS that may pull from the national programs, current CMS Innovation Center Initiatives (e.g., the Comprehensive Primary Care Initiative), or other sources.

- Delivery of high quality and efficient care – potentially looking to the core measures recommended by the PCMH Evaluators’ Collaborative established by the Commonwealth Fund¹³, which includes measures in the following domains: clinical quality (process and outcome), utilization, cost and patient experience of care.
- Delivery of coordinated care, which could be determined, in part, by recognition of non-primary care practices through the Specialty Practice Recognition program currently being developed by NCQA for release in spring, 2013. This program will assess a specialty/subspecialty practice’s ability to integrate/coordinate with primary care practices, and engage in processes to deliver patient centered care, improved patient access, improve care quality and implementation of “meaningful” health information technology.
 - In addition, the Agency for Healthcare Research and Quality (AHRQ) has available an atlas of care coordination measures;¹⁴ and
 - The National Quality Forum (NQF) has established a platform for the development of care coordination measures consisting of a set of domains, principles and preferred practices.¹⁵

Measures and measure strategies should be thoughtfully aligned with – and where possible leverage – the regular practice assessment, reporting and quality improvement activities that individual physicians already are required to undertake as part of their specialty board Maintenance of Certification (MOC). For example, the American Board of Internal Medicine (ABIM), which is the largest of the certifying boards, includes in its MOC program a suite of quality measurements, reporting and improvement tools specifically focused on patient-centered primary care/specialist communication, and will soon introduce a care coordination module developed by several of the

¹³ Rosenthal MB, Abrams MK, Biton A. et. al. Recommended core measures for evaluating the patient-centered medical home: Cost, utilization and clinical quality. Commonwealth Fund. May 2012. http://www.commonwealthfund.org/~media/Files/Publications/Data%20Brief/2012/1601_Rosenthal_recommended_core_measures_PCMH_v2.pdf

¹⁴ Agency for Healthcare Research and Quality. Care Coordination and Measures Atlas. Accessed at <http://www.ahrq.gov/qual/careatlas/>

¹⁵ NQF. Preferred practices and performance measures for measuring and reporting care coordination. 2010. Accessed at http://www.qualityforum.org/Publications/2010/10/Preferred_Practices_and_Performance_Measures_for_Measuring_and_Reporting_Care_Coordination.aspx

experts who also helped shape the Medical Neighbor concept, described below. Aligning PCMH/N practice accreditation standards with professional MOC assessment and improvement activities will send a powerful signal to physicians about the significance of the PCMH model, reduce redundant reporting requirements and facilitate participation by smaller practices.

2. Patient-Centered Medical Home – Neighborhood

The importance of involvement of the “medical neighborhood” to the ultimate success of the PCMH model to fully achieve its quality and efficiency goals has been highlighted by recent policy papers by ACP¹⁶ and the Agency for Healthcare Quality and Research (AHRQ).¹⁷ Specialty and subspecialty practices, hospitals, and other health care professionals and entities that provide treatment to the patient need to be recognized and provided with incentives—both non-financial and financial—for engaging in patient-centered practices that complement and support the efforts of the PCMH to provide high quality, efficient, coordinated care. The above cited College policy paper outlines a model using care coordination agreements to promote a functioning PCMH-Neighborhood. Reciprocal recognition of professional MOC standards and activities that focus on these same skills and systems, including implementation of such agreements, is a potent lever.

The NCQA, acknowledging the importance of the involvement of the “medical neighborhood” in support of PCMH (primary) care, is in the process of developing a “medical neighbor” recognition process that identifies specialty and subspecialty practices that engage in activities supportive of the PCMH model—with particular emphasis on care coordination and integration. This decision was made following the conclusion of a comprehensive feasibility study in which this concept was strongly supported by multiple health care stakeholders—including physician groups, employers, health plans, state and federal payers, and patient

¹⁶ American College of Physicians. The patient centered medical home neighbor: The interface of the patient centered medical home with specialty/subspecialty practice. 2010. Accessed at http://www.acponline.org/advocacy/where_we_stand/policy/.

¹⁷ Agency for Healthcare Research and Quality (AHRQ). Coordinating care in the medical neighborhood: Critical components and available mechanisms. 2011. Available at http://pcmh.ahrq.gov/portal/server.pt/community/pcmh_home/1483/what_is_pcmh.

advocates. In addition, the American Board of Internal Medicine and the NCQA are collaborating to align aspects of Maintenance of Certification and the new “medical neighbor” recognition process.

Efforts to promote processes to coordinate care between primary care practices and the other physicians and health care professionals providing treatment to the patient have been an integral part of both private and public integrated care systems (e.g. Kaiser, Department of Veterans Affairs) and are an important component of the developing Accountable Care Organization (ACO) models. This new NCQA program, and similar efforts, can serve to encourage specialty/subspecialty practices and other “neighborhood” health care entities currently not involved within an integrated system—settings in which most care is currently being delivered—to implement these important processes. This is already happening in several areas of the country. For example:

- The Vermont Blueprint for Health program is implementing a program in which medical home and related, anchored subspecialty practices engaging in efficient, integrative processes will be sharing a monthly care coordination fee for the treatment of COPD, CHF, diabetes, and asthma.
- The Texas Medical Home Initiative will require participating primary care practices to establish care coordination agreements with their most frequently referred to specialist and hospital settings.
- Programs in both the Denver and Grand Junction areas of Colorado are in the process of implementing “medical neighborhood” programs that promote increased integration among primary and specialty care practices.

3. Accountable Care Organizations (ACOs)

The ACA instructed the Secretary of Health and Human Services (HHS) to implement, no later than January 1, 2012, a voluntary shared savings program that promotes accountability for services delivered to a defined Medicare fee-for-service (FFS) patient population with the goals of increasing the quality and efficiency of services delivered.

Eligible participants consist of groups of clinicians and other providers, referred to as Accountable Care Organizations (ACOs), which have established a mechanism for shared governance and take joint responsibility for the quality and efficiency of the services delivered to a defined population. These groups can consist of physician group practice arrangements, networks of individual practices, partnerships and joint-ventures between hospitals and other providers, hospitals employing physicians and other professionals, and other arrangements determined appropriate by the Secretary of HHS.

The Role of ACOs in a Post-SGR Environment

The ACO model, either using a shared savings or alternative “capitated payment” model, facilitates a “sea change” regarding care delivery. Rather than care being delivered in clinical silos and focused on the production of volume, care will be aligned with measures of quality, efficiency and clinical coordination. Value will be rewarded rather than volume. Substantial evidence toward ACO development throughout the country is already occurring with the implementation of the Pioneer (32 approved programs) and Medicare Shared Savings Programs (132 approved programs) within the public sector, and the report of over 220 ACOs being developed across 45 states and the District of Columbia within the private sector – an increase of 38 percent in the private sector within only the past 6 months.¹⁸ The selected ACOs operate in a wide range of areas of the country and almost half are physician-driven organizations serving fewer than 10,000 beneficiaries, demonstrating that smaller organizations are interested in operating as ACOs. One example of these private sector programs is the Alternative Quality Contract offered through BCBS of Massachusetts, which has shown both improved quality and a downward bending of the cost growth curve after only one year of implementation.¹⁹ The growth of the ACO model has led NCQA (released) and URAC (in process) to develop an ACO recognition process that helps

¹⁸ Muhlestein D et. al. Growth and Dispersion of Accountable Care Organizations: June 2012 Update. Leavitt Partners. Accessed at <http://leavittpartners.com/wp-content/uploads/2012/06/Growth-and-Dispersion-of-ACOs-June-2012-Update2.pdf>

¹⁹ Song B, Safran D, et. al. Health Care Spending and Quality in Year 1 of the Alternative Quality Contract. *N Engl J Med* 2011; 365:909-918 September 2011. Accessed at <http://www.nejm.org/doi/full/10.1056/NEJMsa1101416#t=articleTop>.

ensure that these organizations engage in processes that promote patient centered, high quality, efficient integrative care.

OTHER PROMISING PAYMENT MODELS

4. Comprehensive Global Payment Model²⁰

This model proposes a comprehensive payment structure consisting of a global payment for primary care (coordinated, comprehensive, continuous, personalized care) to replace visit-based compensation paid to the practice. The global fee is linked to the number of patients in the practice and covers the cost of all necessary staff and technology to the practice, as well as a respectable income for the physicians. The global payment would cover:

1. All care and coordination provided by the primary clinician
2. All services rendered by other professional and administrative staff on the treatment team (e.g. follow-up nurses, social workers, nutritionists)
3. Essential practice infrastructure and systems – particularly an interoperable EHR with clinical decision support

This global payment model maintains population risk with the payer, while practices accept technical risk for providing the required ambulatory care in a manner that minimizes waste and inefficiency and facilitates adherence to professional standards of care and referral. The model also includes a meaningful component of payment (15-25 percent) that is outcome-based and linked to validated measures of patient satisfaction, clinical performance, and efficiency.

²⁰ Goroll AH, Berenson RB, Schoenbaum SC, Gardner LA. Fundamental reform of payment for adult primary care: comprehensive payment for comprehensive care. *J Gen Intern Med.* 2007;22:410-415. Summary available at http://www.commonwealthfund.org/~media/Files/Publications/In%20the%20Literature/2007/Mar/Fundamental%20Reform%20of%20Payment%20for%20Adult%20Primary%20Care%20-%20Comprehensive%20Payment%20for%20Comprehensive%20Care/Goroll_fundament%20reform%20payment%20adult%20primary%20care_1014_it%20pdf.pdf.

Eligibility for this payment would be limited to those practices that demonstrated having the infrastructure and general capability to deliver the requisite services, as assessed by an organization such as NCQA or URAC. The care provided would be documented by an annual random sample of practices. The documentation typically required for each visit would be significantly reduced and payment would be heavily risk- and needs- adjusted to match each patient's burden of care. This payment model is currently being piloted within the Capital District Health Plan in Albany, New York. Initial data reflects decreased costs and improved care quality compared to a cohort control.²¹

5. ***"Prometheus" Evidence-informed Case Rate (ECR) Model***

This payment model, developed by the non-profit PROMETHEUS Payment Inc. establishes case rates for the treatment of specific conditions based on the cost of all services, pharmaceuticals, tests, equipment, etc. needed to treat the condition following agreed upon evidence-based clinical practice guidelines. The case rate is triggered by a diagnosis and, for chronic conditions, takes the form of a yearly rate. The amount of the payment to the practice also depends upon its performance on a quality scorecard and the efficiency of care provided by the other physicians and health care professions throughout the system providing care to the patient for the defined condition. Pilot demonstrations are being implemented in Rockford, Illinois and Minneapolis, Minnesota with a third site in Utah.²² PROMETHEUS Payment Inc. has also outlined how this model can be used for the payment of primary care services, including the provision of funds to transform primary care practices into medical homes.²³

INCORPORATING HIGH VALUE CARE INTO PAYMENT POLICIES

²¹ Feder J. A health plan spurs transformation of primary care practices into better-paid medical homes. *Health Affairs* 2011 30 (3): 397-399.

²² Prometheus Newsletter 2. Accessed at <http://www.prometheuspayout.org/news-events/newsletters/2009/PPInewsletter09issue2.pdf>.

²³ Prometheus Payment Incorporated. Sustaining the Medical Home: How Prometheus Payment Can Revitalize Primary Care. 2009. Accessed at <http://www.prometheuspayout.org/publications/pdf/STMH%20Full%20with%20Apps.pdf>.

Medical specialty societies, including ACP, are taking a leading role in developing and implementing programs to improve the value of care provided to patients.

ACP's High Value, Cost-Conscious Care Initiative (HVCCC), which includes clinical, public policy, and educational components,²⁴ was designed to help physicians and patients understand the benefits, harms, and costs of an intervention and whether it provides good value, as well as to slow the unsustainable rate of health care cost increases while preserving high-value, high-quality care.

For the clinical component of the HVCCC Initiative, ACP has released materials focused on three areas: low back pain, oral pharmacologic treatment of type 2 diabetes, and colorectal cancer. Furthermore, as part of this initiative, ACP convened a workgroup of physicians that identified, using a consensus-based process, 37 common clinical situations in which screening and diagnostic tests are used in ways that do not reflect high-value care.²⁵ Furthermore, on July 10, ACP and the Alliance for Academic Internal Medicine (AAIM) unveiled a high-value, cost-conscious care curriculum to help train internal medicine residents about how to avoid overuse and misuse of tests and treatments that do not improve outcomes and may cause harm. The free curriculum, available at www.highvaluecarecurriculum.org, is designed to engage internal medicine residents and faculty in small group activities organized around actual patient cases that require careful analysis of the benefits, harms, costs, and use of evidence-based, shared decision making. The flexible curriculum consists of ten, one hour interactive sessions that can be incorporated into the existing conference structure of a program.

ACP has also joined other leading professional medical organizations in the Choosing Wisely campaign,²⁶ which complements our HVCCC Initiative. An initiative of the ABIM Foundation, the goal of the Choosing Wisely campaign is to promote thoughtful discussions among physicians, patients, and other stakeholders about how to

²⁴ Additional information can be found at: http://www.acponline.org/clinical_information/resources/hvccc.htm.

²⁵ Qaseem A, Alguire P. et al. Appropriate Use of Screening and Diagnostic Tests to Foster High-Value, Cost-Conscious Care. *Ann Intern Med*. 2012;156:147-149. Accessible at <http://www.annals.org/content/156/2/147.full.pdf+html?sid=10a2df33-7fa3-45e1-a01d-de7ecd1b9f6c>

²⁶ More information on this initiative can be found at: <http://choosingwisely.org/>.

use health care resources to improve quality of care. In April 2012, ACP unveiled our list of "Five Things"²⁷ internists and patients should question in internal medicine.

On April 19, ACP and Consumer Reports announced a new collaborative effort to create a series of *High Value Care* resources to help patients understand the benefits, harms, and costs of tests and treatments for common clinical issues. The resources will be derived from ACP's evidence-based clinical practice recommendations published in *Annals of Internal Medicine*. The initial pieces of the *High Value Care* series will be two patient brochures about diagnostic imaging for low back pain and oral medications for type 2 diabetes. The *High Value Care* resources will be available on the websites of ACP (ACPOnline.org), Consumer Reports (ConsumerReports.org), and *Annals of Internal Medicine* (Annals.org).²⁸

Finally, the educational component of the program involves elements for both physicians and patients. The next edition of ACP's Medical Knowledge Self Assessment Program (MKSAP) will have a focus on optimal diagnostic and treatment strategies, based upon considerations of value, effectiveness, and avoidance of overuse and misuse.

Programs like ACP's HVCCC initiative and *Choosing Wisely*[®] could be incorporated into Medicare payment policies by: (1) reimbursing physicians appropriately for spending time with patients to engage them in shared decision-making based on the recommendations from those programs and similar efforts by other specialty societies and (2) developing a way to recognize, with higher payments, physicians who can demonstrate that they are incorporating such programs into their practices and engagement with their patients.

IMPROVING MEDICARE FEE-FOR-SERVICE TO SUPPORT CARE COORDINATION

²⁷ This document can be found at: http://choosingwisely.org/wp-content/uploads/2012/04/5things_12_factsheet_Amer_College_Phys.pdf.

²⁸ More information on this effort can be found at: http://www.acponline.org/pressroom/high_value_care_ed_materials.htm.

Even as new models of payment are being evaluated, and some like the PCMH scaled up more broadly through the program in the near-term, Medicare fee-for-service (FFS) will continue to be the principal way that most doctors will be reimbursed for at least the next several years. In addition, FFS is an element of other payment and delivery models, including PCMHs and ACOs. Consequently, it is important to make FFS improvements to recognize and support the value of coordinated care.

Specifically, ACP support the development and recognition under Medicare fee-for-service payment policies of two new CPT codes—(1) for chronic, complex care and (2) transition care following a facility-based discharge. These new codes have been developed by a CPT Panel workgroup and approved by the CPT Editorial Panel during their May 2012 CPT Meeting. These codes are currently undergoing a survey process in order to be assigned recommended values by the Relative Value Update Committee (RUC), and then receive a final valuation by the Centers for Medicare and Medicaid Services (CMS). These codes are designed to allow physicians to report their non-face-to-face time, and the clinical staff (team) time spent on patient cases—an important element of the overall Patient Centered Medical Home (PCMH) model, which was discussed above. The College is also encouraged by the inclusion of a similar new transition of care code applicable to post-hospital discharge situations in the recently released Medicare 2013 Physician Fee Schedule proposed rule.

A LEGISLATIVE FRAMEWORK TO REPEAL THE SGR AND PROGRESS TO BETTER MODELS

Today's testimony demonstrates that enough progress is being made to develop, implement and evaluate new payment and delivery models to serve as the basis for replacing the SGR. Getting from here to there, though, will require that Congress enact a legislative framework to eliminate the SGR, stabilize payments during a transition phase, evaluate and implement new models, and specify a pathway and timetable to such models.

Specifically, ACP envisions two phases in the SGR reform process. During the first stage, Medicare would stabilize and improve payments under the current Medicare fee schedule for at least the next five years by

eliminating the SGR as a factor in establishing annual updates and by ensuring higher payments and protection from budget neutrality cuts for undervalued primary care, preventive and care coordination services. This sustained period of stability is needed to ensure access to care, while allowing time for Medicare to work with physicians to test, disseminate, and prepare for adoption of new patient-centered payment and delivery models.

During stage two, physicians would be given a set timetable to transition their practices to the models that Congress and the Department of Health & Human Services (HHS) have determined to be most effective based on experience with the payment/delivery system models evaluated during stage one, leading to permanent replacements to the existing Medicare payment system. ACP supports full testing of models including the patient-centered medical home and the patient-centered medical home neighborhood, Accountable Care Organizations, and other models that meet suggested criteria for value to patients. We recommend the development of different payment initiatives for different specialties and types of practice, rather than a “one-size-fits-all” model for all physicians.

The Physician Payment Innovation Act of 2012, H.R. 5707: Reps. Allyson Schwartz (D-PA) and Joe Heck (R-NV) recently introduced legislation, consistent with ACP’s core principles above, outlines the pathway to full SGR repeal and implementation of new value-based models of care that focus on quality of care, as opposed to volume of care, as occurs under the current payment system.

H.R. 5707 achieves five key policy goals:

1. Repeals the Sustainable Growth Rate (SGR).
2. Protects access to care for seniors, disabled persons, and military families, by eliminating all scheduled SGR cuts, including a nearly 30 percent cut on January 1, 2013. Patients need the certainty of knowing that the government will not impose cuts that could force many doctors out of the Medicare and TRICARE programs. (TRICARE updates are set by the Medicare SGR formula, so military families are

at the same risk of losing access to doctors as persons enrolled in Medicare because of the scheduled cuts.)

3. Stabilizes payments through 2018, with no cuts for the next six years and positive updates to all physicians during 2014-2017. The Medicare Physician Payment Innovation Act would continue current Medicare rates through 2013; provide modest positive updates of 0.5 percent to all physicians in calendar years 2014-2017, and then extend the 2017 rates through December 31, 2018. This sustained period of stability is needed to ensure access to care, while allowing time for Medicare to work with physicians to test, disseminate and prepare for adoption of new patient-centered payment and delivery models.
4. Provides a higher update for undervalued primary, preventive and coordinated care services, whether delivered by primary care physicians or by other specialists. The bill provides a 2.5 percent annual update in calendar years 2014-2017 for designated primary care, coordinated care, and preventive services codes when provided by physicians for whom 60 percent of Medicare allowable charges come from these designated codes. Such incentives are critical to improving care coordination and addressing historical payment inequities that contribute to severe shortages in internal medicine, family medicine, internal medicine subspecialties, neurology, and other fields.
5. Accelerates development, evaluation, and transition to new payment and delivery models, developed with input by the medical profession and with external validation. The six-and-a-half years established by the bill for CMS to develop, evaluate, and then adopt at least five new models, including an alternative fee-for-service option for physicians who participate in designated quality improvement programs, will help ensure sufficient time for CMS and Congress to “get it right.”

ACP recognizes that there may be variations on the framework proposed by H.R. 5707 that could achieve the same goals of eliminating the SGR, stabilizing payments, recognizing the importance of improving payments for undervalued primary, preventive and coordinated care services, and establishing a clear pathway to patient-

centered, value-based models. We are open to discussion of how best to achieve a transition consistent with the above goals, while recognizing that H.R. 5707 is the first and only bipartisan bill that we are aware of that translates the above critical policy goals into a practical legislative framework.

PRINCIPLES TO CREATE A TRANSITIONAL VALUE-BASED PAYMENT INITIATIVE

Finally, ACP believes that additional steps could be taken, during a period of stable payments such as proposed in H.R. 5707, to start more physicians on the road to better payment models, and reward “early adapters” who already have taken the leadership and risk of participating in new models like PCMHs and ACOs. During this transitional period, physicians would get higher updates for demonstrating that they have successfully participated in an approved transitional value-based payment program (VBP). We offer the following principles for developing a transitional VBP program:

1. ACP supports in concept the idea of providing an opportunity for performance based updates based on successful participation in an approved Transitional VBP initiative.
2. Transitional performance based update programs should be incorporated into a broader legislative framework to stabilize payments and transition to new models, such as that proposed in H.R. 5707. This is important so that physician and the Medicare program have a clear “destination” and pathway to achieving it, even as physicians begin the journey through the transitional VBP initiative.
3. Any transitional performance-based payment updates should be in addition to a higher “floor” on payments for undervalued primary care/preventive/and coordinated care services, such as that specified by H.R. 5707. This is important to address the continued under-valuation of these critically important services, even as payments also begin to reflect physician participation in the transitional VBP initiative.

4. The transitional performance-based payment program should include models for which extensive data and experience already exist, and that can more readily be scaled up for broader adoption by Medicare. Specifically, participation in the PCMH and PCMH-N models, as determined by practices meeting designated standards through an accreditation body and/or standards to be developed by the Secretary with input from the medical profession. Other established models that have demonstrated the potential to improve care coordination, such as ACOs, bundled payments, and global primary care payments should also be considered for inclusion in a transitional VBP program. In addition, physicians who agree to incorporate programs, like ACP's High Value, Cost-Conscious Care Initiative, into their clinical practice through shared decision-making with patients, might also qualify for a transitional VBP payment.
5. Existing QI/VBP payment models—the Medicare PQRS, e-RX, and meaningful use programs—if included in a transitional performance-based payment update program, should be improved to harmonize measures and reporting to the extent possible and to establish a consistent incentive program across all-elements. Efforts should also be made to align them with specialty boards' maintenance of certification programs.
6. Transitional performance based updates could be tiered so that programs that provide coordinated, integrated and patient-centered care get a higher performance update than less robust programs build on the current, silo-ed fee-for-service system.
7. CMS will need to improve its ability to provide “real time” data to participating physicians and practices. A method will need to be created to map practice-level participation in a transitional QI/VBP initiative to the individual physician updates under the Medicare Physician Fee Schedule.

ACP welcomes the opportunity to work with the Subcommittee and other physician organizations to develop the details of a transitional VBP initiative, as part of a broader legislative framework to repeal the SGR, stabilize

payments, provide higher updates for under-valued primary, preventive and coordinated care services, and transition to better payment and delivery models by a defined date.

SUMMARY AND CONCLUSION

Based upon our above responses, the College specifically recommends that:

1. Congress should look to the PCMH as being one of the most promising models for improving outcomes and lowering costs; learning from the extensive and growing experience in the private sector and from the new CPCi and Advanced Primary Care Initiatives in CMS as well as from private sector recognition and accreditation programs. We are confident that the PCMH model, and the related PCMH-Neighborhood, can be scaled up in the more immediate future, as part of a transition to better payment and delivery systems to replace the SGR and pure fee-for-service.
2. Congress and CMS should work with the medical profession on reducing barriers to the PCMH model, including facilitating the coordination of care among physicians and across settings; facilitating the use of health IT in meaningful ways; aligning the multiple federal initiatives with the goal of health care transformation, including timely payment to those physicians that meet the requirements of these initiatives; recognizing existing professional quality reporting and improvement activities where applicable, and facilitating participation in these initiatives by all payers.
3. Congress should support continued evaluation of Accountable Care Organizations, Advanced Payment ACOs, Prometheus, and other promising alternative payment models that could be offered to physicians, following a transition period, along with PCMHs.
4. Medicare should adopt payment policies that support the efforts by ACP and other physician membership organizations to provide guidance to physicians on high-value, cost-conscious care, including payment

policies to support shared decision-making strategies to engage patients in making decisions with their physician on their care, informed by evidence on value and effectiveness.

5. Medicare should make improvements in the existing Medicare physician fee schedule to create incentives for care coordination.
6. The Energy & Commerce Committee should report legislation to repeal the SGR, provide for stability in payments for all physicians, higher updates for undervalued care coordination, preventive, and primary care services, and transition to new payments and delivery models, working from the bipartisan Medicare Physician Payment Innovation Act, H.R. 5707.
7. Congress and the Medicare program should work ACP and other physician organizations to develop a transitional value-based payment initiative, which would provide higher updates to physicians who successfully participate in a transitional VBP initiative, consistent with the principles discussed above.

The College appreciates the opportunity to share our observations, experiences and recommendations on how Congress can work with ACP and others in the medical profession to advance comprehensive, patient-centered, and value-based payment and delivery system reforms.

Mr. PITTS. OK. Chair thanks the gentleman. Dr. Hoyt is recognized for 5 minutes.

STATEMENT OF DAVID B. HOYT

Mr. HOYT. Chairman Pitts, Ranking Member Pallone, and members of the committee, I wish to thank you for inviting the American College of Surgeons to discuss the role of quality and improving the Medicare physician payment system. My name is David Hoyt. I am a trauma surgeon and the Executive Director of the American College of Surgeons. The ACS appreciates your recognition that the current Medicare physician payment system and its sustainable growth rate formula are fundamentally flawed. We wish to be a partner in the effort to develop a long-term solution that improves the quality of care while helping to reduce costs. My comments today will focus on the College's efforts in the area of quality improvement and the use of an ACS program to propose a Medicare physician payment proposal called the Value Based Update, or VBU.

Our belief is that any new payment system should be part of an evolutionary process that achieves the ultimate goals of increasing quality for the patient and reducing growth in health care spending. Over the past year, we have improved our quality improvement principles into the VBU, a Medicare physician payment reform proposal. Our proposal is predicated on Congress finally eliminating the current SGR formula and fully offsetting the cost of permanent repeal. I will caution you that this is still a draft proposal. We look forward to working with Congress and other stakeholders to continue to develop this option.

In developing the VBU, we took the lessons learned in the American College of Surgeons National Surgical Quality Improvement Program, or NSQIP, and other quality improvement efforts and sought to expand them into the larger provider community. At the outset, we had a number of key concepts in mind. To be practical, we felt that the proposal must be patient-centered, politically viable, responsive to the changing needs of the health care system, and inspired by quality. Specifically, our proposal first compliments the quality-related payment incentives in current law and regulation, while making necessary adjustments in the current incentive programs to facilitate participation by specialists. Secondly, it incorporates the improvement of quality and the promotion of appropriate utilization of care into the annual payment updates. Third, it accounts for the varying contribution of different practices to the ability to improve care and reduce costs, and finally, it creates a mechanism to incentivize the provision of appropriate services that primary care can bring to the management of increasingly more complex medical populations.

The VBU accomplishes these goals by allowing physicians who successfully participate in CMS quality programs to choose quality goals for the specific patients or conditions they treat. Rather than basing compensation on overall volume and spending targets, the VBU bases performance on carefully designed measures. The VBU is designed to break down the—of care among physicians and to begin to measure service lines of care.

The central component of the VBU is the Clinical Affinity Group, or CAG. Each CAG will have its own patient-oriented, outcomes-based, risk-adjusted quality measures designed to foster continuous improvement and help lower costs. These measures will be crafted in close consultation with the relevant stakeholders, including the specialty societies, who in many cases are already developing measures and other quality programs on their own. Providers will select their Clinical Affinity Group, but will have to meet certain eligibility requirements, based on patients they see and conditions they treat. Physicians whose specialties would work in concert to meet specific quality measurement goals which have met would improve care and help drive down the cost of care. Physicians would be measured against benchmarks that both occur at a national and a regional level, allowing for continued innovation with medical communities. Finally, once implemented, physicians will have the opportunity to select their CAG on an annual basis. Goals can be adjusted regularly to ensure that the quality of care provided to the patient is continuously improving. Annual updates would then be predicated on this quality improvement. We believe this kind of a system will take 5 to 7 years to fully implement.

The College strongly believes that improving quality and safety offers the best chance for transforming our health care system. Cost reduction alone cannot be the primary driving force of change. Change must instead be driven by quality measurement. The ACS has a rich history in quality improvements, and we have distilled what we have learned into four basic principles: first, set appropriate standards; second, build the right infrastructure to deliver the care; third, use the right data to measure performance; and fourth, expose yourself to external verification through peer review.

The ACS NSQIP program is built on these principles, and is the prime example of how properly structured quality improvement leads to cost savings. Participating hospitals have been seen to reduce expensive complications, and it is these same principles that we are, in this program, promoting for a Medicare physician payment system.

Our next payment system should focus on individual patients and patient populations, and rely on physician leadership to achieve improved outcomes, quality, safety, efficiency, effectiveness, and patient involvement. Improving outcomes in care processes and slowing the growth of health care spending are, in fact, complementary objectives.

Thank you again, Mr. Chairman, for the opportunity to participate in this hearing.

[The prepared statement of Mr. Hoyt follows:]



**Statement of the
American College of Surgeons**

**Presented by
David Hoyt, MD, FACS**

**before the
Subcommittee on Health
Committee on Energy and Commerce
United States House of Representatives**

RE: Using Innovation to Reform Medicare Physician Payment.

July 18, 2012

Executive Summary

For nearly 100 years, the American College of Surgeons has led national and international initiatives to improve surgical quality. The College strongly believes that improving quality and safety offers the best chance of transforming our health care system in a way that expands access and improves outcomes while simultaneously slowing the growth in spending.

Over the past year the College has developed our quality improvement principles into a draft Medicare physician payment reform proposal called the Value Based Update (VBU). The VBU proposal is built upon a few key concepts. It is designed to be patient-centric, flexible, responsive to the changing needs of the health care system, inspired by quality and politically viable for all key stakeholders.

Under the VBU, physicians who successfully participate in existing individual-level quality programs would choose a set of quality goals for the specific patients or conditions they treat. Rather than basing compensation on overall volume and spending targets, the VBU adjusts compensation based on attainment of carefully chosen and properly designed quality goals.

The core of the VBU is the concept of the Clinical Affinity Group or CAG. A CAG is a group of physicians and providers who care for a specific condition, disease or patient population. Each CAG will have its own patient-oriented, outcomes-based, risk-adjusted quality measures designed to foster continuous improvement and help lower costs.

Based upon our rich history of quality improvement, the ACS strongly believes that Improving outcomes and care processes, and slowing growth in health spending are *complementary* objectives that are too often addressed separately.

Chairman Pitts, Ranking Member Pallone, and Members of the Committee, on behalf of the more than 78,000 members of the American College of Surgeons (ACS or the College), I wish to thank you for inviting the College to participate in today's hearing. My name is David Hoyt, I am a trauma surgeon and the Executive Director of the American College of Surgeons. The ACS appreciates your recognition that the current Medicare physician payment system and its sustainable growth rate (SGR) formula are fundamentally flawed and we wish to be a partner in the effort to develop a long-term solution that improves the quality of care while helping to reduce costs. The testimony today will focus on the new ACS Medicare physician payment proposal called the Value Based Update (VBU) and the College's leading efforts in the areas of quality improvement.

The College recognizes that developing a long-term solution to the Medicare physician payment system is a challenging, yet essential undertaking, especially given the need to limit the growth in health related spending. The College understands that the current fee-for-service model as the predominant form of physician payment is unsustainable. The ACS asserts that any new payment system should focus on individual patients and populations and rely upon physician leadership to achieve improved outcomes, quality, safety, efficiency, effectiveness, and patient involvement. Improving outcomes and care processes holds promise to reduce the growth in health care spending, complementary objectives that are too often addressed separately.

The ACS has a rich history of quality improvement efforts and our belief is that any new payment system should be part of an evolutionary process that achieves the ultimate goals of increasing quality for the patient and reducing growth in health care spending. We continue to assert that quality improvement and cost reduction are directly related objectives, and over the past year we have developed our quality improvement principles into the VBU, our Medicare physician payment reform proposal. Our proposal is predicated upon Congress finally addressing the flawed sustainable growth rate (SGR) formula and fully offsetting a permanent repeal. I will caution you that this is still very much a draft proposal, and we look forward to working with Congress and other stakeholders to continue to develop this option.

The Value Based Update Proposal

The Value Based Update proposal is built upon a few key concepts. The proposal must be patient-centric, flexible, responsive to the changing needs of the health care system, inspired by quality, and be politically viable for all key stakeholders. Specifically, the proposal should:

1. Complement the quality-related payment incentives in current law and regulation while making necessary adjustments in the current incentive programs to facilitate participation by specialists. This includes the Physician Quality Reporting System (PQRS), e-Prescribing (eRx), and meaningful use requirements for electronic health records (EHR).

2. Incorporate the improvement of quality and the promotion of appropriate utilization of care into the annual payment updates, first by utilizing existing quality measures but also by developing practice-specific quality priorities and measures in the future.
3. Account for the varying contribution of different practices to the ability to improve care and reduce costs. To do this we have shifted the focus to the patient and created the concept of Clinical Affinity Groups (CAG), each with its own evidence-based quality measures.
4. And finally, create a mechanism to incentivize the provision of appropriate services that primary care can bring to the management of an increasingly more complex medical population.¹

The VBU accomplishes these goals by allowing physicians who successfully participate in CMS quality programs to choose quality goals for the specific patients or conditions they treat. Rather than basing compensation on overall volume and spending targets, the VBU bases performance on carefully designed measures. It also makes sustained investments in primary care beginning in the early phases of implementation.

Implementation of the VBU will be a multi-step process, but must be preceded by immediate and permanent repeal of the SGR formula. While we are confident in the ability of quality improvement to save funds moving forward, the VBU does not

¹ There are significant physician workforce issues that must be addressed to ensure continued access to care across the country. The ACS believes that we must address these issues as a whole and not pit certain segments against one another.

seek to address paying down the accrued debt of the SGR, and therefore the ACS continues to advocate the use of savings in the Overseas Contingency Operations (OCO) account to offset this cost and allow a new system to be implemented.

The core of the VBU is the Clinical Affinity Group (CAG). In concept, a CAG is a group of physicians and providers who care for a specific condition, disease or patient population. CAGs might include categories such as cancer care, surgery, primary care/chronic care, cardiac care, frail elderly/end of life, digestive diseases, women's health and rural. Each CAG will have its own patient-oriented, outcomes-based, risk-adjusted quality measures designed to foster continuous improvement and help lower costs. These measures should be crafted in close consultation with relevant stakeholders including the specialty societies, who in many cases are already developing measures and other quality programs on their own.

A sufficient number and variety of CAGs must be created to accommodate all physicians. Physician compensation would be reflective of the quality of care provided at multiple levels, including through application of existing individual-level modifiers, performance of their specific CAG(s), and overall attainment of quality goals by all CAGs. Once fully implemented, goals can be adjusted regularly to ensure that the quality of care provided to the patient is continuously improving.

Continuous Quality Improvement

The College strongly believes that improving quality and safety offers the best chance of transforming our health care system in a way that expands access and improves outcomes while slowing the accelerating cost curve. Quite simply,

improving quality leads to fewer complications, and that translates into lower costs, better outcomes, and greater access. We offer a caveat – cost reduction cannot be the driving force of change; change must be driven by quality measurement. With the right approaches, we *can* both improve the quality of patient care and, at the same time, reduce health care costs.

The College has proven physician-led models of care that have allowed us to use clinically meaningful data to measure and improve surgical quality, reduce costs, and thereby increase the value of health care services. For nearly 100 years, the American College of Surgeons has led national and international initiatives to improve quality in hospitals overall, as well as the more specific fields of trauma, bariatric surgery, cancer, and surgical quality. These initiatives have been shown to significantly reduce complications and save lives.

Complex, multi-disciplinary care – such as surgical care – requires a commitment to continuous quality improvement. Surgeons have a long history of developing standards and holding themselves accountable to those standards. Four years after ACS was founded in 1913, leaders such as pioneering surgeon Earnest Codman of Boston helped to form the Hospital Standardization Program in 1917, which became The Joint Commission in 1951. Dr. Codman believed it was important to track patient “end results” and use those results to measure care, learn how to improve care, and set standards based on what was learned.

Since then, the College has helped establish a number of key quality programs, including the Commission on Cancer in 1922, the Committee on Trauma

in 1950, the American College of Surgeons Oncology Group in 1998, the National Surgical Quality Improvement Program or “ACS NSQIP” in 2004, and the National Accreditation Program for Breast Centers and the Bariatric Surgery Center Network Accreditation Program, both in 2005.

Based on the results of our own quality programs, we have learned that there are four key principles required for any successful quality program to measurably improve the quality of care and increase value. They are:

- Setting appropriate standards
- Building the right infrastructure
- Using relevant, timely data to measure performance
- Verifying the processes with external peer review

Establishing, following, and continuously improving **standards** and best practices is the core for any quality improvement program. Standards must be set based on scientific evidence so that surgeons and other care providers can choose the right care at the right time given the patient's condition. It could be as fundamental as ensuring that surgeons and nurses wash their hands before an operation; as urgent as assessing and triaging a critically injured patient in the field; or as complex as guiding a cancer patient through treatment and rehabilitation.

The right **infrastructure** is absolutely vital to provide the highest quality care. Surgical facilities must have in place appropriate and adequate infrastructures, such as staffing, specialists and equipment. For example, in emergency care, we know hospitals need to have the proper level of staffing, equipment such as CT scanners,

and infection prevention measures such as disinfectants and soap dispensers in the right quantity and in the right locations in their emergency departments. If the appropriate structures are not in place, the risk for the patient increases. Our nation's trauma system is an example of the importance of having the right infrastructure in place. The College has established trauma center standards for staffing levels and expertise, processes, and facilities and equipment needed to treat seriously injured patients. Trauma centers are independently verified by the Committee on Trauma and receive a Level I, II, III or IV designation, based on the care they are able to provide. Ideally, the most challenging cases are immediately rushed to the nearest Level I or Level II center. There is good scientific reason for this: Patients who receive care at a Level I trauma center have been shown to have an approximately 25 percent reduced mortality rate.

We all want to improve the quality of care we provide to our patients, but hospitals cannot improve quality if they cannot measure quality, and they cannot measure quality without valid, robust **data**. The College has learned that surgeons and hospitals must have sufficient relevant data to yield a complete and accurate understanding of the quality of surgical care. This data must also be comparable with that provided by similar hospitals for similar patients. Therefore, it is critical that quality programs collect information about patients before, during, and after their hospital visit in order to assess the risks of their condition, the processes of care and the outcome of that care. Today, patients' clinical charts – not the current insurance or Medicare claims – are the best source for this type of data. Eventually, capturing

the relevant data from electronic health records should enhance accuracy and timeliness.

The fourth principle is to **verify**. Hospitals and providers must allow an external authority to periodically verify that the right processes and facilities are in place, that outcomes are being measured and benchmarked, and that hospitals and providers are responding appropriately to the findings. The best quality programs have long required that the processes, structures, and outcomes of care are verified by an outside body. The College has a number of accreditation programs that, among other things, offer a verification of standards that help ensure that care is performed at the highest levels. Whether it is a trauma center maintaining its verification as Level I status or a hospital's cancer center maintaining its accreditation from the Commission on Cancer, the College has long stressed the importance of review by outside authorities. Undoubtedly, increased emphasis on such external audits will accompany efforts to tie pay to performance and to rank the quality of care provided.

Together, these principles form a continuous loop of practice-based learning and improvement in which we identify areas for improvement, engage in learning, apply new knowledge and skills to our practice and then check for improvement. In this way, surgeons and hospitals become learning organisms that consistently improve their quality – and, we hope, inspire other medical disciplines to do so as well.

ACS NSQIP is built on these principles. The ACS NSQIP program, which has its history in the Veterans Health Administration, is now in more than 400 private sector hospitals around the country. ACS NSQIP uses a trained clinical staff member to collect clinical, 30-day outcomes data for randomly selected cases. Data are risk adjusted and nationally benchmarked, so that hospitals can compare their results to hospitals of all types, in all regions of the country. The data are fed back to participating sites through a variety of reports. Guidelines, case studies and collaborative meetings help hospitals learn from their data and implement steps to improve care.

ACS NSQIP hospitals have seen significant improvements in care; a 2009 *Annals of Surgery* study found 82 percent of participating hospitals decreased complications and 66 percent decreased mortality rates. Each participating hospital prevented, on average, from 250 to 500 complications a year. Given that major surgical complications have been shown in a University of Michigan study to generate more than \$11,000 in extra costs on average, such a reduction in complications would not only improve outcomes and save lives, but greatly reduce costs.

If ACS NSQIP can be expanded to the nation's more than 4,000 hospitals that perform surgery, we could prevent millions of complications, save thousands of lives, and recoup billions of dollars each year. ACS NSQIP's success will require collaboration from the broader surgical community; other providers, including hospitals; healthcare policy experts; and government officials and elected

representatives. We need to get ACS quality programs into more hospitals, more clinics, and more communities.

Implementation of the *Patient Protection and Affordable Care Act* is intensifying the focus on quality by requiring hospitals and providers to be increasingly accountable for improving care through measurement, public reporting and pay-for-performance programs. By taking an outcomes-based approach that relies on setting and following standards, establishing the right infrastructure, collecting the right data, and outside verification, we have shown that complications and costs can be reduced and care and outcomes improved on a continual basis.

The College welcomes the focus on quality and believes it offers an extraordinary opportunity to expand the reach of our programs and, most importantly, puts the country's health care system on a path towards continuous quality improvement. The evidence is strong: We *can* improve quality, prevent complications, and reduce costs. That's good for providers and payers, government officials and taxpayers. Most of all, that's good for patients.

Again, while we acknowledge the need to further develop the VBU proposal, we strongly believe in the concept of tying physician Medicare reimbursements to the quality of the care provided as reflected in quality measures that are meaningful and directed specifically at the type of care that a physician provides to his or her patients. We believe that controlling health care costs in Medicare should be achieved not through methods that would endanger patients' access to care², but

²The College is concerned about the impact of the Independent Payment Advisory Board (IPAB), which is scheduled to make recommendations on overall Medicare spending in 2014. The College remains vitally

through improving quality and value, and we are confident that the ACS's Value Based Update proposal is a step in that direction. The ACS appreciates the opportunity offered by the Chairman and the committee to share the College's draft proposal and comments about its quality programs.

concerned that, should the SGR remain in place when the IPAB takes effect, physicians will be subject not only to the SGR but also to further reductions in Medicare reimbursement based on IPAB's authority. In tandem, we believe the IPAB and SGR hinder the ability to transition to a new physician payment system; acting as blunt and flawed budgetary axes, and endangering seniors' access to high quality care in the Medicare program.

Mr. PITTS. Chair thanks the gentleman, and now recognizes Dr. Patel for 5 minutes for opening statement.

STATEMENT OF KAVITA PATEL

Ms. PATEL. Thank you, Chairman Pitts, Ranking Member Pallone, and members of the Health Subcommittee for inviting me to testify today on this important topic. My name is Kavita Patel, and I am a fellow at the Engelberg Center for Health Care Reform at the Brookings Institution, and a practicing primary care physician.

Industries are often challenged with redefining what their business models are, and how they produce value. Health care is at this crossroad now. As a country, we are presented with an opportunity to make care and how we pay for it more rational, more productive, and better able to meet the needs of the American people. I would like to highlight the following key points, and then elaborate with a couple of clinical examples to illustrate a pathway forward in the near and short term, away from our current fee-for-service system.

One thing that is very clear is that our current reimbursement system does not incentivize the type of clinical practice efficiency that promotes value in care. We have heard from my other panelists, and as all of you have testified yourselves, this is a fact.

Number two, innovations in clinical practice must be paired with timely and usable data from CMS and other payers, robust quality metrics and transparent measurement that is consistent. The timeliness and transparency of this is essential. Receiving data a year or even 6 months after your clinical practices are going on is not going to help physicians and other clinicians change the way they deliver care in that moment, and this has been an often criticized setback from a multitude of payers.

Third, over the next several years—not decades, not even more than 5 years—I would say over the next several years we must migrate towards a model that deals with coordination of care, as other panelists have outlined, but more importantly, sets a sight on translating that coordination of care into a larger, episodic or more globally-based payment model that takes into consideration the very flexibilities that we need for different types of clinical efficiencies. One size does not fit all, and we must therefore allow for flexibility in this transition. In this process, however, the importance of taking what we are currently doing right now and translating that into something that is more coordinated towards the path of flexibility is the way to move forward today from our current system.

For example, the American Board of Internal Medicine Foundation has already called upon a number of specialties to say what are we doing right now that we do not need to be doing? This is something that the professional societies have corralled around to say, “Here are the top five things we each know that we do not need to be doing.” This is a perfect basis from which we can take current reimbursement and translate that by clinically evidence-informed models into a different form of payment towards that pathway for more coordinated care.

I will offer you an example in cardiology, since that gives us a great way of identifying one, some that the professional societies

have agreed to. For example, in cardiology, a universal recommendation was to not perform stress cardiac imaging or advanced noninvasive imaging in the initial evaluation of patients without cardiac symptoms unless high risk cardiac markers are present. Sounds very straightforward; however, this is a very costly expense to Medicare today. So translating some of these services that have been brought forward by physicians and other clinical leaders into a case-based payment could get us on a pathway away from what we currently do today. Two practices in very different parts of the country are already doing this in cardiology, and have found reductions in cardiac spending on the level of millions of dollars, but they can't get payers to take them up on it. They are simply proposing a novel way to translate how they deliver care to patients with chest pain and with congestive heart failure with communications between primary care physicians, cardiologists, hospitalists, surgeons, and other specialists. A way to communicate through test messaging, e-mail, when we need to have a consult with a cardiologist, allowing for primary care physicians to be able to readily access that specialist and open an honest, timely delivery of data between physicians will allow for this type of care coordination that I described, all with the purpose of helping to teach clinicians how they can better reduce the numbers of services that they provide that they have acknowledged that do not provide value. That is one example in cardiology.

The second example, a short one, in primary care and behavioral health. We have a critical shortage of psychiatrists and mental health professionals in this country, yet depression and other mental illnesses are an overwhelming problem in primary care. Translating some of what we currently do to allow for better collaboration between a telepsychiatrist, for example, who does not need to see a patient, and a primary care physician to offer advice for high risk management is exactly the type of payment model that can move us away from our fee-for-service system.

I have many more examples with tangible savings that could be accomplished today; however, payers, including those that are public and private, need to be responsive to do this, and it can start with action by Congress.

I hope that I have illustrated that not only does one size not fit all, but that there are absolutely elements of our current reimbursement system that we must retain in order to improve. And that instead when we give providers more flexibility, we can accomplish this in both the short term as well as deal with what we have started with the SGR.

I thank you and welcome any questions.

[The prepared statement of Ms. Patel follows:]

**STATEMENT BY
KAVITA PATEL MD, MS**

**Hearing on "Using Innovation to Reform Medicare Physician Payment"
Committee on Energy and Commerce
Subcommittee on Health**

**United States House of Representatives
July 18, 2012**

Kavita Patel, MD, MS
Fellow, Economic Studies and Managing Director
Engelberg Center for Health Care Reform
Brookings Institution
1775 Massachusetts Ave. NW
Washington, DC 20036
202-797-2475
kpatel@brookings.edu

**House Energy and Commerce Committee
Subcommittee on Health
“Using Innovation to Reform Medicare Physician Payment”**

Summary of Written Testimony

Payment reform in Medicare is at a critical juncture. Important initiatives have been started by the Centers for Medicare and Medicaid Innovation (CMMI) but they must be coupled with innovations that are also taking place around the country with little acknowledgment by payers—public or private. In most cases, these innovations are inspired by the stories of patients and the struggles of many clinicians to help deliver the best care in the country.

In my testimony, I summarize the challenges of a fee-for-service (FFS) reimbursement model and illustrate using current ongoing clinical examples that it is indeed feasible to start moving from payments solely based on FFS to payments that give providers more flexibility to improve the efficiency and quality of their own services and support better coordination with potential savings from overall system wide savings.

Introduction

Mr. Chairman, members of the Subcommittee, fellow members of this panel- as a practicing physician and Fellow at the Engelberg Center for Health Care Reform at the Brookings Institution, it is a privilege and an honor to have been invited to participate in this hearing today. I congratulate the Committee for its willingness to confront the difficult issues surrounding Medicare payments to physicians by looking to innovative clinical practices, ideas and solutions.

The current problem of physician payment is not new and is part of a series of bipartisan legislative efforts aimed at creating a stable system of Medicare physician payment rates and yearly updates to keep health care spending in line with overall economic growth year over year. First, legislation creating the Resource Based Relative Value Scale (RBRVS) was enacted in 1989 and led to the development of relative value units, or RVUs, for each of the physician-related services paid for in the traditional Medicare program. As the number of billable service codes grew over time, an extensive regulatory process was enacted to develop RVU weights and update them year over year. The goal of these updates was to keep the (relative) payments made by Medicare to accurately reflect the value of services.

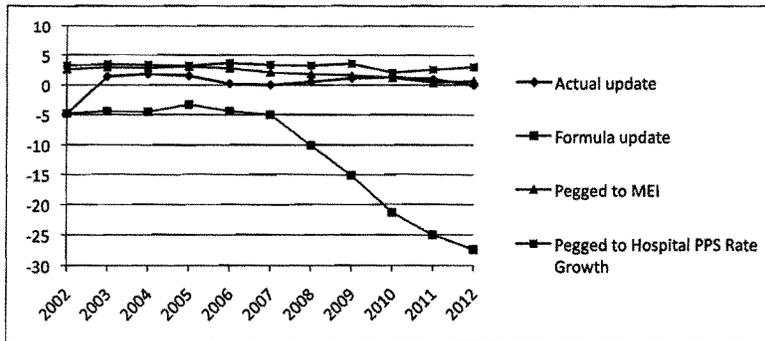
The problem with this approach is the development of the term “relative.” Over time, the RVU updating system has placed an increasing importance, evidenced by RVU weights, on procedures, scans, and other technical services that fix certain ailments or problems. This has resulted in an emphasis on volume over value and the maintenance of silos in health care, which have eroded the quality of care we deliver to our patients. Non-technical or nonprocedural physician services, including for example “cognitive” services such as spending time with a patient reviewing the risks and benefits of a treatment course or a counseling session to help a patient exercise more or eat healthier foods, have not received significant RVU weight increases over time. Additionally, new services such as email consultations and new approaches to care such as nurse or pharmacist-led care management teams may not be included at all in the list of covered services. These omissions in the RVU system are even more significant as we head into an era of more personalized medicine where the right treatment at

the right time for each patient is increasingly individualized-where some patients with heart disease may benefit from a certain imaging procedure but others may not.

The 1997 Balanced Budget Act inadvertently exacerbated the problem with the introduction of the sustainable growth rate or SGR. The SGR was intended to keep the growth in Medicare physician-related spending per beneficiary in line with growth in the nation's gross domestic product (GDP). In the early years of the SGR, this worked fine, as spending growth was lower than the calculated GDP target and payment rates for physician services increased. But starting with the recession in 2002, spending growth per beneficiary began to exceed GDP growth. In 2002, payment rates were reduced accordingly, by 4.8 percent.

Every year since then, the scheduled SGR payment rate reductions have not taken full effect. Instead, because of concerns about access to care and the sufficiency of payments, Congress has headed off the full payment reductions on a short-term basis. Typically, this has involved offsetting at least some of the budgetary costs with payment reductions affecting other Medicare providers. These short-term patches have not kept up with inflation: between 2000 and 2010, the total cumulative increase in physician payment rates in the Physician Fee Schedule was 8 percent, while the "market basket" for physician services (the Medicare Economic Index) rose 22 percent.¹ As Figure 1 illustrates, actual updates as well as the SGR formula update still grow at rates far below input costs (MEI) and payment rates for other providers, thus exacerbating systemic flaws. The system is permanently broken.

Figure 1: Percent (%) Change of Payment Update Under Multiple Scenarios



Source: CMS Office of the Actuary

So here we are today, facing yet another possible physician payment cut of 27 percent, and we ask ourselves, “What can be done?” First, we must achieve a long-term vision for payment reform that will help chart a path towards clinician-driven, evidence-based medicine that preserves the autonomy of the physician-patient relationship while moving the profession towards greater accountability. Then, we must look to current innovations, especially those that are clinician-led to help us achieve broader system wide savings.

A Long-Term Vision for Innovation in Physician Payment

The goal of any meaningful Medicare physician payment has to have three essential elements. First, payments must incentivize coordination between providers and across different provider settings. The treatment and management of chronic diseases, acute illness, and prevention and health promotion does not occur within a single physician office or with a single physician or other provider for most individuals. It occurs between specialists in the hospital, in outpatient and rehabilitation facilities, in pharmacies, in community-based organizations, and in the home. The payment system must recognize that incentivizing providers to work together across these divisions is crucial to both the improvement of care for patients and the reduction in unnecessary, redundant, and sometimes harmful or deadly care. Up to \$45 billion dollars in health spending each year are attributed to failures in coordination, up to \$226 billion in overtreatment and up to \$389 billion in administrative complexity.ⁱⁱ

Second, payments must inject flexibility into physician practices and clinical processes to remove the sole reliance on the provision of services, tests, and drugs as sources of income. The current fee-for-service model (FFS) incentivizes behaviors that are not in the best interest of patients in many cases and places the emphasis on volume over value and patient-centeredness. In addition, in the era of accountable care—that is, providers being held accountable for the cost and quality of the care that they deliver to patients through financial means—there are numerous elements of care that do not currently fit into the FFS model and are thus uncompensated. Services such as extended office visits, email correspondence, end-of-life counseling, comprehensive treatment plan development and tracking, and critical health IT

infrastructure are not part of any fee schedule. Yet these elements of care have been proven to improve the quality of care *and* lower the overall total cost of care for patients. Any savings from investments made in these areas by providers goes straight to payers.

Third, payments must be tied to appropriate performance and quality measures and embedded into continuous quality improvement programs. This ensures against providers withholding care or providing cheaper care at the expense of patient needs to increase their income. This also reinforces incentives for physicians to adhere to established guidelines, practice evidence-based medicine, and treat patients individually.

With those three elements in mind, it is also important to reinforce that the transition to a new payment system for physician services must occur in stages. A switch to a complete non-FFS system cannot possibly happen in the short term. But it is critical to put into place a process to begin the transition away from a pure volume based, FFS system toward a flexible, blended payment system with payments tied to quality and performance measures, and aligned to coordinated care processes.

At the Engelberg Center for Health Care Reform at Brookings, we have been working with physicians, clinical societies, and other provider groups to start defining the pathway forward, and as a practicing physician, I understand how critical it is to work directly with these groups to make significant progress on this path. We also highlight several key efforts across a variety of specialists with tangible reductions in cost and improvements in quality.

Innovation in the Public Sector

A significant number of important steps to achieve meaningful payment reform have started within the Center for Medicare and Medicaid Innovation (CMMI), including models for bundled payments, coordination among multi-payers in comprehensive primary care and Pioneer Accountable Care Organizations, but I will focus on reinforcing our long-term vision for physician payment by also highlighting where transformation is taking place outside of CMMI. These innovations are noteworthy since in some cases, they have been in place for years with little recognition and acknowledgement by public or private payers. In terms of advancing CMMI's initiatives, there is broad consensus that the Secretary should advance payment

reforms as quickly and responsibly as possible in order to create force multipliers that can achieve the long-term vision outlined above. In particular, I encourage CMMI to identify mechanisms to further their multi-payer efforts such that the important work conducted in the Engelberg Center and elsewhere will transform the delivery system. Finally, the recently announced Challenge Grants offer great insights into clinical innovation. A proposal by Dr. Barbara McAneny of New Mexico Cancer Center (NMCC) was awarded a CMMI grant to expand staff and hours of operation NMCC's staff and hours of operation to provide an alternative to expensive and inconvenient emergency department services. Under the grant, NMCC will be comparing its quality of care and the cost of care with control-group practices and hospital-based systems. By the end of the third year, Dr. McAneny and her practice colleagues will have a better understanding of all facets of cancer care costs so they can provide a bundled payment mechanism. There is indeed great promise in these examples that should be brought to scale for the nation.

Innovations Informed by Clinical Leadership

Frustrated by the growing cost of care and the scarce time with patients to address important issues, physicians and other clinical leaders are already moving to implement delivery system transformations that are improving care and reducing the total cost of care, many of which are unfunded or uncompensated by payers but still offer the best promise for better care everywhere. Several of my fellow panelists will highlight these efforts.

For example, teams of physicians and health system leaders in Portland, Oregon have implemented an innovative cardiology program led by Drs. Xiaoyan Huang and John Peabody aimed at improving quality, lowering costs and advancing the patient care experience. Known as the Accelerating Clinical Transformation for Cardiovascular Disease (ACT-CVD) Program, the team is redesigning the care of cardiovascular disease by bringing together cardiologists, hospitalists, and primary care providers in a dense urban population in Oregon. Working toward a full-scale system transformation, they have changed care in two general areas: clinical and business. The clinical work has centered on identifying disease specific quality improvements, determining care coordination between specialists and primary care providers,

7

streamlining workflows for high-risk patients, and adoption of appropriate use criteria. The parallel stream of business activities has led to the creation of a large cardiac disease episode of care/bundle to aggregate all cardiovascular costs (approximately \$15,000 per patient per year for the high-risk population), the generation of budget expectations for the population, and new physician contract language that incorporates quality and the patient experience. Quality and savings opportunities identified include the following:

- Chest pain phone triage to reduce unnecessary ER referral and utilization
- Congestive Heart Failure Nurse Practitioner and Physician Assistant case management
- Use of comparative effectiveness research to ensure appropriate use of stress testing and teaching aids for students, residents and fellows to better understand true cost of care
- Tele-medicine consulting including live chat with cardiologists and electronic medical record review
- Co-management of high risk patients between cardiology, surgery, hospitalists, and primary care physicians

The Oregon ACT-CVD program estimates a potential savings of approximately \$49.4 million in a target patient population of 77,000 lives connected by hundreds of cardiologists and primary care physicians. But the program still struggles to achieve broad scale largely due to competing incentives in the current reimbursement system—simply put, it is very hard to do this work when the innovations are not recognized by codes, claims, or payers.

Innovation led by physicians is also helping to shape interactions between the multitudes of specialists involved in medical decision-making around cancer care. Dr. John Sprandio, a medical oncologist in Pennsylvania, has changed his practice to promote the concept of a patient-centered medical oncology home (PCMOH). The concept advocates investments in electronic health records, standardization of documentation, physician document review processes, referring/consulting physician access to records, current and longitudinal data reporting, assessment plan development and customization, telephone triage, palliative care programs, and a number of patient tracking processes as the bedrock of their

enhanced oncology provider model.ⁱⁱⁱ Participation in quality efforts advanced by professional oncology societies gave Dr. Srandio specialty specific quality metrics to ensure that his care was consistent with the latest guidelines and clinical pathways.

In just five years, his practice saw significant reductions in both ED visits and hospital admissions leading to significant savings to the system overall, but he faced a dilemma—he was still practicing in a RVU driven, FFS environment that did not necessarily reward any of these innovations, and as a result, there were times when Dr. Srandio found it challenging to subsidize the coordinated care. Despite this, he persevered. Imagine if payment mechanisms were aligned to incentivize this type of coordination.

Innovation is also occurring in the fields of primary care and other specialties as physicians are consistently voicing concerns that the lack of support for *meaningful* communication between primary care and specialties results in a breakdown in the management of patients.^{iv} A perfect example of an innovative solution to deal with this is in the field of behavioral health care. Patients suffering from depression often fail to seek treatment and primary care physicians often feel overwhelmed with cases that might require more intense monitoring or involvement of an already time constrained and often inaccessible mental health specialist. A multisite effort in the states of Washington , California, Indiana, Texas, and North Carolina (known as the IMPACT Project) aimed to deal with these issues began over a decade ago led by a team of clinicians and quality improvement experts. Primary care practices in eight FFS and capitated settings agreed to engage several depression care managers and a consulting psychiatrist who could electronically review charts and speak with the PCP regarding complex patient treatments. Cost of the care manager and consulting psychiatrist as well as research to study the program’s effects were subsidized by philanthropic foundations and internal resources. The care manager would ensure that close follow-up was scheduled and that care did not “fall through the cracks” as they often do in transitions between primary care and specialties. The consulting psychiatrist worked virtually, covering multiple practices at a time and working over weekends if necessary. Savings of approximately \$896 per patient per year were sustained along with demonstrable improvement in mental health outcomes and other indices of chronic disease. Diabetics with depression improved their

glucose control. The potential for scale is great, but incentives to change the system are few and far between and all too often, great cost saving opportunities go unrealized.

There are many more examples in additional specialties and primary care—all with the theme that reinforces the need for a payment system that is flexible to innovation but provides a path towards better coordination of care and quality improvement. There will be elements of the FFS system that will need to be retained in this transition and potentially beyond but that should no longer delay progress to achieving better care at a lower cost.

The Importance of Data in Driving Innovation in Medicare Payment

Now that I've highlighted the long-term vision and the innovations in the public and private sectors, I must emphasize the role of data in reinforcing principles of payment reform. Physicians and other clinicians believe in data and are driven to improve their performance based on data. Perhaps the biggest tool we can give physicians to drive care quality and cost savings is relevant, timely, actionable data about their patient populations—both clinical and financial. The current state of quality and performance measurement suffers from a few deficiencies. All too often, measures mandated by CMS and other payers are heterogeneous and do not accurately reflect the nature of an individual specialty or population of patients. For example, many of the CMS Physician Quality Reporting System (PQRS) measures are not necessarily broadly applicable to specialties such as cardiology or orthopedic surgery, yet these are important specialties which play a significant role in both cost and quality. The same is true for stage one Meaningful Use Measures—they are essential to usher medicine into the technological age but are largely process measures and not necessarily relevant across health care disciplines. Reporting back to clinicians must also be timely and actionable—this is a promising aspect of the CMMI Pioneer ACO program that is engaged in timely data feeds to clinicians. Receiving patient outcomes data even one to two months much less years later does no good.

An attempt to strengthen significant quality measurement has propelled clinical societies to develop quality improvement programs using unique, clinically vetted, peer-reviewed quality and performance measures. These programs are often completely self-funded,

and voluntary from an implementation standpoint, yet have shown incredible promise as vehicles for uniform care improvement and cost reduction. Clinicians developing the measures draw clear lines around conflict of interest and transparency is of the utmost importance. The American Society of Clinical Oncology has developed and refined their Quality Oncology Practice Initiative (QOPI), a clinically approved high-performing set of oncology related practice quality and performance measures. The Society of Thoracic Surgeons (STS) has been a vanguard in developing registry-based quality metrics that have largely moved the profession from great variations in quality and cost to a model for others to follow. Cardiology is doing the same with the National Cardiovascular Data Registry (NCDR), a comprehensive, outcomes-based quality improvement program representing approximately 11 million patient records that can support quality improvement in congestive heart failure and other cardiac conditions. More examples can be found in other clinical disciplines; a payment system that acknowledges this important work can be paramount in ensuring that a transition from our current payment system to a broader vision can be done with high expectations around quality and measurement reporting.

Supplying Medicare data on these clinician-developed measures and creating a payment system based on performance on these measures over the long term will drive cost reductions and care improvements. Additionally, there are efficiencies of scale to be gained from promoting consistent measures that are developed, collected and reported in a more homogenous manner—practices having to juggle six to eight different quality reporting streams to achieve payment bonuses only exacerbates waste and the silos in health care.

We need to move to a system of quality and performance measurement and reporting that takes advantage of the leadership already shown by many specialty groups to define unique, clinically approved, appropriate measures; incentivize participation in reporting programs; and, ultimately, move over time to a payment system that rewards high performing providers on these issues and penalizes those who do not.

Moving Forward Now

The path forward is not easy but the opportunity cost of doing nothing is no longer tenable. I hope that I have illustrated that it is feasible to start moving now from payments

based on FFS to payments that instead give providers more flexibility to improve the efficiency and quality of their own services, and also to support better coordination, with potential additional support and savings from overall system wide savings. These system wide savings have been well documented and are found in reductions in unnecessary care, administrative simplifications that allow for streamlined quality measurement and transitions in care, timely data reporting, and cost transparencies. It is important to note that while I have focused on examples led by physicians, these are interdisciplinary efforts that reflect the depth and breadth of a great deal of health professions, some of which face significant shortages and supply issues that are significantly affected by disparities in reimbursement.

Thank you again for allowing me to participate in this hearing today and I look forward to further dialogue on this issue.

ⁱ Centers for Medicare and Medicaid Services Office of the Actuary, accessed July 14, 2012

ⁱⁱ Berwick DM, Hackbarth AD. Eliminating Waste in US Health Care. *JAMA*. 2012;307(14):1513-1516. doi:10.1001/jama.2012.362

ⁱⁱⁱ Sprandio J. 2010. Oncology-Patient Centered Medical Home and Accountable Cancer Care. *Community Oncology*. 7(12):565-572

^{iv} Referral and Consultation Communication Between Primary Care and Specialist Physicians: Finding Common Ground. *Arch Intern Med*. 2011;171(1):56-65.

Mr. PITTS. The Chair thanks the gentlelady, and that concludes the opening statements.

I have a unanimous consent request. The chair requests the following statement be introduced into the record. It is a statement by Garrison Bliss, M.D., President of Qliance Medical Group, Seattle, Washington. You have seen it. Without objection, it is so ordered.

[The information follows:]

**Statement of Garrison Bliss, MD
President, Qliance Medical Group
Seattle, WA**

**Written Testimony Submitted for the
Energy and Commerce Subcommittee on Health Hearing:
Using Innovation to Reform Medicare Physician Payment**

July 18, 2012



Chairman Pitts, Ranking Member Pallone, distinguished members of the Subcommittee on Health. It is my pleasure to present testimony to subcommittee today regarding on ideas to replace the Medicare Sustainable Growth Rate (SGR) payment formula and to shift away from Fee for Service (FFS) payments, which creates enormously inappropriate incentives in our healthcare system and leads to poor health outcomes and much higher costs. I bring a primary care physician's perspective to the debate and offer some concrete and rather simple solutions to the huge problems facing primary care providers with Medicare and private insurance alike. A start to those solutions lies in bipartisan legislation introduced by Representative Bill Cassidy, MD along with former Rep. Jay Inslee (D-WA) called the Direct MD Care Act, which I will address later in my testimony.

Fee for Service in Primary Care

Fee for Service (FFS), bluntly speaking, simply does not work as a payment system for primary care. Paying physicians by the procedure puts an emphasis on volume over high quality clinical care. I personally chose to abandon the FFS system and its arbitrary payment formulas 15 years ago in favor of a flat monthly fee model our patients and practitioners alike feel makes the most sense for the delivery of top notch primary care services. Thousands of physicians have followed this trend since then in a variety of different models.

I founded Qliance Medical Group in Seattle in 2005, building on my experience pioneering the Direct Practice model over the 10 years prior, with the goal of offering exceptional access for all Americans to the best primary care services for a low monthly fee, operating separately from traditional insurance plans. Since one of our key business goals is to retain patients, we are driven by medical outcomes, patient satisfaction, and creating value in a system that promotes quality over volume.

The high overhead and low reimbursement associated with primary care FFS in Medicare necessitates what I call the "hamster wheel" effect for physicians. Doctors must see 25-35 patients in a day just to cover overhead. In many cases, this means they cannot spend sufficient time with each patient to make the proper diagnosis, recommend treatment, and then work with the patient to help them come to the best decision for themselves. The result is clear: doctors miss things, and patients don't get the care they need, let alone truly understand their own health. And in an environment where 75% of the increase in healthcare spending is due to the rise in prevalence of preventable chronic disease, we simply cannot afford to keep on missing things. This drives patients from low cost primary care—fixed cost in our DPCMH model—to much more expensive treatments in the ERs, hospitals, with specialists. All primary care doctors are pretty good at diagnosing Type II Diabetes when it has progressed. What we need to do, however, if we are going to get a hold of higher costs is to diagnose the pre-diabetic patients and the depression and co-morbidity that goes with most of these chronic conditions so that we can prevent complications and improve outcomes. And you can only do that if you have time to spend with your patient. The DPCMH model shifts the focus of care back to primary care and gives the physician the time they need to do good medicine.

The FFS system creates financial disincentives for patients to seek as much care as needed, whenever needed, in the lower-cost part of the healthcare system. Because of deductibles, co-payments or co-insurance, there is a tendency to delay care until issues evolve into more serious problems that are

more costly to treat. In addition, it can create a disincentive to seek sufficient preventive care (which is why insurance must now include certain preventive care for “free”).

FFS also drives existing providers and medical students away from primary care, since the “hamster wheel” practice style leads to unsatisfying relationships with patients, excessive administrative burdens, and tedious workdays. DPCMH practices, on the other hand, attract them back into primary care, offering them sufficient time with each patient to provide the care they were trained to provide, satisfying doctor-patient relationships, professional growth, and a balanced lifestyle. In other words, a strong primary care foundation is critical to a well-functioning, cost-effective health care system, for patients and providers alike.

The Qliance Model

Under our flat fee model, patients between \$49 – \$89 per month based on age for comprehensive primary care services, regardless of health status. There are no barriers to utilizing primary care services, as there are no co-pays or additional fees, and patients can be seen the same or next day for urgent health care matters. Qliance offers appointments seven days a week, with extended hours Monday through Friday. Patients can also be in contact with their primary care provider by phone or email, and enjoy unrestricted 30-60 minute appointments. When the office is closed, patients always have direct phone access to a physician from the practice for urgent matters. Qliance eliminates the costs and time associated with insurance billing and fee for service, allowing providers to invest all their time and energy in providing exceptional access and high quality care for their patients. Since primary care, when operating as it is supposed to, can address up to 90% of patients’ healthcare needs, Qliance is able to diminish its patients’ dependence on the more expensive parts of the system. And patient response to Qliance has been extremely positive. Patients appreciate the low cost, excellent access and amount of time their doctor is able to spend with them.

Analysis of internal data as well as total claims data from self-insured companies whose employees select Qliance for their primary care show that, under the Qliance model, utilization of emergency room, hospital, specialty care, advanced radiology and surgical care are greatly diminished. This decrease in utilization translates to a savings of approximately 22% in overall healthcare costs. Initial Qliance data demonstrate a significant reduction in utilization of downstream medical services as seen in Table 1:

Type of Referral	Qliance # per year, per 1000 patients	Regional Benchmark*	Difference**
ER Visits	60	158	-62%
Hospitalizations (in days)	136	184	-26%
Specialist Referrals	909	2000	-55%
Advanced Radiology	414	800	-48%
Surgeries (#/1000/year)	33	124	-73%
Surgeries (# days/1000/year)	83	168	-51%

*Based on regional benchmarks from Inqurix and other sources. **Based on best available internal data, may not capture all non-primary care claims
Source: Qliance Medical Group Non-Medicare Patients, 2009 (n=2,316)

Direct Primary Care Medical Homes (DPCMH) in Medicare

CMS has no provision to cover monthly fee based payments to primary care physicians who treat Medicare patients. Section 1301 (a) (3) of the Patient Protection and Affordable Care Act would allow state-based healthcare exchanges to offer coverage through a DPCMH plan operating in combination with a wrap-around insurance policy as long as the two together satisfy all exchange coverage requirements. Medicare patients should have access to this model as well, as a means of controlling costs and improving health outcomes in this growing high-need population.

This is especially important for dual eligible beneficiaries who are the most expensive and chronically ill of all patients. Per capita spending among dual eligibles exceeds \$20,000 per year. The duals make up a small percentage of total enrollment—just over 9 million individuals, yet they account for 36 percent of total Medicare spending. Dual eligibles have high rates of chronic illness. Over half of all dual eligibles are under treatment for 5 or more chronic conditions. Some 42 percent of dual eligibles with both a mental and chronic physical condition are hospitalized and 28 percent enter a nursing home as a result of a chronic disease that could have been prevented.

Regardless of the fact that there is no option to offer the DPCMH model to patients enrolled in Medicare, many Medicare patients choose to pay DPCMH plans like Qliance out of their own pocket — above and beyond the cost of FFS Medicare. This has the strange effect of patients subsidizing Medicare by paying for their own primary and preventive care and reducing downstream costs. Clearly not all patients can afford this. But since Medicare patients enrolled in Qliance save money on co-pays and coinsurance through decreased utilization of downstream care, all Medicare patients could benefit from these innovative arrangements, and if the Qliance data holds, the Federal Government would benefit through substantial cost savings.

These plans are now offered in as many as 21 states—and provide all primary care services. Under a DPCMH model providing primary care services, FFS would only be used for hospitalization and specialty care—to which it is better suited. But as the data in Table 1 indicates, Medicare patients would use a lot less of these more expensive services, saving Medicare significantly in the form of administrative expenses and downstream costs.

That is why Representative Bill Cassidy, MD along with former Rep. Jay Inslee (D-WA) introduced H.R. 3315 a bipartisan proposal to bring this high quality care delivery model to Medicare and dually eligible Medicare-Medicaid beneficiaries last year. The Direct MD Care Act would create a demonstration project allowing CMS to pay direct monthly fees to practices using the Direct Primary Care (DPC) model. The program is aimed at gathering data to show CMS that the DPC model can improve health outcomes for patients and reduce health care costs for the Federal government. The ultimate goal is to enable the CMS Innovation Center to expand the model as an alternative to the fragmented care received by most patients in traditional fee-for-service Medicare, particularly for those patients who are dually eligible in Medicare and Medicaid.

We think it is imperative that any redesign of the current payment system incentivize Medicare patients to get as much primary care as they can consume by enrolling in a DPCMH plan. Rather than just trying to fix the SGR yet another time, we urge Congress to consider innovative Medicare payment reforms, such as the flat monthly fee model. Only by fixing the underlying problem with FFS as a poor primary care payment arrangement, will Congress truly be able to rein in costs and improve health outcomes in the Medicare population.

Mr. PITTS. I will now begin the questioning. I recognize myself 5 minutes for that purpose.

Mr. Serota, relatively small number of patients, perhaps 10 percent, especially those with chronic conditions and multiple comorbidities may consume the majority of health care services and resources. It seems to make sense to target resources toward the care of those patients. How do you get physicians across specialties to do this?

Mr. SEROTA. The idea of identifying those high risk patients or those high-utilizing patients with chronic conditions is the—essentially the essence of the health informatics that we use for clinical care. We work with providers to provide them a comprehensive look at their patient populations. All the care that they are receiving, we try to identify those patients which are consuming care, and then the genesis or the foundation in a patient-centered medical home is to get the primary care physician to manage all of those attributes, all of those providers that are participating in the care to ensure that there is a lack of duplication and better coordination of the care that those patients receive.

Mr. PITTS. Dr. Nash, your model appears to be a form of capitation payment. In the 1990s, capitation arrangements fell into disfavor in many markets because of certain weaknesses. How does your model address those weaknesses?

Mr. NASH. Yes, I stated among many physicians when you bring up the “C” word, capitation, there is a reaction, and a lot of that is from the experience of the '90s where many capitations were structured around actually putting physicians at risk for services that they didn't directly provide. So they weren't prepared to handle that financial risk, that is what an insurance company really needs to handle. So that is part one. The model we have is really only for the services the physician directly provides.

The second major aspect, though, is capitations of those days were really just age/sex adjusted, so that I, as a family doc, you know, if I am in my office and I am paid on that model from the '90s, if I had a 40-year-old patient come in to see me from a plan being paid in that way, a 40-year-old male but I happen to get one with diabetes and asthma, I was not paid adequately for that because I was being paid on the average. So this specific model pays more for the sicker patient, so we pay significantly more for that patient so the doctor can spend more time with that patient.

Mr. PITTS. Thank you. Dr. Bronson, we hear a lot about how primary care providers are undervalued in comparison to specialists. Most people agree that a robust primary care workforce is essential. However, according to the Association of American Medical Colleges Center for Workforce studies, there will be not only a shortage of about 45,000 primary care physicians; there will also be a shortage of 46,000 surgeons and medical specialists in the next decade. Yet, in a system with finite resources, how do you increase reimbursement for primary care without reducing reimbursement for specialists, and thereby jeopardizing access to specialty care?

Mr. BRONSON. Thank you, Mr. Chairman. We strongly believe that the patient-centered medical home concept and the value con-

cepts provided here will provide additional funding through shared savings opportunities to support those initiatives.

Mr. PITTS. OK. Dr. Hoyt, how are physicians assigned to the Clinical Affinity Groups you described? Do physicians self-assign, or are they assigned automatically based on the patients they treat?

Mr. HOYT. You know, we are still having a lot of discussion about that, but the general principle you ask about is a physician would self-select, and the success of that, we believe, will be in getting the types of groups that would be naturally incentivized to work together to lower costs and improve quality would be the premise of these groups.

So you know, there is going to be potentially some conflict in that if you are talking about the management of, let us say, coronary syndromes, you are going to have specialists that right now are not necessarily incentivized to work together, but that is, in fact, the concept, that somebody could control what they selected to be a part of, whether it is a coronary group or a GI group or oncology group, based primarily on what they practice.

Mr. PITTS. OK. And Dr. Patel, one major criticism of the ACO model is that it is overly prescriptive. It may work in one part of the country or for certain medical specialties, but not for everyone. Providers often complain that they need to make significant changes in their practices in order to comply with ACO requirements. How can Medicare incorporate innovative models that are more flexible, and therefore, less disruptive to existing practices?

Ms. PATEL. Thank you, Mr. Chairman. I think Medicare is doing just that with trying to introduce, in addition to the Accountable Care Organization model, other such models that incorporate other payers such as the Advanced Primary Care Initiative and others that are going on as we speak. I do think it is worth noting that the Accountable Care Organization movement has blossomed and we now have over 2.5 million Medicare lives in the currently funded Medicare shared savings programs and pioneer ACO programs. So adding that flexibility I know is critical to ensuring the retention of the clinical excellence in those beneficiaries.

Mr. PITTS. My time is expired. Chair recognizes the ranking member for 5 minutes for questions.

Mr. PALLONE. Thank you, Mr. Chairman. I am trying to get in a bunch of questions here, so I am going to ask you to be brief, if you can. I am shortening my questions.

Many members have supported using—this is for Dr. Bronson and Dr. Hoyt. Many members have supported using the OCO funding, the Overseas Contingency Operation funding, to offset the cost of repealing the SGR. There are even some Republicans who have supported it. So I wanted to ask you, would you support using the OCO funding as a way to pay for repealing SGR, and if not, do you have an alternative suggestion? Mr. Bronson first, I guess?

Mr. BRONSON. Thank you, sir.

Mr. PALLONE. Dr. Bronson.

Mr. BRONSON. We are supportive of using the OCO concept for providing this particular funding that is necessary for this program. I will add, we are not experts in funding and are open to other idea.

Mr. PALLONE. OK, thank you. Dr. Hoyt?

Mr. HOYT. Yes, we would support use of that for the offset.

Mr. PALLONE. Thank you both.

Now Dr. Bronson, there is a consensus that many of the delivery reform models discussed today hold promise for Medicare, however, it takes time to disseminate those models nationwide. In the meantime, there is clear evidence that there is a problem with the incentives for primary care payment. Are there steps we can take now that will help boost primary care and better reward primary care practitioners?

Mr. BRONSON. We very much believe that this is—the first thing we need to do is really fix this SGR problem for all practices. Without doing that, we don't have the flexibility that we need to go forward and improve primary care as effectively as we could. Supporting the patient-centered medical home initiative is very important. My personal practice, more than half of my patients and internists are Medicare beneficiaries. It is hard to reorganize your practice into a—fully into a patient-centered medical home if you are not getting reimbursed effectively by your largest payer. We need to move fast on this issue.

Mr. PALLONE. Now the July 6 proposed rule issued by CMS creates a new code for care management post discharge. Do you believe that this new initiative is a good one, or is there anything else CMS can do to boost primary care?

Mr. BRONSON. Well absolutely it is a good one, and a necessary one, but it needs to be filtered in—more effort needs to be filtered into a comprehensive solution that changes the practice paradigm to manage populations and prevent unnecessary—I shouldn't say unnecessary, but preventable utilization.

Mr. PALLONE. OK. Now I am just going to ask a general question. I don't know what time is left here for anybody. We all talk about getting rid of the SGR, but we really mean simply eliminating the formula that provides a global cap on spending unrelated to physician performance or quality. The underlying fee schedule which payments are based off would likely still remain. You know, we have heard from witnesses at this hearing notice that at the heart of the fee schedule we have mis-valued codes and payment incentives that still aren't aligned to value, the right care at the right time, and of course, primary care remains undervalued. I would like to ask any witness, first, whether you support eliminating the SGR mechanism. I think the answer is yes, so let us just go to the second, whether you believe that if the SGR mechanism is eliminated, we will still need to retain the fee schedule, and assuming there is agreement to retain the fee schedule, what needs to be done to better align payment incentives there? So my question is about the fee schedule. I guess I will start with Mr. Serota and see how far we go with the time.

Mr. SEROTA. Well I will try to be brief. I think that the most critical element is to link reimbursement with outcomes and quality, and to begin to reimburse providers based on the managing of populations, rather than the episodic care. We can't get there overnight, so I think the elements of a fee schedule will have to remain in place for some period of time as we transition to a differing—different type of payment model, so I don't think it can be elimi-

nated immediately. But I do think we have to evolve away from a fee-for-service model at some point.

Mr. PALLONE. Dr. Nash?

Mr. NASH. We have eliminated the fee schedule in the program that I am speaking about. You know, it has been well demonstrated that fee-for-service just promotes more care, but I think the main method I would give is it limits innovations. It is really only rewarding for that face-to-face between the doctor and a patient. It really doesn't reward for team-based care, it doesn't reward for telephone care, web based care, a whole variety. So if we want comprehensive care, we should pay comprehensively.

Mr. PALLONE. Dr. Bronson, you may be the last one because we are running out of time.

Mr. BRONSON. I couldn't agree more with Dr. Nash. We have important shortages in several specialties, primary care, general surgery. Adjustment of fee schedule can help, but you know—in a proactive way, but we need to go to a more comprehensive solution in the long run.

Mr. PALLONE. Dr. Hoyt?

Mr. HOYT. Well, we actually anticipate the need for this in our proposal by anticipating the need to adjust primary care. But to your question, in the future do we need a way to relatively value services, I think we still do because background, education, training, commitment to various kinds of efforts is going to lead to a different valuation of some services, and I think the—our proposal would be to have physicians still be in charge of doing that. I realize that that seems self-interested, but we feel that, as evidenced through committees like the RUC that that is really what the RUC has been able to do. Maybe not always correctly in some people's minds, but it is really intended to try and foster that debate amongst physicians what the relative value of a particular service is.

Mr. PALLONE. Thank you.

Mr. PITTS. Chair thanks the gentleman and now recognizes Dr. Burgess, 5 minutes for questions.

Mr. BURGESS. Dr. Patel, you got left off that last sequence. Would you care to respond to the ranking member's question?

Ms. PATEL. Thank you. I would agree, briefly, that we should definitely improve on the fee-for-service elements, and there will be a need, as I mentioned, to retain elements such that when we move towards these more flexible payment models, we can incentivize the right behavior. And I do think it is about helping to recalculate what the relative value of those payments are, to make them more accurate for what we actually want to achieve, which we don't have right now.

Mr. BURGESS. And that is why I wanted you to give that answer, so I am grateful that you did.

Moving to a model where fee-for-service no longer exists is, in some ways, problematic because it is the world that many of us—I practiced medicine for 25 years. It is the world that many of us grew up in. We understand it, we can converse easily about that world.

At the same time, if there is—and I will be honest with you, there are places in Texas where I don't honestly see how you do

a bundled payment or a value-based purchasing or an ACO model in Muleshoe, Texas, where you got one guy. I mean, I don't know how you do that. That person has to have a fee-for-service environment, at least in my limited view of the world. They have to have a fee-for-service environment, and if all of our effort with SGR reform is to move away from fee-for-service, what do you do with the patients who are seeing the doc in Muleshoe, Texas?

Ms. PATEL. Thank you for that question, Mr. Vice Chair. I couldn't agree with you more. I am from Texas myself, and understand exactly the kinds of practices that you are speaking of, and I can tell you that that is why the element that really helps to link a way forward is retaining some of our current system that can help to—allow physicians to continue practices such as you pointed out, but also, I would say to you that that physician and those of us who practice in more isolated settings, or even smaller settings in a city, what we are all looking for is a way to coordinate our care better and to reach out, just like we did in medical school and in training, to other colleagues that we know can help us respond to our patient's needs.

So I think a step towards something that is different than what we have now is to allow the solo practicing doctor to be able to engage in a model for some of their patients that have high risk cardiac conditions that need to go to San Antonio, and coordinate care better there and reward that behavior.

Mr. BURGESS. Right, and most—can we just stipulate for the record, since you are from Texas, that Muleshoe, Texas, actually exists? I didn't just make that up.

Ms. PATEL. I can—I will tell you where it is on a map even, yes.

Mr. BURGESS. But the—you know, when we talked about this, and we have talked about it at the committee level, you know, how do you go to a world beyond fee-for-service? It just seems to me we are going to have to—whatever we do with SGR, and I know there are people who say we need alternative payment models, we need a value-based system, we need an ACO model, we need a bundled payment model. But honestly, we have got to allow for the rich panoply of practices that are out there to continue to thrive, because after all, the name of the game is not just reworking a formula, the name of the game is seniors need access to care. And right now, that access is not being—is in jeopardy because of the actions taken by Congress that instituted this payment system, and then our last-minute rescues every year have been the—have put practices on kind of a tenuous financial footing if they have got to go to their banker for a short-term note at probably 9 to 12 percent interest to fund because their cash across the counter was reduced by 15 percent because Congress said oh, we will just hold your check at CMS until we get back from congressional recess. I mean, that sort of activity is just devastating to practices. So I want to see us figure that out.

Now, you talked a little bit about not doing tests that are not necessary, and I agree with that, but at the same time, I think anyone who has been in clinical practice also recognizes that people don't often always function according to protocol, and I think one of the comments you made was in cardiology that there was no

testing, no dynamic testing unless there were high risk markers present. Did I understand you correctly with that?

Ms. PATEL. Yes, that is correct. That is from the American College of Cardiology.

Mr. BURGESS. But we have all been in situations where we have that patient come in at the end of the day who describes an unnatural fatigue, and you say OK, look. It is the end of the day. I am tired, you are tired, we are all tired. Go on about your business. But we have all had the situation where we have referred that patient on for testing, and in fact, she has been quite ill with really minimal systems and had you not had that little spark of curiosity, you might not have referred for the testing. But now if you got someone looking over your shoulder saying look, you are a high utilizer for this type of testing and these indications are very soft, who is going to help us with the liability side of that question?

Ms. PATEL. So I will try to respond briefly.

Mr. BURGESS. No, you can use as much time as you want. The chairman is very tolerant. I know him well.

Mr. PITTS. You may proceed.

Ms. PATEL. Thank you for that.

So the first element is that this cannot be something where it is a dictum or a direction to providers that you may never—notice when the American College of Cardiology participated in identifying that very example around cardiac stress imaging, it wasn't—it is not a “you must never do this,” it was chosen as one of the conditions in which the profession can help to teach themselves and their own clinicians how to best deal with imaging issues when patients present, and that includes the ability to order that test when it is necessary, or you do have that spark of curiosity.

So in the model that I am describing for payment that helps to also deal with some of the issues you bring up of liability or feeling the responsibility to order something or not order something, it would be to take that—we know that there is a proportion of payments that we are delivering in the fee-for-service system right now that are being used to deliver those services. Take a proportion of those payments and say to cardiologists, to internists, to family practice doctors in Texas and say you know what, we know that there are things that you don't like about the way you practice that are responsive to what you think might be issues around liability or things that might spark a curiosity, and you want the flexibility to deal with that. But what we will give you—we are not just going to give you free reign, you can't just do what you want. What we want for you to do is agree to be responsible by following what your own profession and your own colleagues have said are the best-informed evidence around an issue. Does that mean that it is 100 percent an absolute? No. Does that mean that we would need rich ability to measure what we are doing and learn from it? I think that is what is essential, and I think that is what physicians are craving. They want to know that they have some flexibility and autonomy to practice the way they want, but also to get the information that can help them be better. And that will help the very small businesses that are small practices to thrive in a newer business model and be more efficient.

Mr. PITTS. Chair thanks the gentleman and now recognizes the ranking member of the full committee, Mr. Waxman, for 5 minutes for questions.

Mr. WAXMAN. Thank you, Mr. Chairman. I want to thank all the witnesses. This has been an excellent panel, and I think you have given us a lot to think about.

We want a health care system that works. We want some innovation, experimentation, but no one size fits all, and we have got to be open to looking at what makes sense, given the circumstances. Of course, the main thing that makes sense at the moment is to deal with this SGR problem because it is—nothing else seems to work unless we take care of SGR. That is why it is so frustrating that we didn't use the OCO, which is just a bookkeeping thing, but the SGR is just a bookkeeping thing, and we are stuck. And we ought to solve those two issues, pay for it, get this thing resolved.

Dr. Patel, I am not sure how closely you have been following what has been going on in the House of Representatives, but last week, the Republicans brought forward a bill to repeal the Affordable Care Act. Not only does the Affordable Care Act provide countless benefits for families, such as protections against pre-existing condition exclusions and lifetime caps on coverage, tax breaks of \$4,000 a year per family for health care, improve free preventive care, lowered out of pocket costs for prescription drugs, but the Affordable Care Act also includes important provisions to drive delivery, reform, in fee-for-service Medicare. One part of the Affordable Care Act provides for Accountable Care Organizations within Medicare, or bundled payment programs in Medicare. The law even established the innovation center, which is taking unprecedented steps to help providers, payers, and patient groups develop and spread new and successful innovations, including through medical homes and multi-payer initiatives.

Obviously, the Affordable Care Act is just one piece of improving quality and outcomes for Medicare, but I believe it is an important one. If the Republican plan to repeal the Affordable Care Act were to become law, what effect would that have on Medicare's work to improve quality and outcomes and realign payment incentives to focus on value? Do you believe that would be a setback?

Ms. PATEL. I do believe it would be setback to turn back all of the important work that has been done in the past 2 years and beyond, even before the Affordable Care Act was passed, around savings and Medicare system, the Medicaid system, and then what is even more remarkable is that we can't turn back, even with the repeal, what has already taken place as a result of the important initiatives you mentioned, sir, in the private market.

So now we have created a very complex web that is starting to produce some amazing results, as you have heard today. So a repeal and any setback would really undo valuable work and send a signal, I believe, to clinicians around the country who are looking for a way to move forward.

Mr. WAXMAN. It certainly would send a signal to a lot of people who don't have health insurance that they are not going to have an opportunity to get health insurance because of the barriers that they have been unable to overcome prior to the Affordable Care Act being passed and being fully implemented.

It occurs to me as I listen to the testimony that our health system has hundreds, if not thousands, of groups pursuing reform in some way. Each health plan, provider organization, even Medicare and Medicaid has a slightly different take on a medical home or an Accountable Care Organization, for example. I am wondering how we ensure that all of these efforts are complimentary, not contradictory?

Dr. Patel, in your testimony you mentioned the need to identify mechanisms to further multi-payer efforts to transform the delivery system. I know that CMS is, as a result of the new authority in the Affordable Care Act, is working on some of these multi-payer initiatives. For example, the Comprehensive Primary Care Initiative is a collaborative effort between public and private payers and primary care practices to reward care management. The Multi-payer Advanced Primary Care Demonstration is developing State-led multi-payer collaborations with primary care practices to improve care. Dr. Patel, could you talk about why multi-payer initiatives are so important; what CMS, through the Affordable Care Act, is doing in this area, and what more can be done?

Ms. PATEL. Multi-payer initiatives are critical because it is very hard for clinicians to provide care for only one stream of patients, measure quality on those patients, and then have a completely different set of expectations, incentives, and reporting, which is what is going on right now. So some of the important initiatives that you just mentioned at the State level, in the primary care setting, and even the Accountable Care Organization model really send a strong signal to other payers, and that started with actions taken in Medicare by CMS as a result of the Affordable Care Act. So do believe that the continuing work of encouraging, but then also having a way to set forward the actual mechanism for other payers to be involved. And that means, as I said in my testimony, consistent quality measures. We can't have one set of quality measures that I report to for one payer, which is what I do in my practice now, and a completely different set of metrics for another. That is where the multi-payer efforts are huge and critical.

Mr. PITTS. Chair thanks the gentleman. Now recognizes Dr. Cassidy, 5 minutes for questions.

Mr. CASSIDY. As an open question to follow up on Mr. Waxman's affection for the ACA, according to who you listen to, Medicare is going bankrupt in 5 to 12 years. I am sure he and his affection would love that ACA takes \$500 billion in savings from Medicare and spends it elsewhere as opposed to shoring up the program. That is a feature that Republicans object to, and frankly, it is terrible for Medicare. But that is part of the ACA and I am sure he would not want that repealed either.

That said, as a practicing physician myself, I have observed that only fiduciary linkage between patients and physicians seems to consistently lower costs. That is a little bit of a theme I have heard from you.

Mr. Serota, I am curious, do you do MA plans, Medicare Advantage programs?

Mr. SEROTA. We do have Medicare Advantage programs, yes.

Mr. CASSIDY. What is your—so you have got a very nice system where you are getting feedback—each of you described this, Dr.

Nash, Dr. Patel—where you are giving feedback to the practicing physician, clearly, that costs money. What is the MLR, your medical loss ratio, of the MA plans that you have?

Mr. SEROTA. It is widely varied based on the marketplace. I don't have a single—

Mr. CASSIDY. Is it over 15 percent?

Mr. SEROTA. The medical loss ratio itself? The administrative expense piece of that?

Mr. CASSIDY. Yes.

Mr. SEROTA. In some markets it may be.

Mr. CASSIDY. Now you are contracting with these physician groups. I am assuming they have their own MLR—and Dr. Nash, you can weigh in as well. Are you doing Medicare Advantage as well?

Mr. NASH. Yes, we are.

Mr. CASSIDY. So can I ask what you are contracting with the—are you directly contracting with CMS or with the Medicare Advantage program?

Mr. NASH. We—our Medicare Advantage program is directly through CMS.

Mr. CASSIDY. So you are an MA plan?

Mr. NASH. Correct.

Mr. CASSIDY. So you get—what is your MLR?

Mr. NASH. Well, the medical loss ratio is an amount of premium that is spent on medical care, so we are roughly about 88 percent or something of that nature.

Mr. CASSIDY. So your administrative cost is only 12 percent?

Mr. NASH. Correct.

Mr. CASSIDY. That is pretty good. Some other plans similar to yours seem to have higher than that. It has been instructed some of the physician groups contracting with the insurance companies, the insurance company keeps 12 but then the medical plan itself has an additional MLR. Mr. Serota is kind of nodding his head yes. It seems that in the aggregate, the MLR is greater than the 15 percent or 20 percent defined by the so-loved ACA.

Now, if you didn't have the ability to do your data systems, would you be as effective in managing that care? Yes.

Mr. NASH. Absolutely not. I mean, the data is essential for any of this.

Mr. CASSIDY. That wasn't a trick question. It seemed so self-evident. By the way, I admire the fact that you as practicing physicians understand there are some things fee-for-service works better for. Then again, as a practicing doc, I also see that, so let me just kind of compliment you on that model.

Now, for all of you—Dr. Hoyt, it seems like yours is effectively a bundled payment system, correct? If somebody has—I have a pain in my neck and it is not from any of you, it is just from a bad neck, so if I am grimacing, that is the reason why. It seems like you are a bundled system. If somebody has colon cancer, they would come to you and contract, if you will, for the management of that care, is that correct?

Mr. HOYT. Well, in our system bundled payments could be accommodated, but the system is really about updates for the overall Medicare reimbursement on an annual basis. And it simply puts a

group of physicians to quality of metrics around a specific disease target or something like that. It doesn't necessarily, per se, bundle the responsibility by, you know, that same group.

Mr. CASSIDY. Let me ask you, because really, this is about finding ways to save enough money and translate those savings into doing away with SGR forever, once and for all, and continuing to reward patients for appropriate payment, correct?

Mr. HOYT. Correct, and I think, you know, that is an assumption in our model that we have to prove. We are planning to do some modeling to actually see if it shakes out, but your comment that all of these attempts at cost savings is ultimately where the extra money comes from to pay for increased access or individual—more individualized care for high risk patients, et cetera, that has to be the assumption, that there are some ways that can be—

Mr. CASSIDY. Dr. Patel, I really liked your testimony. I like your written, and I like the way you delivered it. Let me just compliment you. But that said, everybody has talked about somewhat of a big government-type solution. You are going to need a lot of structure here. You are going to need this big, overarching overhead. And going back—I will go to Louisiana, FP and Pointe Coupee Parish, small place, overworked, underpaid, driven, wife is wondering why he is not home on time. And that is too common. Now what do you think about the direct medical care model? We have the written testimony from Qliance where you pay the doc \$50 to \$100 a month depending on the complexity and age of the patient, and she or he manages all the outpatient services, referring to the inpatient setting as separate. It is not totally capitated, but it allows a doc to manage the outpatient and then the inpatient then goes on another ticket. What are your feelings about that?

Ms. PATEL. I have had a chance to learn more about the Qliance model over a year ago, and have been very interested in exactly the way they are able to risk adjust and charge a sliding fee per month for beneficiaries and have amazing kind of access points for those beneficiaries to e-mail with their doctors, talk to them, and I think that that is a great model that would actually fit in nicely with helping to offer a flexibility for a primary care physician in Louisiana to do something exactly like that, and that would be a very rich way to ensure financial sustainability in their practice—

Mr. CASSIDY. Exactly.

Ms. PATEL [continuing]. All the while really creating models inside that practice that reward coordination. Let the doctors and the MAs and the nurses figure out what they need to do.

Mr. CASSIDY. Sounds good. My last thing, and I am out of time. Thank you, Mr. Chairman.

Mr. Serota, for the record, I will ask you if you would give us your MLR for your various MA plans, and what you estimate that the MLR is of the group with whom you are contracting, because I think that would be very informative to us.

Mr. SEROTA. We can get that information.

Mr. CASSIDY. Thank you.

Mr. PITTS. Chair thanks the gentleman, now goes to—recognizes Mr. Dingell for 5 minutes for questions.

Mr. DINGELL. Mr. Chairman, I thank you. I commend you for this hearing. I commend the panel. This is one of the best presen-

tations and one of the best hearings I have heard for a while. I also want to commend our panelists for their fine testimony.

These questions will go to Dr. Patel. I want to thank you for being here today. Please answer the following questions yes or no. Is it fair to say from your testimony that fee-for-services models do not promote the highest quality and highest value health care? Yes or no.

Ms. PATEL. Yes.

Mr. DINGELL. Is it also fair to say that models such as the patient-centered medical home have the most promise to provide our citizens with the best and most affordable health care? Yes or no.

Ms. PATEL. Yes.

Mr. DINGELL. Is it possible that other benefits from these things could occur, such as a reduction in both cost and the rate of growth of cost?

Ms. PATEL. Yes.

Mr. DINGELL. Now Doctor, I believe that on March 23, 2010, the President signed the Affordable Care Act into law. I am sure you are aware that ACA provides a shared savings program through Accountable Care Organizations that serve 2.4 million Americans, is that right?

Ms. PATEL. Yes.

Mr. DINGELL. Now Doctor, ACA is legislation that includes the authority to embark on many innovative paths. I believe that is a desirable thing, is it not?

Ms. PATEL. Yes.

Mr. DINGELL. Now Doctor, are you aware that CMS programs such as innovation advisors, and innovation challenge grants that seek to promote groundbreaking work in health care, would you say that is useful? Yes or no.

Ms. PATEL. Yes.

Mr. DINGELL. By the way, Doctor, I am sorry to do this to you. You are a very good witness, but I have got a lot of questions and not much time.

Ms. PATEL. No problem.

Mr. DINGELL. Dr. Patel, it is clear from your testimony that you understand the importance of excellent primary care. This is an area of great shortage in this country, and potentially worse shortage, is it not?

Ms. PATEL. Yes.

Mr. DINGELL. Did you know that CMS has a comprehensive primary care initiative that encourages public/private collaboration on promoting primary care? Yes or no.

Ms. PATEL. Yes.

Mr. DINGELL. Dr. Patel, I think we both agree that CMS must do more to reform physician payment systems. Is that your view?

Ms. PATEL. Yes.

Mr. DINGELL. And I hope you also recognize that the Affordable Care Act is assisting CMS in beginning the important process towards these vital reforms. Do you agree with that statement?

Ms. PATEL. Yes, sir.

Mr. DINGELL. Doctor, do you want to make a comment as to how that particular process is working? This is not a yes or no question.

Ms. PATEL. Thank you. Yes, I am happy to just briefly tell you that I do know that CMS has been working, even with the most recently mentioned physician payment rule that was released last week, to add modifications that acknowledge some of the issues we discussed today around the relative value of some fee-for-service elements, as well as ways to better integrate quality with work that is already going on in clinical specialty societies and primary care.

Mr. DINGELL. Does that offer promise for the future in addressing these miserable problems we have—

Ms. PATEL. It does, sir.

Mr. DINGELL [continuing]. With regard to cost increases and things of that kind?

Ms. PATEL. It does, and it also offers insights into what we need to do more work in, even outside of the Medicare program.

Mr. DINGELL. Now how does—how is it that this program is going to benefit us in terms of addressing cost increases and the rate of increase of costs?

Ms. PATEL. It all has to do with making sure that what we are incentivizing, where we put the dollars, actually matches towards the value that has already been identified that we do not attain in this country. So it is really about taking resources that we know are not going towards valuable care, and redirecting those towards things that we know promote value. And those come from the very work that we are hearing about that are led by clinicians.

Mr. DINGELL. Now you just said something very important. How do we do that? What are the steps that we take to make that happen?

Ms. PATEL. The very short-term steps over the next 2 years, for example, transferring a proportion of what we do in fee-for-service payment right now into this coordinated care model that we are discussing. It is even beyond the patient-centered medical home. It could be a model that allows for an oncologist, for example, to better coordinate care for a colorectal cancer patient. And then from that point, what we can't do is leave it alone at that step. What we must do is transfer and think about how that money, those dollars and care coordination can not only be reinvested back into the system, but what savings we create from that can move towards either these larger kind of episode or bundled payments that we have discussed, or other mechanisms that other physicians have brought up today.

Mr. DINGELL. Do you believe that the medical profession will support that?

Ms. PATEL. I believe they will, and I believe they have already been putting these models forward, sir.

Mr. DINGELL. Thank you. Thank you, Mr. Chairman.

Mr. PITTS. Chair thanks the gentleman and now recognizes the gentleman from Ohio, Mr. Latta, 5 minutes for questions.

Mr. LATTA. Thank you, Mr. Chairman, and thanks very much to our panel members for being with us today. It has been very enlightening.

If I could start with Mr. Serota, if I could ask you—it is kind of interesting in your first page of your testimony, you state that U.S. health care spending exceeds \$2.5 trillion annually, and studies es-

estimate that 30 cents of every health care dollar goes to care that is ineffective or redundant, and those dollars are not being well spent.

Let me ask you, why is that happening and where are those dollars going?

Mr. SEROTA. Well, I think you have heard virtually everyone on the panel answer that question in a slightly different take, but the reality is that we are providing care, as Dr. Patel just said, that isn't valuable and we need to redirect that care to things that are going to provide better outcomes. Why is it happening? We have a system that incents volume and doesn't incent population management, quality, and outcome. So when you have a system that incents volume, you get volume. That is what is transpiring.

Mr. LATTA. Let me ask, does this include a lot of tests that don't need to be done because folks out there are fearful if they don't do the test that they will be held liable?

Mr. SEROTA. Certainly.

Mr. LATTA. And what should we do about that?

Mr. SEROTA. Well, I think we have to look at the health care system comprehensively, which would include looking at reforming the tort system as well.

Mr. LATTA. Dr. Nash, I saw you nodding your head.

Mr. NASH. Yes, absolutely correct. I mean, if you speak to physicians, that is the first thing I put forward and was raised even in today's discussion. But the other side of the coin is really the patients and the patients demand for services because of their own anxieties and concerns, and both need to be dealt with.

Mr. LATTA. That is one of the things, you know, that we have been talking about around here and that we have to get done, because you can't really, you know, have meaningful health care reform if we don't do something about the tort system in this country and a lot of these junk lawsuits.

Let me ask this question. This is to Dr. Bronson. I was just over at Cleveland Clinic on Monday for a meeting, and I am from north-west Ohio, but you know, we have been talking a lot about what is happening in the health care system here, but let me ask you this. We hear a lot about the physician's role in promoting high quality of care and avoiding unnecessary spending, and you know, really, what is the role of the patient now that we have to be looking at?

Mr. BRONSON. Well, the role of the patient is very important, and that is why we support initiatives to get patients more actively engaged in shared decision making in an effective manner, and that should be supported in practices. I would like to add to the comment on liability reform, that we are very strongly in support of a variety of steps for liability reform. You may recall that I came to your office and spoke to you about the—health courts is something that we should test nationally to see if having impartial judges involved in this type of process, instead of volatile juries could be a more effective manner in handling liability reform.

Mr. LATTA. As we look at that, how do we incentivize those patients to make sure that they can do more, and those people that are in the system, to make sure that, you know, they are not—we were talking about this the other day about, you know, 20, 30, 40

years ago folks couldn't go to the emergency room as much, you know. Folks might have stayed home and taken care of things a little bit more. But how do we incentivize those people for making better health care decisions on their own?

Mr. BRONSON. Well, number one, we have to fix the access problem in primary care. My experience is patients really don't want to be sitting 3 to 4 hours in the emergency room waiting to be seen for an acute minor problem. They would really rather see their personal physician. Part of the concept of what we are getting at is rewarding efforts to enhance access to restructure practices to be more effective, to use extenders more efficiently in practices to get patients in. We believe that those types of steps will reduce unnecessary utilization, and hopefully avoid preventable omissions and expenses.

Mr. LATTA. OK. If I could, Dr. Nash, ask you this question. You know, if the SGR, let us just say, is reduced at the end of this year by 27-1/2 percent, how would that affect rural areas in this country, and would they suffer disproportionate hit more than an urban area? How would you see that?

Mr. NASH. If it was not?

Mr. LATTA. Right, if it—

Mr. NASH. If it remained enforced?

Mr. LATTA. Right.

Mr. NASH. Yes, it would be devastating, you know. The access currently for Medicare patients across the country, particularly in rural areas, is threatened even on the current state, let alone if that was the outcome.

Mr. LATTA. Mr. Chairman, I yield back my time.

Mr. PITTS. Chair thanks the gentleman and recognizes the gentleman from New York, Mr. Towns, 5 minutes for questions.

Mr. TOWNS. Thank you very much, Mr. Chairman. Let me begin by first thanking you for having this hearing, and to thank these panelists for outstanding testimony. I think that as has been stated, this is a very serious issue and of course, I think that we need to spend as much time as we need to do in order to try and correct some of the problems that are going on as we look at access and of course, liability and all of these things I think are connected.

So let me begin with you, Dr. Patel. If we shift away from the FFS payment system, what would that transition process look like? We have identified the resource base relative value scale, particularly the RVUs as a source of much trouble, direct and focused to volume instead of value. So are you proposing we do away with RVUs altogether, and how else can we quantify the value of physician services?

Ms. PATEL. I think it is important to preserve the notion of what a value unit is. I think it is what relative value units have been that have been the problem, so in a transition, I mentioned that even in a long-term vision we would need to keep some elements of our current reimbursement system because there are elements that work. But I do think that in order to improve the RVU process, as well as how we incentivize some of the fee-for-service services that we cover, in the short term, in the next year or two, we need to actually identify what it is that we are not deriving value from, and what that amount of dollars are in the Medicare system,

and translate that to models that are not necessarily RVU driven. That doesn't mean that we are eliminating all the RVUs, but taking the proportion of RVUs that we know are really not providing that very term, relative value, and improving upon them to create incentives for care coordination.

So taking what we have, not eliminating it totally, taking what we have that we know does not provide value and translating that into dollars and payments that do provide value, and improving—meanwhile, I think improving upon the RV system, which is what CMS is trying to do right now with the updates to payments in primary care, for example.

Mr. TOWNS. All right, thank you very much.

Dr. Hoyt, you mentioned the right infrastructure is absolutely—in order to provide high quality care. What do you really mean by that? Could you expound on that?

Mr. HOYT. Well, you know, I think when you describe standards for care, you are really describing outcome standards or you are addressing what the ultimate goal of treating a disease is. The infrastructure standards are really the details of the actual physical plan, the communications, the essential specialists that need to be part of decision making. When you are talking about complex disease, having consensus and then committing to the building of the infrastructure is really the second step in the quality process. So for instance, if you are going to develop a trauma center, which is my background, you have to commit to certain elements. If you are going to develop a cancer center, you have to commit to certain elements. And you have to do more than that; you have to actually commit to being externally peer-reviewed if you are really going to assure the public that what you say you are doing, you are actually doing.

Mr. TOWNS. You know, the term here today that has been used, one size does not fit all, what do you really mean by that? I understand what you are saying, but what do you really mean when you say one size does not fit all?

Mr. HOYT. I don't believe that was my comment, but I will be glad to—

Mr. TOWNS. Thank you, Dr. Patel.

Ms. PATEL. I do not think that the very situation that we got into with our current reimbursement system was an attempt over time to have a unifying kind of standard. Even though we talked about relative value unit, what we have ended up doing is really incentivizing volume. And to say that one size does not fit all, that is an acknowledgment that not every clinical practice, when you open the door to see the doctor, is going to look the same, nor should it look the same, and that is the kind of payment model that Medicare needs to reach, so that we are not actually just saying to doctors—which is what we are doing right now—we will pay you more if you do more. That is not a message we should send. And so one size fits all means that there are many different models, and we are already seeing some of these in practice, that can offer more value and save the system money overall.

Mr. TOWNS. All right. Thank you very much, and I see my time is expired.

Mr. PITTS. Chair thanks the gentleman, and now recognizes Dr. Gingrey for 5 minutes for questions.

Mr. GINGREY. Mr. Chairman, thank you very much. I will first go to Dr. Bronson and Dr. Hoyt.

Doctors, you were asked earlier in your testimony and the Q&A about the OCO money being used to eliminate the cliff in regard to the SGR problem and fixing—eliminating the SGR and, of course, paying the \$300 billion to get the baseline back to zero. And OCO money, for those who might not know—I think everybody pretty much does—Overseas Contingency Operation, basically supplemental appropriations that are used on an annual basis to fund a war effort, not part of the standard appropriation procedure, emergency funding. So if you don't use that money, if you cut back on the war effort and you don't need it, how can you actually use it to pay for something else? And you said you would be in favor of using it to pay for something else. Do you want to confirm that that is your opinion on that, both of you, Dr. Bronson and Dr. Hoyt?

Mr. BRONSON. I will confirm that. Of course, it is a congressional decision, but yes, I would confirm that we support that.

Mr. GINGREY. Dr. Bronson, do you feel the same way?

Mr. HOYT. Yes—Hoyt.

Mr. GINGREY. Dr. Hoyt.

Mr. HOYT. Yes. Well, we understand the discussion of some disagreement of whether it is real money or not, or whether it can or cannot be used. We—if it is available and it exists, we would support using it.

Mr. GINGREY. If funny money is going to be used, you want it to be used to kind of help your situation. I understand.

Mr. HOYT. If we could put it that way.

Mr. GINGREY. Let me say this. I support SGR repeal, and I think all physicians do. I also understand that because of Obamacare, the Affordable Care Act, the threat to physicians is compounded by a second SGR known as IPAB. Except in this instance, physician reimbursements will now be used to control cost in all of Medicare, not just Part B. How important is IPAB repeal to physicians, and do you believe Congress and the President should support the repeal of IPAB, again, Dr. Bronson and Dr. Hoyt?

Mr. BRONSON. We support the concept of IPAB, but a significant change in IPAB. We think IPAB should be an advisory body to Congress who, with a straight up and down vote, could deal with their recommendations that Congress is accountable to the people and should have the opportunity to respond to their advice.

Mr. GINGREY. Dr. Hoyt?

Mr. HOYT. We have not supported IPAB in principle because of the concern that there is not adequate oversight and participation of Congress, but also physicians.

Mr. GINGREY. Would the two of you—thank you for your answer. Would the two of you submit that response to me in writing? I would appreciate that very much. Mr. Chairman, thank you.

Let me go to Dr. Patel. Dr. Patel, I just want to clarify something that I heard from my colleagues, Mr. Dingell and Mr. Waxman. They made statements that Medicare innovation would go away if Obamacare was repealed. Maybe they have forgotten or aren't

aware that CMS demonstration projects on payment models was begun back in 2005 under President Bush. In fact, the Institute of Medicine called for them back in 2001. Obamacare merely copied that idea and Republicans would continue reforming Medicare if Obamacare is repealed. Would you like to comment on that? Do you agree with me or disagree with me on that statement?

Ms. PATEL. I agree, sir, that the concept of innovation as it has been introduced in Medicare started before the Affordable Care Act, absolutely. Demonstrations—in fact, it is important demonstrations that occurred, the physician group practice demonstration and some other chronic disease demonstrations that have taught us what we need to do better, and also where we did not necessarily understand enough about cost savings and the system. So I agree, sir, that they did, in fact, begin before the Affordable Care Act, but I will tell you that I think would be important to keep and preserve absolutely are not just the Center for Medicare and Medicaid Innovation, which has a great deal of activity right now, but embedded into that language is also a number of authorities that allow the Secretary and the Centers for Medicare to rapidly scale those payments—

Mr. GINGREY. Right, and my time is about to expire, but thank you very much for that response, because I agree with you that as we point out—and there are a number of things were mentioned that are popular in the Affordable Care Act. We always hear that keeping young people on their parent's health insurance policy until they are 26 years of age, even if they are not still in school, is probably a good thing. Eliminating lifetime and even, indeed, in many cases annual caps, making sure that children with pre-existing conditions—I could go on and on. There are several things that just like this innovation that existed before Obamacare, PPACA was enacted, these other things that we all like in a bipartisan way could easily be reincorporated into a new plan.

And with that, I see my time is expired, and I thank the chairman.

Mr. PITTS. Chair thanks the gentleman, and now recognizes the gentleman, Mr. Engel, for 5 minutes for questions.

Mr. ENGEL. Thank you very much, Mr. Chairman. I just have to comment that I have heard some of my colleagues on the other side talking about Medicare potentially going bankrupt. The Affordable Care Act extended the solvency of Medicare, and I just find it very strange that we fought two wars on the credit and we have had Bush tax cuts for the wealthy, Medicare Part D unpaid for. We had surplus Bill Clinton left office and we could have used that to shore up Medicare, so I think that when we kind of look at why we are in the trouble we are in, there is a lot of blame to go around on all sides.

First of all, let me thank all of you for excellent testimony. Every one of you was really excellent testimony, and I think it is very, very important. This is an important subject to have so many questions, and I just have to kind of cut down.

But let me just say, the SGR is obviously seriously flawed and needs to be permanently replaced. I really believe that physicians deserve to be fairly and appropriately compensated for the important work they do, and the SGR formula is failing our physicians.

I think there is nothing wrong with physicians wanting to be adequately and fairly reimbursed. And that is why I want to say that the Affordable Care Act appropriated \$10 billion in funding for the Center for Medicare and Medicaid Innovation over 10 years. I think that is very, very important.

I want to ask this question. Now, all of us recognize the current fee-for-service model has resulted in emphasis on procedures and quantity over quality of health care provided. I am introducing legislation—one field I am particularly interested in is palliative care, and it relies heavily on care coordination and communication with patients. I believe they are vital aspects to providing quality care, but ones that are not properly incentivized under the current fee-for-service system, and yet properly done, I think palliative care often saves money, extends life of patients, and gives them peace of mind.

So let me ask Dr. Nash, Mr. Serota, and Dr. Patel, what role do you see for palliative care as the health care system undergoes extensive delivery system reforms, and how can we incentivize the integration of palliative care for professionals into coordinated care teams?

Mr. NASH. Dr. Nash. I believe that—yes, palliative care is very important, and we have programs within our plan to work with our physician community and the community at large in regard to improving care at that phase of life. You know, it is difficult in a few minutes to talk about how that should be incorporated into payment models. I think it is a broader dialog in regard on a community level that many communities across the country have been successful with.

Mr. SEROTA. This is an important issue for us, and we do have a number of plans that—programs in place to help members with advanced illness. As an example, our Anthem Blue Cross Blue Shield plan in Virginia has an integrated cancer care medical management model, which is, at its core, trying to provide improved access to palliative care. They—members who receive timely access to palliative care generally achieve a better quality of life during these end stage, lower cost related end of life treatment and acute hospitalizations. They employ skilled care management nurses, decision support tools, medical director support, and it is a comprehensive program. We also have a similar program in Pittsburgh with our Highmark plan that, in fact, provides coverage for consultative services to its members with palliative care professions to ensure that that care is appropriate. We think it is an essential element, and often overlooked, so we appreciate your attention to it.

Mr. ENGEL. Thank you. Dr. Patel?

Ms. PATEL. So very briefly, the concept of a patient-centered medical oncology home is exactly alluding to the kinds of services you are referencing, specifically palliative care. Oncologists right now are caught up in the same quantity over quality system that we all have to be reimbursed in, and moving towards a coordination type fee, oncologists have already put forward ideas and are practicing palliative care referrals as well as palliative care medicine in the space of their cancer patients.

Mr. ENGEL. Thank you. Let me get in one quick question. As part of the Affordable Care Act, Medicare started paying primary care

physicians a 10 percent incentive payment, and it is my understanding that more than 156,000 primary care providers have benefitted from this. Now, I am curious to see what efforts are being taken in the private sector to incentivize physicians to practice in primary care. Perhaps Mr. Serota, Dr. Nash, can you elaborate on how your organizations are working to encourage physicians to go into primary care?

Mr. SEROTA. Sure. We have done similar things. We have increased the rate we pay primary care physicians. An example in Philadelphia, our Independence Blue Cross plan doubled base reimbursement to primary care physicians, increased it—paid out nearly \$37 million additional dollars in 2011. Anthem Blue Cross Blue Shield has announced a major investment in strengthening primary care, increasing revenue opportunities, bumped the fee schedule by 10 percent, including payments for non-visits, essentially care coordination, preparing care plans, managing patients with complex conditions, and also have shared savings models for quality improvement and reducing costs.

So the whole concept is partnership with the primary care physicians to improve their access to additional funds, provided the outcomes and the improved safety is present for our members.

Mr. NASH. Those physicians in our program who commit the time and energy to work over the period of time towards the principles of the patient-centered medical home, we put on a payment model as described which reimburses at a rate that is 20 percent higher in this global model than they were receiving fee-for-service, and they get another opportunity for 20 percent performance-based bonus, which you know, has attracted a lot of attention among the physician community.

Mr. ENGEL. Thank you. Thank you, Mr. Chairman.

Mr. PITTS. Chair thanks the gentleman. I now recognize the gentleman from Illinois, Mr. Shimkus, 5 minutes for questions.

Mr. SHIMKUS. Thank you, Mr. Chairman, and I also want to applaud the panel for being here. I have been a member since January, '97 I got sworn in, voted for a balanced budget act, amendments, created the SGR. It has been a bane to my existence ever since. We did that to preserve and protect Medicare. That is why we did it. Every year, we have to deal with this, and for me, it will be 16 years now dealing with the SGR. Also, just I am glad—and Mr. Gingrey mentioned about the Overseas Contingency Operations. That is not going to happen. Don't plan on it. We are not going to use it to fix the SGR, so get that off the table. That is why this panel is important, because if we just use that, then we are in the same position. We haven't reformed, we haven't changed things, we haven't moved forward.

I also want to address this. Medicare, by the actuary, says it is going to go broke 2024. It did get extended by the \$500 billion cuts in—from Obamacare, but the \$500 billion also was supposed to go to help pay for the Affordable Care Act, the health care bill. We had Secretary Sebelius right in the other hearing room. She admitted they double counted, double counted \$500 billion. Extend solvency of Medicare, pay for Obamacare. That is what we are living under. So those who extol the virtues of that, they are promoting the ability of double counting \$500 billion.

Now Dr. Patel, that is not good budgeting processes, is it? You wouldn't encourage using the same \$500 billion to say you are preserving and extending Medicare when you are also using that same money to fund the expansion of health care?

Ms. PATEL. I would not encourage double counting.

Mr. SHIMKUS. Thank you. I would agree.

So let us first—and the other issue is we have always talked about tort reform. We always talk about insurance—private insurance being regulated by states. The federalism—we are back on the federalism bandwagon. I am glad. It helps us talk about this. Now we are talking about Medicare, but the tort reform savings, if—are significant, but we have got this State issue of tort law and federalism that I like to think—I know the Affordable Care Act did provide some money for states for pilot programs, which I applaud, and I hope that more states look at that.

Where am I headed with all this? I am heading with this—I am glad to hear what we are doing. I don't hear much about the individual consumer. I hear about the primary practice physician, I hear about—I mean, the fact that we don't want to incentivize volume. We don't want overconsumption. We don't want one size doesn't fit all. Where is the consumer in this? Anyone?

Mr. BRONSON. The word patient-centered is in this effort, patient-centered medical home. Consumer is really dead set in the middle—

Mr. SHIMKUS. Where? How?

Mr. BRONSON [continuing]. And it is key—how?

Mr. SHIMKUS. Under a government-run program, what is the consumer—what skin do they have in the game financially?

Mr. BRONSON. Well, they have whatever co-pays and other things they have to—

Mr. SHIMKUS. Significant co-pays really affect change?

Mr. BRONSON. I don't know. I honestly don't know.

Mr. SHIMKUS. Anybody?

Mr. BRONSON. Well, I will take that back. I do know. I think we are seeing a decline in our business and our market because of very high deductible policies, and people are second-guessing questions about services and delaying services. Sometimes it is very effective and appropriate; sometimes it is dysfunctional. I think it needs to be looked at and organized in a way that you don't harm the health of the person, but you don't incent overutilization.

Mr. SHIMKUS. Let me go to Mr. Serota.

Mr. SEROTA. Congressman, you put a twist in the question when you said in a government-run program. I think that what we are doing in the Blues in our markets is a three-tiered strategy, and the third tier in that strategy is patient engagement. A critical element of success for us in the marketplace has been arming patients with information about costs, about quality, about which providers to select, and having them actively participate, and that includes actively participate economically, as well as with information.

Mr. SHIMKUS. My time is expiring, and I appreciate that. I am just going to finish up with this observation. If we don't do that type of process—health care costs are going up for everybody, even the private sector. In corporate insurance, what are they doing? They are incentivizing their workforce through wellness programs,

they are doing healthy living. They are really pushing people and they push it by what, a price signal. And if we don't do that in a government-run health care system and we always expect the Federal Government or CMS or some agency other than the Federal Government to do that for them, we are losing the opportunity to really reform our health care system.

Thank you, Mr. Chairman. I yield back.

Mr. PITTS. Chair thanks the gentleman. I now recognize the gentleman from Pennsylvania, Dr. Murphy, for 5 minutes for questions.

Mr. MURPHY. Good morning. This is of great concern to me of how we handle this. Look, we all get it. If all things being equal, if you pay someone by how many widgets they make versus giving them a flat salary, they will make more widgets. We understand that. The question comes of how we reform this, and we are throwing around a lot of phrases here, you know, quality, patient-centered, et cetera. I really want to get into some of the specifics.

I think yesterday the U.S. News and World Report annual rating of hospitals came out. I don't know if any of you saw that, big thing about Johns Hopkins was bumped out by Mass General and who else in the top 10. Are you all aware of how those ratings are done? Am I correct they survey thousands of specialists and say who do you like best, right?

Mr. BRONSON. They use objective measures.

Mr. MURPHY. What are some of the objective measures that they use?

Mr. BRONSON. Some of the CMS measures.

Mr. MURPHY. Such as?

Mr. BRONSON. The core measures I believe are being used. I would like to confirm that, but there is a combination and it depends on the specialty.

Mr. MURPHY. Can you give me an example?

Mr. BRONSON. An example in psychiatry, for example, they use almost all reputation as an—

Mr. MURPHY. Exactly, exactly. So it is articles they publish, who knows who. I look upon it as voting for prom king and queen.

Mr. BRONSON. Right, right.

Mr. MURPHY. They do not—because you can't survey thousands of specialists around the country and ask them what hospital has the best outcome measures? Who has the fewest surgical complications? Who has the fewest nosocomial infections? Who has the fewest ventilator-assisted infections? Who has longer or shorter than expected risk adjustment stay in an ICU? Who has different rehospitalization rates? Yet am I correct in saying that those are the kinds of things we need to be measuring? OK.

Now, I am wondering in that in terms of those—and if there are other ideas you have, too, how we change this system from what I refer to as the poke, prod, pinch, push, pull and prescribe payment system? That is what we get paid for as health care professionals. We want to pay for quality. In a very specific way, do we then attach dollar value to some of these things so if a hospital has a decline in the number of ICU days, a decline in the number of readmissions, decline in the number of nosocomial infections, how do we pay for that? Anybody? Dr. Nash?

Mr. NASH. As mentioned earlier, we do have experience working with our hospital partners, and we are regional plan. But it is really a shared savings approach, not too dissimilar to what Medicare is looking at, and that is we identify opportunities where there is a chance to improve quality, and instead of just taking all of that savings and funneling it back into premium reductions, we are sharing some of that with the hospitals for the opportunity for them to transform their systems.

Mr. MURPHY. So I just want to make sure, because I am trying to understand this. I am not trying to put you on the spot. I have been working this since I wrote the patient bill of rights law in Pennsylvania where we are fighting managed care plans who would give a global payment to a practice or hospital and say you figure it out, and the scandals that came out of there were people were told you couldn't—you had to drive by this emergency room because you had to go to this one, because this is the one that is covered. Or you were not going to get covered for this, we are going to cover you for that. And my worry is that I want to make sure we don't get into those kinds of models where someone is just saying OK, well, we will save money today so we can get paid with this year's fund, and if the patient ends up with the problems next year that is OK, they are probably going to be with a different insurance company. How do we avoid that? Dr. Patel, you look like you are—

Ms. PATEL. Yes. I want to just say that the two things we do to avoid that, we shouldn't have something that is so absolute, like a reduction in ICU days or reduction in that unless we know that the second piece of information exists, which is that a reduction in ICU days is actually proven by evidence to have improved outcome in some way. So the scenario that you are describing, I think the way to instill—we have all talked in our societies and in our clinical professions about some of the metrics that we are coming up with, even as we speak, to ensure that those exact examples don't happen.

Mr. MURPHY. What you just said is absolutely golden, and something that this committee actually discussed when we read it was knocked out of the health care bill, and that was if we allow the societies, the colleges, the specialties in medicine that have their own protocols to determine things appropriate as opposed to an IPAB board, it is a big difference. An IPAB board takes an act of Congress to change what they are coming up with, but you are saying this is something that the various professional medical organizations themselves are constantly looking at?

Ms. PATEL. Yes.

Mr. MURPHY. Dr. Hoyt, you were going to say something on that?

Mr. HOYT. Well, yes. We have spent a lot of time thinking about this, and in our model, the updates would really require an annual rethinking of what the new target would be, realizing that as a group of physicians reach a target, that is no longer going to incentivize them to reduce costs, so you are going to have switch the target. But I think if the professional societies are charged with developing that, they are capable of it.

Mr. MURPHY. Anyone else want to comment on it?

Mr. SEROTA. Yes, I guess I would just say that in our programs—we call it Blue Distinction—we used professional societies to determine the appropriate quality standards, and we do want to be careful to avoid substituting one piece work measure for another piece work measure. So if we are not paying for poking and prodding but we are paying for days reduction, we still are not getting at paying for outcomes, paying for better quality and better outcomes, which is where I think we ultimately have to get.

Mr. MURPHY. And I think this is one of those things we still have to figure out how to do this, because quality is a very nebulous term. But I still believe that empowering the professional colleges and societies and panels in medicine is more important than having an IPAB board by which, by law, has to be less than half physicians and medical people.

I yield back. Thank you, Mr. Chairman.

Mr. PITTS. Chair thanks the gentleman. That concludes the members of the subcommittee. We have Dr. Christensen who is here to ask questions. Dr. Christensen, you are recognized for 5 minutes for questions.

Ms. CHRISTENSEN. Thank you, Mr. Chairman, and no question, the SGR has outlived its non-usefulness and we need a new methodology to fairly and adequately reimburse physicians and other providers for care. But just to get this off my chest, for the record, if the system had been set up to pay primary care physicians for what we have always done, provide patient-centered care, spend time with patients and their families, and provide comprehensive care, whether at home, in the hospital, or in the office, and to coordinate the care with specialists, we wouldn't be where we are today. The Affordable Care Act, though, has done much to lay the foundation to change this and add new models of care that are being tested that you have been discussing and enable us to once again practice the art of medicine and again, for the record, it has strengthened Medicaid, it has improved benefits, and it has actually lengthened the solvency, rather than hurt Medicare.

But this hearing is a really good beginning to move us forward. I want to thank the chair and ranking member for holding it, and thank all of our panelists for their time, their work, and their thoughtful testimonies.

I want to ask everyone this question. How did the approaches that you are recommending take into account physicians and other providers of color or who work in poor communities where services are very limited, and the patients are sicker with many comorbidities, especially when we are focusing a lot on outcomes? How do we take into account where that patient started from, and when we are talking about evidence-based medicine when many people of color, and sometimes people with other comorbidities are not in the clinical trials that produce that evidence?

Mr. SEROTA. I guess what I would say is our philosophy is—I mean, the term that has been used up here is one size doesn't fit all. We really in the Blues believe you have to meet the physician's practices where they are, and you can't take a cookbook approach across the country and say it worked here, therefore it will work everywhere. You have to work with the local physician communities and the local provider communities and develop a program

that starts from where they are and provides incentives, information, and data to help them move the needle forward so that from wherever they are starting from, you pay and you reimburse for improvements from where they are, not measures against some mythical standard that exists on a global basis.

So we really believe that the closer you get to local management, the better the outcomes and the better results you are going to get from patient-centered medical homes. So that is the way we would deal with those issues in all cases.

Ms. CHRISTENSEN. Dr. Nash?

Mr. NASH. Yes, CDPHP is our region's largest provider of managed Medicaid services, and we partner very closely with our federally qualified health centers and other private providers with large Medicaid populations. We support them not only by paying them more comprehensively, as I have been describing this morning, which allows them to sort of deploy those resources as they see fit for those patients, but we deploy our own resources and that is we created community health workers to work in the communities to go outreach the patients to bring them into the doctors who aren't being seen, as well as putting pharmacists and behavioral health workers in those practices.

Ms. CHRISTENSEN. Dr. Bronson, did you want to add?

Mr. BRONSON. Well, there is nothing more important that we learn how to reward practices for improving the health status of their patients, and you have to go to where they are at and understand the risk profile of that community, the risk profile of those specific patients, and have incentives that make sense for those communities. It is well-observed that certain demographic characteristics will not support—people with those characteristics will not achieve the same outcomes as others in certain areas, and that is very complex. Sometimes it is socioeconomic, sometimes it is other issues of disparity that we need to understand. So these have to be adjusted appropriately to support those practices. We shouldn't disadvantage those who are helping those in great need.

Ms. CHRISTENSEN. Thank you. Anyone else want to add?

Mr. HOYT. Yes, our past president, L.D. Britt, has made the comment that there is no quality without access. And I think that has led to us as an organization really trying to profile where we are deficient in some of those areas. One of them is in the—sort of the systemus of delivery of care is to assure that limited access populations, whether it is geographic or it is economic or color, et cetera, that those are overcome by getting adequate data. And so we are really making a concerted effort to make sure that the data we collect at a large hospital in a large city is the same as the data that we can collect in a smaller hospital or in a more remote or financially challenged area to try and identify those problems, and then start to create solutions for them.

Ms. PATEL. One additional thing that the Affordable Care Act included were provisions for coverage of costs associated with clinical trials, such that the very issue you describe with deep disparities in clinical trial enrollment, especially in cancer, can be dealt with, and that is very important.

Ms. CHRISTENSEN. I thank you for your answers, and thank you, Mr. Chairman, for giving me the time.

Mr. PITTS. Chair thanks the gentlelady. That concludes all the questions from the members. Again, let me say this has been an excellent panel. Thank you for your testimony, your answers, and we will send you any further questions from the members——

Mr. PALLONE. Mr. Chairman?

Mr. PITTS [continuing]. If you please respond.

Mr. PALLONE. Mr. Chairman, I just wanted to—I have heard a number of my colleagues mention this double counting issue, and I think it is a red herring, so I am asking to insert Secretary Sebelius's letter on the matter into the record. I would ask unanimous consent.

Mr. PITTS. Without objection, so ordered.

[The information follows:]



THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

March 30, 2011

The Honorable Frank Pallone, Jr.
Ranking Member
Energy and Commerce Committee
Subcommittee on Health
U.S. House of Representatives
Washington, D.C. 20515

Dear Representative Pallone:

Thank you for your March 23, 2011 letter regarding my statements before the Committee on Energy and Commerce on March 3, 2011. I remain committed to working with you and your colleagues to ensure successful implementation of the Affordable Care Act, and appreciate the opportunity to respond directly to questions regarding efficiencies in the Medicare program.

It is important to reiterate the facts: the new law will not cut guaranteed benefits for seniors or alter the current protections for Medicare beneficiaries. In fact, the Affordable Care Act will add benefits such as free prevention services, an annual wellness visit, and a phase-out of the Medicare donut hole in the prescription drug benefit. Moreover, by reducing waste, fraud, and abuse and cracking down on overpayments, the law will lower beneficiary premiums, reduce beneficiary cost sharing and, as I stated in my testimony, slow the projected growth rate of Medicare over 10 years, extending the life of the Medicare Hospital Insurance Trust Fund by 12 years.

As I have testified, the Congressional Budget Office (CBO) estimates that the Affordable Care Act will reduce the deficit by \$210 billion in the first decade and \$1 trillion in the next decade. Additionally, the Medicare Trustees estimated that the Medicare trust fund will remain solvent for an additional 12 years because of changes called for in the Affordable Care Act.

In developing these estimates, CBO and the Trustees are following the budgeting methods put into law in 1990 and used for more than two decades. Similarly, since 1981, Republican and Democratic Congresses alike have enacted at least ten laws that the CBO and the Medicare Trustees estimated would achieve savings in Medicare, extending the solvency of the Medicare Part A Trust Fund and reducing the deficit. For example, this process was used to estimate savings during the Balanced Budget Act of 1997 and the Deficit Reduction Act of 2005.

As Joseph Antos, the Wilson H. Taylor Scholar in Health Care and Retirement Policy at the American Enterprise Institute, recently testified before the Energy and Commerce Committee Subcommittee on Health, this budgeting method has been in use for many years and is not a budgeting gimmick. CBO is not double counting.

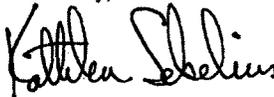
The Honorable Frank Pallone, Jr.
March 30, 2011
Page 2

To better understand these budget calculations, it is important to note that the Medicare savings, like other trust fund savings, are part of a larger deficit calculation. Under these longstanding budget practices, Medicare spending is part of the unified federal budget. Therefore, program changes that reduce the growth in spending contribute to reducing the budget deficit. When these changes specifically affect Medicare Part A spending, they also favorably affect solvency projections for the Hospital Insurance Trust Fund.

Paul Van de Water, a Senior Fellow at the Center on Budget and Policy Priorities, also recently testified that there is no double counting in recognizing that Medicare savings improve the status of both the Federal budget and the Medicare Trust Funds. He gave an example, "In the same way, when a baseball player hits a homer, it both adds one run to his team's score and also improves his batting average. Neither situation involves double-counting."

Thank you again for your letter and for seeking clarity in my responses to these important questions. I look forward to continuing to work with you and your colleagues to responsibly implement the Affordable Care Act and deliver its benefits to the American people. A similar response has also been provided to Representative Waxman.

Sincerely,

A handwritten signature in black ink that reads "Kathleen Sebelius". The signature is written in a cursive style with a large initial "K".

Kathleen Sebelius



THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

March 30, 2011

The Honorable Henry A. Waxman
Ranking Member
Energy and Commerce Committee
U.S. House of Representatives
Washington, D.C. 20515

Dear Representative Waxman:

Thank you for your March 23, 2011 letter regarding my statements before the Committee on Energy and Commerce on March 3, 2011. I remain committed to working with you and your colleagues to ensure successful implementation of the Affordable Care Act, and appreciate the opportunity to respond directly to questions regarding efficiencies in the Medicare program.

It is important to reiterate the facts: the new law will not cut guaranteed benefits for seniors or alter the current protections for Medicare beneficiaries. In fact, the Affordable Care Act will add benefits such as free prevention services, an annual wellness visit, and a phase-out of the Medicare donut hole in the prescription drug benefit. Moreover, by reducing waste, fraud, and abuse and cracking down on overpayments, the law will lower beneficiary premiums, reduce beneficiary cost sharing and, as I stated in my testimony, slow the projected growth rate of Medicare over 10 years, extending the life of the Medicare Hospital Insurance Trust Fund by 12 years.

As I have testified, the Congressional Budget Office (CBO) estimates that the Affordable Care Act will reduce the deficit by \$210 billion in the first decade and \$1 trillion in the next decade. Additionally, the Medicare Trustees estimated that the Medicare trust fund will remain solvent for an additional 12 years because of changes called for in the Affordable Care Act.

In developing these estimates, CBO and the Trustees are following the budgeting methods put into law in 1990 and used for more than two decades. Similarly, since 1981, Republican and Democratic Congresses alike have enacted at least ten laws that the CBO and the Medicare Trustees estimated would achieve savings in Medicare, extending the solvency of the Medicare Part A Trust Fund and reducing the deficit. For example, this process was used to estimate savings during the Balanced Budget Act of 1997 and the Deficit Reduction Act of 2005.

As Joseph Antos, the Wilson H. Taylor Scholar in Health Care and Retirement Policy at the American Enterprise Institute, recently testified before the Energy and Commerce Committee Subcommittee on Health, this budgeting method has been in use for many years and is not a budgeting gimmick. CBO is not double counting.

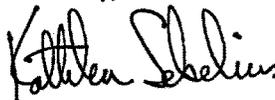
The Honorable Henry A. Waxman
March 30, 2011
Page 2

To better understand these budget calculations, it is important to note that the Medicare savings, like other trust fund savings, are part of a larger deficit calculation. Under these longstanding budget practices, Medicare spending is part of the unified federal budget. Therefore, program changes that reduce the growth in spending contribute to reducing the budget deficit. When these changes specifically affect Medicare Part A spending, they also favorably affect solvency projections for the Hospital Insurance Trust Fund.

Paul Van de Water, a Senior Fellow at the Center on Budget and Policy Priorities, also recently testified that there is no double counting in recognizing that Medicare savings improve the status of both the Federal budget and the Medicare Trust Funds. He gave an example, "In the same way, when a baseball player hits a homer, it both adds one run to his team's score and also improves his batting average. Neither situation involves double-counting."

Thank you again for your letter and for seeking clarity in my responses to these important questions. I look forward to continuing to work with you and your colleagues to responsibly implement the Affordable Care Act and deliver its benefits to the American people. A similar response has also been provided to Representative Pallone.

Sincerely,

A handwritten signature in black ink, appearing to read "Kathleen Sebelius". The signature is written in a cursive, flowing style.

Kathleen Sebelius

Mr. PITTS. I remind members that they have 10 business days to submit questions for the record, and I ask the witnesses to respond to questions promptly. Members should submit their questions by the close of business on Wednesday, July 31. Without objection, the subcommittee is adjourned.

[Whereupon, at 12:07 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

**Opening Statement
Chairman Fred Upton
Subcommittee on Health Hearing on “Using Innovation to Reform Medicare
Physician Payment”
July 18, 2012**

(As Prepared for Delivery)

The deficiencies of the current Medicare physician payment system are well known. In fact, this year marks a decade of repeated congressional action to avoid substantial fee cuts to physicians in the Medicare program. And the toll keeps mounting. In January, physicians will once again face cuts of at least 27.5 percent; the price tag to get rid of this flawed system is over \$300 billion.

The purpose of this hearing is not to perpetuate the old conversation about the failings of the Sustainable Growth Rate system, but rather to continue a conversation begun by the Energy and Commerce Committee over a year ago on how we build a better payment and care delivery system for the future. Through feedback from physician groups, a hearing in May of last year, and continued input from a number of stakeholders, we have been able to identify widespread agreement on certain elements that a future payment system will need to incorporate.

First, we need to repeal the SGR and put an end to this perpetual cycle of payment instability and threatened access to care. Next, we need to introduce incentives that will encourage physicians and other providers to deliver care that results in better patient outcomes, maintains access to needed medical services for beneficiaries, pays providers adequately and fairly, and reduces the rapid growth in spending in the Medicare program.

We have heard from many different groups about the need for a period of stability in Medicare payments. However, it is not constructive to offer criticism without solutions. Those who argue for stability must also help us develop the policy that will eventually replace the SGR.

The urgency for action to break this cycle could not be greater, especially as our country ages with 10,000 Baby Boomers now turning 65 every day. I want to thank the witnesses for helping us as we work to resolve this difficult problem and I look forward to your testimonies.