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SGR: DATA, MEASURES, AND MODELS; BUILDING A FUTURE MEDICARE PHYSICIAN PAYMENT SYSTEM

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE
HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRTEENTH CONGRESS

FIRST SESSION

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SGR: DATA, MEASURES AND MODELS; BUILDING A FUTURE MEDICARE PHYSICIAN PAYMENT SYSTEM

THURSDAY, FEBRUARY 14, 2013

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

The subcommittee met, pursuant to call, at 10:18 a.m., in Room 2123 of the Rayburn House Office Building, Hon. Joe Pitts (chairman of the subcommittee) presiding.

Members present: Representatives Pitts, Burgess, Hall, Shimkus, Murphy, Gingrey, Lance, Cassidy, Guthrie, Griffith, Bilirakis, Ellmers, Upton (ex officio), Pallone, Dingell, Engel, Capps, Green, Barrow, Christensen, Castor, Sarbanes, and Waxman (ex officio).

Staff present: Clay Alspach, Chief Counsel, Health; Matt Bravo, Professional Staff Member; Steve Ferrara, Health Fellow; Julie Goon, Health Policy Advisor; Debbee Hancock, Press Secretary; Robert Horne, Professional Staff Member, Health; Carly McWilliams, Legislative Clerk; John O'Shea, Senior Policy Advisor, Health; Andrew Powaleny, Deputy Press Secretary; Chris Sarley, Policy Coordinator, Environment and Economy; Heidi Stirrup, Health Policy Coordinator; Alli Corr, Democratic Policy Analyst; Amy Hall, Democratic Senior Professional Staff Member; Elizabeth Letter, Democratic Assistant Press Secretary; and Karen Nelson, Democratic Deputy Committee Staff Director for Health.

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

Mr. PITTS. The subcommittee will come to order. The chair recognizes himself for 5 minutes for an opening statement.

The background and details of the topic of today's hearing are well known to physicians, to this subcommittee, and to most health policy analysts. The Sustainable Growth Rate, or SGR payment system, originated with the Balanced Budget Act of 1997. At that time, the intent of the of SGR physician payment system, placing controls on Medicare spending through global spending targets and fee cuts if the targets were exceeded, seemed like a reasonable thing to do. However, within a short time, it became apparent that this policy was flawed.

This subcommittee has had previous hearings that have addressed the shortcomings of SGR, including the repeated threats to

patient access to care, and provider income, and the mounting costs of Congressional actions to override the scheduled fee cuts. Congress has acted to override these statutory cuts on at least 15 occasions, and the cost of these overrides has been staggering. The most recent 1-year extension override comes at a price of $25.2 billion.

Furthermore, all the money spent on avoiding cuts to physician fees has not gotten us any closer to a payment policy that will reimburse physicians for the value rather than the volume of services, will pay physicians and other providers fairly, and ensure access to high quality health care for all Medicare beneficiaries.

Today's hearing is an attempt to move us closer to that goal. This hearing will focus on three themes: data, measures and models. In thinking about the proper payment policy, there seems to be fairly widespread agreement that certain elements are needed to build that system.

First of all, physicians, payers, and other stakeholders need access to reliable data that can be used to improve the value of health care. Appropriate measures also need to be developed on an ongoing basis to continually assess progress in improving the system. In addition, as new and better payment and care delivery models are developed, they should be incorporated into the Medicare program.

The witnesses that are here today are well equipped to address these areas. I would like to express my thanks to today's witnesses who have taken time out of their busy schedules to share their expertise with the subcommittee on this difficult problem which has confronted the Medicare system for more than a decade.

[The prepared statement of Mr. Pitts follows:]

PREPARED STATEMENT OF HON. JOSEPH R. PITTS

The background and details of the topic of today's hearing are well-known to physicians, to this Subcommittee, and to most health policy analysts.

The Sustainable Growth Rate, or SGR payment system, originated with the Balanced Budget Act of 1997. At the time, the intent of the of SGR physician payment system, placing controls on Medicare spending through global spending targets and fee cuts if the targets were exceeded, seemed like a reasonable thing to do. However, within a short time, it became apparent that this policy was flawed.

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I would like to express my thanks to today's witnesses who have taken time out of their busy schedules to share their expertise with the Subcommittee on this difficult problem which has confronted the Medicare system for more than a decade.

Mr. PITTS. Now I would like to recognize the ranking member of the Subcommittee on Health, 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, Chairman Pitts. I want to commend you for holding today's hearing. As our first Health Subcommittee of the 113th Congress, I think it sends a strong message that fixing the Sustainable Growth Rate system is our top priority, and I know it is certainly my top priority.

So let me just note that I was very encouraged by Chairman Upton's remarks yesterday, that it is his goal to put a bill on the House Floor before the August recess. I stand ready to work with you both to meet that goal, and it is my hope that this will be a bipartisan process. But I would be remiss if I didn't express my disappointment to see the release of a Republican framework by the committee and its Ways and Means counterpart. Truthfully, since I understand that there was a commitment to working with us on a bipartisan basis, putting out a Republican-only framework is somewhat perplexing. With little detail, I will refrain from commenting on its substance, so I just ask that moving forward, any future products will include the input of the Democratic members of the committee.

Now, we are here again facing yet another year of uncertainty in Medicare for physicians and beneficiaries. Clearly, we can all agree that the SGR is fundamentally flawed and it is creating instability in the program. While the formula represented an attempt to minimize unnecessary growth in volume of services, it has not only failed to do that, but also fails to reward providers for improved quality and outcomes. As a result, Congress has spent more than a decade overriding arbitrary cuts to physician payments generated by this formula with little to show for that other than an ever-growing budgetary hole. At a time when it is often difficult to find bipartisan consensus, this is one area where people on the left and the right of the political spectrum have come to agreement, and that is that the SGR formula must be repealed and replaced.

But the question that has vexed those us in Congress is how best to accomplish that replacement. While no one proposal is likely to hold a perfect solution, I believe there are a number of elements we should seek to incorporate into a new payment model including building on the reforms that are already underway in Medicare through the Affordable Care Act.

First, we have to reward quality. Providers who contribute to improved health care outcomes and better quality deserve recognition. Second, we must also reward efficiency, delivering the right care at the right time in the right setting. Third, we must reward collaboration and a patient-centered approach. Too often, Medicare is fragmented and a complete view of the patient is missing. We need to

ensure providers have incentives to work together and share information.

Now, today's hearing will delve into these issues by exploring how quality is measured, what data is needed and what models will deliver the best results. These components must be resolved in order to finally replace the SGR. And so I welcome our witnesses here to bring their perspectives to help our members evaluate these essential issues.

I also wanted to say, Mr. Chairman, I don't know how many newer members we have today but I do think my feeling is that the newer members of the committee on both sides of the aisle have a lot to offer with regard to the SGR and looking towards the future, and so I hope that we will get a lot of our newer members involved in whatever final outcome we come up with, because I do think they have a lot to offer.

I want to close with a fact that I think can't be ignored, and that is that SGR repeal is too expensive to pay for with Medicare cuts alone, especially when Medicare cuts are being considered to reduce the Nation's debt. I have said to my colleagues including you, Mr. Chairman, that I really worry that every time there need to be some changes, you know, to meet the SGR goal or to deal with other health care initiatives, it is also assumed that the cuts have to be within the health care system, and whether it is Medicare or Medicaid, we should not always look to provider cuts within the health care system to pay for other provider cuts that have been out there. I know we are all delighted to see that the cost of repealing the SGR is lower than it has been in years, but we are not fools. A hundred and eighty-three billion dollars is still a lot of money, and we simply can't find that amount of savings from Medicare alone, and that is why I have insisted from the beginning that we not only consider savings from within the health care system, I believe we can use another approach to write off the costs such as an unpaid baseline adjustment or the OCO funds. The OCO funds are something I have suggested in the past.

But in any case, the SGR is unsustainable, unreliable and unfair, so the question remains, how do we fix it. I hope we can begin to truly answer that question after today's hearing so that we can provide security and reliability for our seniors and our doctors alike.

I yield back. Thank you, Mr. Chairman.

Mr. PITTS. The chair thanks the gentleman, and I join him in welcoming all the new members to the subcommittee including on our side Mr. Hall, Mr. Griffith, Ms. Ellmers and Mr. Bilirakis.

At this time the Chair recognizes the chairman of the full committee, Mr. Upton, for 5 minutes for an opening statement.

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

Mr. UPTON. Thank you, Mr. Chairman.

You know, by now we are all too familiar with how the current SGR system has caused uncertainty among physicians and threatened access to care for our Nation's seniors. Unfortunately, this issue was ignored in the Affordable Care Act, but continuing to ignore it is no longer an option.

Yesterday, I had the opportunity to address the AMA, and I emphasized our desire to work with physicians and the need for input from the medical profession in order to arrive at a physician payment policy that will in fact achieve real reform. Real reform will mean that doctors no longer have to wonder whether they will face substantial fee cuts and that our Nation's seniors will not have to wonder whether they will be able to see their docs.

During the last Congress, the Energy and Commerce Committee began a bipartisan effort to address the problem that has plagued seniors and their physicians for more than a decade. In 2011, the committee sent a bipartisan letter to more than 50 physician organizations, soliciting input on how to reform the Medicare physician payment system. More than two dozen responded with a good number of valuable ideas.

This subcommittee then held hearings to address the issue, and the committee has continued to engage with physicians and other stakeholders to formulate a payment policy to solve this difficult problem.

Last week, Ways and Means Chairman Dave Camp and I, along with Subcommittee Chairmen Pitts and Brady, as well other committee members, announced the release of a proposal to finally achieve long-term reform of the current SGR Medicare physician payment system. This is a top priority. And as we move closer to the goal, I am confident that we can make it a bipartisan effort. Today's hearing is another step in that way, and I would yield the balance of my time to the vice chair and a very important player as we have formulated the draft and pursue this issue, Dr. Burgess from Texas.

[The prepared statement of Mr. Upton follows:]

PREPARED STATEMENT OF HON. FRED UPTON

By now, we are all too familiar with how the current Sustainable Growth Rate system has caused uncertainty among physicians and threatened access to care for our nation's seniors.

Unfortunately, this issue was ignored in the Affordable Care Act, but continuing to ignore it is no longer an option.

Yesterday, I had the opportunity to address the American Medical Association. I emphasized our desire to work with physicians and the need for input from the medical profession in order to arrive at a physician payment policy that will achieve real reform.

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In 2011, the Committee sent a bipartisan letter to more than 50 physician organizations and others, soliciting input on how to reform the Medicare physician payment system. More than 30 groups responded to our letter with a number of valuable ideas.

The Health Subcommittee then held hearings to address this issue, and the committee has continued to engage with physicians and other stakeholders to formulate a payment policy to solve this difficult problem.

Last week, Ways and Means Chairman Camp and I, along with Subcommittee Chairmen Pitts and Brady, as well other committee members, announced the release of a proposal to finally achieve long-term reform of the current SGR Medicare physician payment system. This is a top priority. As we move closer to this goal, I am confident that we can make this a bipartisan effort. Today's hearing is another step in that process.

I would like to thank the witnesses for volunteering both their time and expertise today and for helping us as we move toward a solution to this problem.

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

Mr. BURGESS. Well, I thank the chairman for the recognition, and we all know that this Sustainable Growth Rate formula, it is an issue whose time has come and should have gone long ago. It is unrealistic assumptions of spending and efficiency. It has certainly plagued this committee, but really, the important thing is, it has been a problem for doctors and it has been a real problem for beneficiaries at a time when beneficiaries are growing at 10,000 a day.

It has already been mentioned about the follow-up where our two committees share jurisdiction. The framework does build off the work done over the past year and a half by the chairman of the subcommittee and his staff and has involved collaboration from doctors and patient groups all over the country. It should be noted, it is not for discriminating between physicians and other providers. It does not seek to benefit one form of medical practice over another. The framework realizes, there are always going to be areas where providers choose or need to practice in a fee-for-service for model. It doesn't mean there are not better ways to revamp fee-for-service but it does mean the fee-for-service may continue to exist.

Our goal cannot be flexibility in practice models if we do not have the ability to quickly evaluate innovative practice environments, and if appropriate, build them into future options. Innovation for the future is critical and every encouraging the reevaluation of adoption of models that adapt to changes in best practices and clinical guidelines and the technology.

I will submit the balance of my remarks for the record and yield the time to Dr. Gingrey.

Mr. GINGREY. I thank Mr. Burgess for yielding.

Mr. Chairman, I am encouraged that Chairman Upton has signaled the SGR repeal and replacement will be a chief concern for the Energy and Commerce Committee this year. I am excited to be here today as it is hopefully the conclusion of a large fact-finding mission this subcommittee has undertaken over these few years. We began with hearings to address the need for action, then to understand past attempts to reform, and now we are finally here today to seek how to use data and other measures to modernize and improve the Medicare payment system as a last step before legislative action.

As a doctor and as co-chairman of the GOP Doctors Caucus, I understand the necessity of these changes, and I look forward to seeing the job of reform completed this year, and certainly, Mr. Chairman, thank you for calling this hearing, and I yield the balance of this time to the gentleman from Louisiana, Dr. Cassidy.

Mr. CASSIDY. Thank you, Mr. Gingrey.

The 113th Congress has a tremendous opportunity and obligation to finally eliminate the SGR payment regime, but I would say as we discuss and contemplate new and innovative payment models, we have to keep in mind that the typical Washington solution involves very large bureaucracies, either public or private. That said,

as a practicing physician, I know many of my colleagues are reluctant to give up their smaller practice, and if we are going to achieve a quicker reform, we must keep that in mind if for no other reason than that is reportedly a major cause of physician burnout and early retirement. So my office is working on a proposal that would allow these physicians to continue to participate in their private practice but to have gain-sharing relationships, participate in those innovative reforms while retaining the independent nature of their current practice, and I would look forward to the Democratic side participating in this discussion as well because I do think that is a bipartisan concern.

I look forward to the panel's testimony and discussion, and I yield back. Thank you.

Mr. PITTS. The Chair thanks the gentleman. At this time the Chair recognizes the ranking member of the full committee, Mr. Waxman, for 5 minutes for an opening statement.

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

Mr. WAXMAN. Thank you, Mr. Chairman. I guess that is called good timing. I was present at another subcommittee hearing upstairs and I wanted to get down here as soon as I could. I want to thank you for holding this hearing.

Today's discussion will focus on some of the critical questions we must address in redesigning Medicare's physician payment system. There is no question about it: Medicare is vital to the health of seniors in our country, and physicians are a vital part of Medicare, and a critical partner to helping us build a health care system that provides better health care and improved health for all patients. We know that the payment system can drive patient outcomes but, unfortunately, right now it is not driving it in the direction of better health and value.

It is clear from this hearing that there is a broad consensus on the need to fix this problem, and even consensus on which direction we need to move. The question is how to get there. The Affordable Care Act provides the foundation for the right path forward. Through its support for new delivery and payment models like accountable care organizations, bundled payments, medical homes and initiatives that boost primary care, it moves us in the direction of improved quality, efficiency and value. Innovative delivery and payment system models are also being developed and implemented by physician groups, health systems, regional health improvement collaboratives, and private payers, in some cases as private-public partnerships. We will hear more about these in today's hearing. We have the opportunity to leverage payment reform in Medicare to support these new delivery and payment models. We need to respect and encourage local innovation, but ensure accountability for improvement and prudent management.

Our challenge is to judiciously balance the many competing interests in our health care system. I believe that we need to approach this discussion with physicians as our partners, but we also need to ensure that other health care stakeholders, including beneficiaries and non-physician providers, have input as well.

It is no longer acceptable to accept the status quo. It is time for us to work together and permanently repeal SGR and put in place a truly sustainable system that aligns provider payments with quality and ensures that all Americans have access to the best care at lower cost.

I am pleased the chairman is moving forward with this hearing early in this Congress, and I am hopeful that we can find common ground on a solution for a problem that has been calling out for one for a very long time. We shouldn't have this SGR threat hanging over us every year with the uncertainty it has meant to the physicians in this country, not knowing whether Medicare is going to be there for them, which has brought about many physicians leaving the Medicare program completely, which is a disservice to the beneficiaries of Medicare.

I thank you for the time allotted to me. I will be happy to yield whatever period of time I have left to any other member that wants me to yield. If not, I will yield back the time.

[The prepared statement of Mr. Waxman follows:]

PREPARED STATEMENT OF HON. HENRY A. WAXMAN

I would like to thank the Chairman for holding this hearing. Today's discussion will focus on some of the critical questions we must address in re-designing Medicare's physician payment system.

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It is no longer acceptable to accept the status quo. It is time for us to work together and permanently repeal SGR and put in place a truly sustainable system that aligns provider payment with quality and ensures that all Americans have access to the best care at lower cost.

I am glad to see the Chairman moving forward early in this Congress, and I am hopeful that we can find common ground on a solution.

Mr. PITTS. All right. The Chair thanks the gentleman.

We have two panels today. Our first panel will have just one witness, Mr. Glenn Hackbarth, chairman of the Medicare Payment Advisory Commission. We are happy to have you with us today, Mr. Hackbarth, and you are recognized for 5 minutes for an opening statement at this time.

STATEMENT OF GLENN M. HACKBARTH, J.D., CHAIRMAN, MEDICARE PAYMENT ADVISORY COMMISSION

Mr. HACKBARTH. Chairman Upton, Ranking Member Waxman, Subcommittee Chairman Pitts and Ranking Member Pallone, I appreciate the opportunity to talk to you today about repeal of the Sustainable Growth Rate system for physicians.

MedPAC, which I chair, first recommended repeal of SGR in 2001. We recommended repeal at that point because we thought that the system would be ineffective in achieving the goal of encouraging efficient use of limited resources but also be inequitable to physicians inasmuch as any penalties apply equally to all physicians without regard to their individual performance.

To those two original concerns, we have now added a third, and that is that continuation of SGR poses an increasing risk to access to care for Medicare beneficiaries. Although we have not yet seen a significant erosion in access at the national level, we have all heard about problems with access to care for Medicare beneficiaries in particular markets and especially for primary care services.

MedPAC's fear is that those problems could spread rapidly if SGR is continued. We have a tight balance between supply and demand for services in many markets, again, in particular for primary care services, and growing physician frustration and anger about SGR means that even small numbers of physicians electing to reduce their participation in Medicare could have significant effects on access to care for Medicare beneficiaries. Now, to be clear, I am not predicting a national crisis at this point but we certainly cannot rule it out either.

We have an especially good opportunity, I think, now to address the SGR issue. As you well know, CBO has recently significantly reduced the budget score attached to repeal of SGR. In effect, SGR appeal is now on sale but the sale may not last forever. If experience is any guide, projections of this sort vary over time. I have been doing this for quite a while now, and I have gone through multiple cycles where we had low periods of growth followed by acceleration and rapid periods of growth, then low periods and then rapid periods again. Right now, we are in a low period of growth in utilization of services and hence the low score for repeal. I think it is important to seize this opportunity.

Repealing SGR alone is not enough, however. MedPAC recommends that the repeal legislation pursue two other goals. First is to balance payments within the physician payment system with particular focus on increasing payments for cognitive services relative to procedures and tests with a particular emphasis on improving payment for primary care services, and the second objective that we recommend is to encourage migration away from fee-for-service to new payment models for Medicare.

The criticism of fee-for-service that one most often hears is that fee-for-service has the incentive to increase volume without regard to outcomes for patients. That is true. But from our perspective, equally important is that fee-for-service enables, if not encourages, a fragmentation of care delivery, and through its siloed nature actually impedes the free flow of resources to where clinicians think they can do the best for patients. We believe that a better approach is a payment system that decentralizes decisions about what is ap-

propriate care in exchange for accountability by clinician and provider organizations for outcome and total cost.

Last point: Moving to these new payment models will take time. These are complicated changes to make, both on the payment side and on the care delivery side. They should take time. For us, that is a reason to begin now and not to delay any further. If we delay longer, it means that we will be well into the bulge of Baby Boomers retiring in the Medicare program and the financial pressures will be heightened, and we believe as a result the risk to both physicians and patients will be greater.

With that, Mr. Chairman, I am happy to take your questions.

[The prepared statement of Mr. Hackbarth follows:]

MEDPAC Medicare Payment Advisory Commission

TESTIMONY

Moving Forward From the Sustainable Growth Rate (SGR) System

February 14, 2013

Statement of

Glenn M. Hackbarth, J.D.

Chairman
Medicare Payment Advisory Commission

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

Chairman Upton, Ranking Member Waxman, Subcommittee Chairman Pitts, Subcommittee Ranking Member Pallone, distinguished Committee members. I am Glenn Hackbarth, chairman of the Medicare Payment Advisory Commission (MedPAC). I appreciate the opportunity to be here with you this morning to discuss MedPAC's approach to moving forward from the sustainable growth rate (SGR) system.

The Medicare Payment Advisory Commission is a Congressional support agency that provides independent, nonpartisan policy and technical advice to the Congress on issues affecting the Medicare program. The Commission's goal is to achieve a Medicare program that assures beneficiary access to high-quality care, pays health care providers and plans fairly, rewards efficiency and quality, and spends tax dollars responsibly.

Each year, MedPAC conducts an analysis of payment adequacy for physician and other health professional services. This analysis covers a range of issues—access to care, quality, and changes in volume and intensity of Medicare-covered services. MedPAC has also considered other approaches to improving the Medicare program, including delivery system reforms (such as accountable care organizations) and the role that physicians and other health professionals would play in those reforms. However, given the focus of this hearing, this testimony focuses solely on the Commission's recent work regarding the SGR system.

Background

Physicians and other health professionals deliver a wide range of services to Medicare beneficiaries, including office visits, surgical procedures, and diagnostic and therapeutic services in a variety of settings. In 2011, the Medicare program paid $68 billion for physician and other health professional services, 12 percent of total Medicare spending.

Medicare pays physicians and other health professionals (such as nurse practitioners or therapists) using a fee schedule that includes payment rates for over 7,000 separate billing codes. Weights for work, practice expense and malpractice insurance are set for each code and are designed to reflect the resources needed on average to provide the service. The sum of the weights is multiplied by a dollar amount called the conversion factor, which produces the total

payment amount for each service. So on net, Medicare's payments for physician services are a function of the number of services the physician orders and the rate for each of those services.

The old system of Medicare physician payment was similar to that used by private insurers. It was based on a percentage (e.g., 75 percent) of prevailing charges in a market and proved to be highly inflationary.[1] Providers learned that by raising charges, they could increase their payments from private insurers and Medicare. Moreover, it resulted in distortions among services and specialties (i.e., primary care vs. procedural based specialties) because certain specialties were more able to raise charges than others.[2] The Medicare physician fee schedule (PFS) was developed by a Harvard physician in consultation with panels of practicing physicians.[3] Upon implementation in 1992 it was intended to rationalize payments across services based on the time a service took to provide and the level of intensity it required, and it was also intended to narrow the differences between primary care/cognitive services and procedural services.[4] However, an additional concern was the volume of physician services. As noted above, physicians are able to order more or fewer services, and Medicare has gone through periods of high volume growth.[5] When the PFS was implemented there were concerns that physicians would respond to fee adjustments by generating more service volume. This led to volume-control policies, such as the SGR, being tied to physician payment.

Under current law, the conversion factor is governed by the SGR formula, which creates a limit on aggregate growth in payments to physicians and other health professionals by reducing the conversion factor if the SGR targets are exceeded. The SGR formula allows for growth in input prices, enrollment, and changes in law and regulation. The SGR formula also allows for volume growth equal to the rate of growth in per capita gross domestic product (GDP). As a result, the

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[1] Holahan, John, and Lynn M. Etheridge, eds. 1986. *Medicare physician payment reform*. Washington, DC: The Urban Institute Press.

[2] Holahan, John, and Lynn M. Etheridge, eds. 1986. *Medicare physician payment reform*. Washington, DC: The Urban Institute Press. Hsiao, W. C., D. B. Yntema, P. Braun, et al. 1988. Measurement and analysis of intraservice work. *Journal of the American Medical Association* 260, no. 16 (October 28): 2361-2370. Physician Payment Review Commission. 1989. *Annual report to Congress*. Washington, DC: PPRC.

[3] Hsiao, W. C., D. B. Yntema, P. Braun, et al. 1988. Measurement and analysis of intraservice work. *Journal of the American Medical Association* 260, no. 16 (October 28): 2361-2370.

[4] Physician Payment Review Commission. 1989. *Annual report to Congress*. Washington, DC: PPRC.

[5] Government Accountability Office. 2006. *Trends in service utilization, spending, and fees prompt consideration of alternative payment approaches*. GAO-06-1008T. http://www.gao.gov/assets/120/114491.pdf.

differential between GDP and volume is an important factor. A rationale for setting GDP as the volume target is that national output—or GDP—reflects a measure of affordability, as government tax collections have generally remained a constant share of national output. And Medicare Part B, which funds physician and other health professional services, receives the bulk of its financing from tax collections.

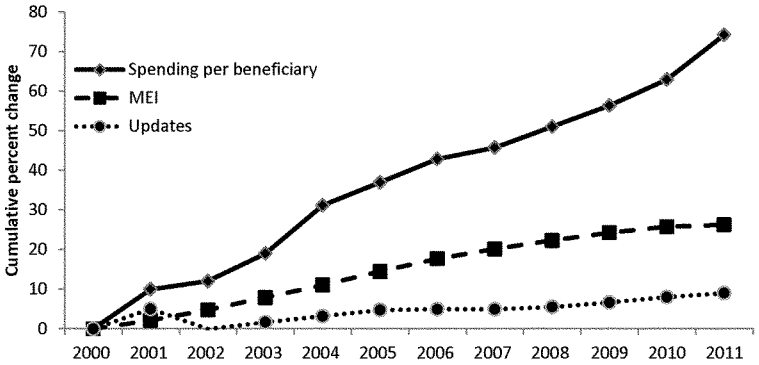
The resulting SGR formula has produced negative payment updates every year since 2003 due to increases in volume and intensity beyond those permitted by the SGR. However, the Congress has implemented short-term overrides of these negative payment adjustments every year since 2003. On January 2, 2013, the estimated 27 percent payment cut to physician fees under the SGR was overridden, and payment rates will remain at their 2012 level until the end of 2013. With the significant accumulation in spending that must be recouped under the SGR, repealing it has a high budgetary cost.

The Commission's position on the SGR system

The SGR is fundamentally flawed and is creating instability in the Medicare program for providers and beneficiaries. The Commission recommends that the Congress repeal the SGR system for many reasons. First, the SGR system, which ties annual updates to cumulative expenditures, has failed to restrain volume growth and may have exacerbated it (Figure 1).

While some physicians and other health professionals contribute to the inappropriate volume growth that has resulted in large payment adjustments through the SGR, others have restrained volume (Figure 2). But the SGR does not differentiate between physicians who restrain volume and physicians who do not restrain volume.

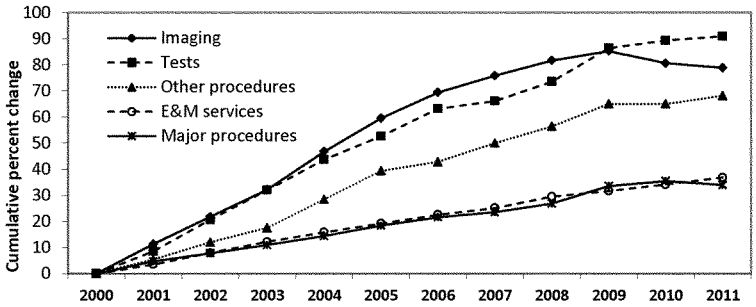
Figure 1. Volume growth has caused spending to increase faster than input prices and updates, 2000-2011



Note: MEI (Medicare Economic Index). The MEI is a measure of input prices for physician services. Updates are actual payment updates for the physician fee schedule.

Source: 2012 Trustees' report and Office of the Actuary 2012.

Figure 2. Growth in the volume of practitioner services, 2000-2011



Note: E&M (evaluation and management). Volume growth for E&M from 2009 to 2010 is not directly observable due to a change in payment policy for consultations. To compute cumulative volume growth for E&M through 2011, we used a growth rate for 2009 to 2010 of 1.85 percent, which is the average of the 2008 to 2009 growth rate of 1.7 percent and the 2010 to 2011 growth rate of 2.0 percent.

Source: MedPAC analysis of claims data for 100 percent of Medicare beneficiaries.

Second, temporary, stop-gap fixes to override the SGR undermine the credibility of the Medicare program because they engender uncertainty and anger among physicians and other health professionals, which may in turn cause anxiety among beneficiaries. Third, the short-term overrides have led to an administrative burden for providers and CMS due to holding of claims, delays in submission of claims, and reprocessing of claims.

The Commission laid out its findings and recommendations for moving forward from the SGR system in its October 2011 letter to the Congress, attached to this testimony as an appendix. Several principles embody our position:

- Repeal of the SGR is urgent.
- Beneficiary access must be preserved.
- The physician fee schedule must be rebalanced to achieve equity of payments between primary care and other specialties.
- Pressure on fee-for-service (FFS) must encourage movement toward new payment models and delivery systems.
- Repeal of the SGR should be done in a fiscally responsible way.

Repeal is urgent

The presence of the SGR and the temporary, stop-gap fixes to the SGR have had a destabilizing influence on the Medicare program by creating uncertainty for physicians, other health professionals, and beneficiaries.

Two reasons have often been given for delaying repeal: the large budgetary cost of repeal and concern about reverting to FFS payment without any limit on volume growth or change in incentives. CBO's recent re-estimation of the cost of repeal may reduce fiscal concerns about repeal or at least make it more feasible to find acceptable offsets. Similarly, implementation of ACOs as a new payment model is a significant first step toward addressing incentives for volume growth in a more effective, and equitable, manner than the SGR. Other new payment models,

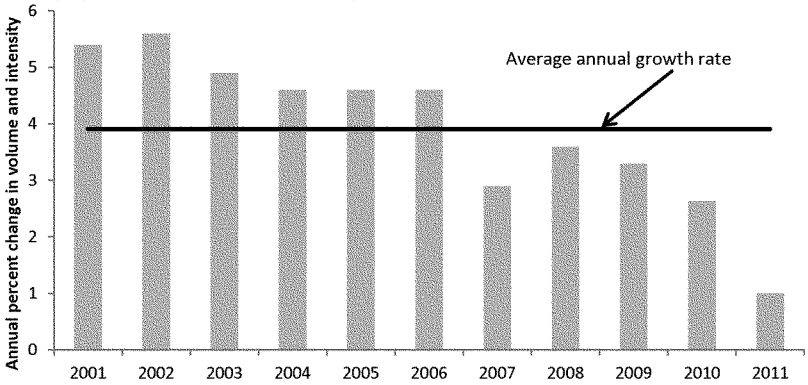
including bundling around hospital episodes and patient-centered medical homes, are now being pilot tested.

In our judgment, further delaying SGR repeal would expose beneficiaries to increasing risk of impaired access, and the budget score attached to repeal could begin to increase again (discussed below). Moreover, the array of new models for paying physicians and other health professionals is unlikely to change dramatically in the next few years. Rather than wait longer, we urge the Congress to repeal the SGR now and to begin rewarding physicians and other professionals as they shift their practices from open-ended FFS to accountable care organizations (ACOs). As additional new payment models move from pilot stage to implementation, similar incentives may be established for them. By committing to this course now, the Congress could stimulate physician interest in new payment models and thus accelerate their development and adoption.

Volatility in the cost estimates for repealing the SGR is another reason to repeal the formula now. The estimates depend on projections of growth in the volume and intensity of services furnished by physicians and other health professionals and the relationship between that volume growth and growth in gross domestic product. The difficulty in making those estimates is that volume growth has proven to be unpredictable. According to GAO, volume growth per beneficiary in the 1980s ranged from at least 3.7 percent to 9.7 percent, and in the 1990s the range was −0.7 percent to 3.4 percent.[6] According to the Commission's analyses, volume growth per beneficiary since 2000 has ranged from 1.0 percent to 5.6 percent (Figure 3).

[6] Government Accountability Office. 2009. Medicare physician payments: Concerns about spending target system prompt interest in considering reforms. GAO-05-85. Washington, DC: GAO.

Figure 3. Growth in the volume of services furnished by physicians and other health professionals has been volatile



Note: Volume growth for one type of service—evaluation and management (E&M)—from 2009 to 2010 is not directly observable due to a change in payment for consultations. To compute volume growth for 2010, we used an E&M growth rate of 1.9 percent, which is the average of the services' 2008 to 2009 and 2010 to 2011 growth rates.

Source: MedPAC analysis of claims data for 100 percent of Medicare fee-for-service beneficiaries.

It is unclear why volume growth has had such volatility. Reasons offered for the slowdown that started in 2009 include a mild flu season in 2010 (compared to 2009) and—in the case of decreases in the use of certain types of imaging services—concerns about radiation exposure.[7] The Commission has found further that there has been a shift in billing for cardiovascular imaging from health professionals' offices to hospitals, a shift that is consistent with reports of an increase in cardiologists' practices owned by hospitals.[8] In turn, the shift has implications for measures of volume growth, increasing the volume of services billed by hospitals but reducing the volume of services billed by physicians and other health professionals.

While uncertainty remains about the reasons for the volatility in volume growth, we do know that scoring estimates for repealing or replacing the SGR have fallen dramatically. Three months ago, before CBO incorporated the most recent experience with volume growth in their budget

[7] Medicare Payment Advisory Commission. 2012. *Report to the Congress: Medicare payment policy.* Washington, DC: MedPAC.
[8] American College of Cardiology. 2012. Findings from the ACC cardiovascular practice consensus. Washington, DC: ACC. http://www.nccacc.org/news/2012USCVPracticeCensusNorthCarolina.pdf.

estimates, the budget impact of a 10-year freeze was higher than it is today by more than $100 billion.[9] However, the volatility in volume growth we have seen historically suggests that circumstances could change again—in the direction not of lower cost estimates but instead ones that are higher.

Beneficiary access must be preserved

Although our latest access survey does not show significant deterioration at the national level, the Commission is nonetheless concerned about access. The balance between supply and demand is tight in many markets, and problems have surfaced in some markets, particularly in primary care. Those problems could spread, perhaps rapidly. The Medicare population is growing as members of the baby-boom generation become eligible for the program, a large cohort of physicians is nearing retirement age, and SGR fatigue is increasing. We do not predict abrupt changes in the national access picture, but we cannot rule them out either.

Because SGR repeal is costly, it may be necessary to replace it with a 10-year schedule of low, or even negative, updates to the conversion factor. That new schedule of updates would establish a new budgetary baseline, but the conversion factors would not be immutable. Each year MedPAC will continue to review whether payments to physicians and other health professionals are adequate—through surveying beneficiaries, conducting physician and beneficiary focus groups, tracking practitioner participation in Medicare, and examining changes in volume and quality of ambulatory care. If, through these analyses, the Commission determines that a change in payment rates is needed to ensure adequate access, the Commission would make such a recommendation to the Congress.

The physician fee schedule must be rebalanced to achieve equity of payments between primary care and other specialties

The Commission finds it crucial to support primary care, considering that the most recent data show that access risks are concentrated in primary care. We see a higher share of beneficiaries in our annual patient survey reporting problems finding a primary care physician than those seeking a specialist, and primary care physicians are more likely to report that they are not taking new Medicare patients than are specialty physicians. The Commission is concerned that there is an

[9] Congressional Budget Office. 2013. The budget and economic outlook: Fiscal years 2013 to 2023. Washington, DC: CBO.

imbalance between supply and demand in primary care, an imbalance that is likely to get worse, and this represents a market signal: the payment level for primary care is too low.

There are two ways to redress the imbalance between fees for primary care and specialty services. One is to improve the methods by which relative values are calculated under the Medicare fee schedule. The other is to use different conversion factors for primary care and specialty services (the primary care bonus in PPACA is a type of conversion factor adjustment). MedPAC believes both approaches are needed.

Pressure on FFS must encourage movement toward new payment models and delivery systems

The FFS payment system inherently encourages volume over quality and efficiency. The rapid volume growth over the last decade which led to the large payment cuts required under the SGR was partially due to the underlying volume incentives in FFS reimbursement. New payment models, such as ACOs and bundled payment, offer an opportunity to correct some of these undesirable incentives and have the potential to reward providers who control costs and improve quality. Incentives for providers to work across settings to improve quality and maximize efficiency are strongest in "risk-bearing" ACOs—where providers take financial risk for poor performance as well as being eligible for financial bonuses for good performance.

The Commission's approach uses two policies to encourage movement from open-ended FFS to better managed models (e.g, risk-bearing ACOs). It creates pressure to exit FFS by reducing and restraining updates. And it encourages movement to an ACO by recommending a performance standard that does not reflect the lower updates. In this way physicians are given a clear opportunity to share in savings by joining an ACO. While movement to ACOs and other models should result in less volume growth, more importantly, they should result in greater coordination of care and ultimately better quality of care.

SGR repeal must be fiscally responsible

The Commission's role is to make recommendations to the Congress that will preserve or enhance beneficiary access to quality care while minimizing the financial burden on beneficiaries and taxpayers. We take seriously our statutory charge to consider the budgetary consequences of our recommendations. Consistent with that charge, our October 2011 letter recommending SGR

repeal includes options for the Congress to consider as budget offsets on the assumption that repeal would need to be fully financed from within Medicare. It bears emphasis that MedPAC is NOT necessarily recommending that repeal be fully financed out of Medicare. Instead, our October 2011 letter offered options for the Congress to consider if it decided to pursue that path. Whether SGR repeal is offset, and how, is for the Congress to decide.

CBO recently lowered its estimate of the cost of repealing the SGR. This re-estimate may provide the Congress with somewhat more flexibility in choosing offsets as well as an appropriate schedule of updates for physicians and other health professionals. For example, the Congress could choose to stabilize payment rates for a period of time, then gradually impose conversion factor reductions for physicians who are not practicing within new payment models.

In considering budget packages to improve the government's fiscal picture, the Congress often looks to Medicare for savings. If those savings are applied to deficit reduction and the SGR remains in place, it will become more difficult to offset the cost of replacing the SGR one or two years from now. At that point, the only option for dealing with an even larger score for SGR repeal may be to add it to the deficit, which may be unpalatable after much effort to get the deficit down.

MedPAC's October 2011 letter on SGR repeal

The Commission's October 2011 letter to the Congress on moving forward from the sustainable growth rate system is attached as an appendix to this testimony. Although the figures and budgetary estimates may be out of date, the letter continues to reflect the findings and principles that guide our recommendations. The letter provides more detail on each of the specific recommendations below.

The Commission made four distinct recommendations. First, the link between cumulative fee-schedule expenditures and annual conversion factor updates is unworkable and should be eliminated. In place of the SGR, the Commission outlined a 10-year path of legislated updates, including updates for primary care services that are different from those for other services.[10]

[10] For primary care, payment rates would be frozen at their current levels. For all other services, there would be reductions in the fee schedule's conversion factor in each of the first three years, and then a freeze in the conversion factor for the subsequent seven years.

Second, CMS should collect data to improve payment adequacy within the fee schedule. Third, CMS should identify overpriced services and adjust the RVUs of those services. And fourth, the Medicare program should encourage movement from FFS into risk-bearing ACOs by creating greater opportunities for shared savings.

Appendix

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October 14, 2011

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The Honorable Orrin G. Hatch
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The Honorable Henry A. Waxman
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RE: Moving forward from the sustainable growth rate (SGR) system

Dear Chairmen and Ranking Members:

The sustainable growth rate (SGR) system—Medicare's formulaic payment method for services provided by physicians and other health professionals—is fundamentally flawed and is creating instability in the Medicare program for providers and beneficiaries. This system, which ties annual updates to cumulative expenditures since 1996, has failed to restrain volume growth and, in fact, may have exacerbated it. Although the pressure of the SGR likely minimized fee increases in the last decade, this effect disproportionately burdened physicians and health professionals in specialties with less ability to increase volume. Additionally, temporary, stop-gap "fixes" to override the SGR are undermining the credibility of Medicare because they engender uncertainty and anger among physicians and other health professionals, which may be causing anxiety among beneficiaries. The risks of retaining the SGR now clearly outweigh the benefits. Moreover, the cost of full repeal, as

well as the cost of temporary reprieves, grows inexorably. It will never be less expensive to repeal the SGR than it is right now.

With this assessment, the Commission recommends that the Congress repeal the SGR system and replace it with a 10-year schedule of specified updates for the physician fee schedule. The Commission drew on three governing principles to form our proposal. First, the link between cumulative fee-schedule expenditures and annual updates is unworkable and should be eliminated. Second, beneficiary access to care must be protected. Third, proposals to replace the SGR must be fiscally responsible.

From these principles, we recommend complete repeal of the SGR system and propose a series of updates that would no longer be based on an expenditure- or volume-control formula. These legislated updates would allow total Medicare expenditures for fee-schedule services to increase annually—roughly doubling over the next ten years. Approximately two-thirds of this increase would be attributable to growth in beneficiary enrollment and one-third would be attributable to growth in per beneficiary service use. Although our proposed updates reduce fees for most services, current law calls for far greater fee reductions and could lead to potential access problems under the SGR. The Commission finds it crucial to protect primary care from fee reductions, considering that the most recent data show that access risks are concentrated in primary care.

As is our charge, each year MedPAC will continue to review annually whether payments to physicians and other health professionals are adequate. To this end, we will continue to survey beneficiaries, conduct physician focus groups, track physician and practitioner participation in Medicare, and examine changes in volume and quality of ambulatory care. If, through these analyses, we determine that a future increase in fee-schedule rates is needed to ensure beneficiary access to care, then the Commission would submit such a recommendation to the Congress. Enacting our recommendation would eliminate the SGR and would alter the trajectory of fee-schedule spending in Medicare's baseline. Therefore, future fee increases relative to this new baseline would require new legislation and would carry a budgetary cost.

Our recommendation for repealing the SGR carries a high budgetary cost. The Congress, of course, may seek offsets for repealing the SGR inside or outside of the Medicare program. Because MedPAC was established to advise the Congress on Medicare policies, we are offering a set of savings options that are limited to the Medicare program. We do not necessarily

recommend that the Congress offset the repeal of the SGR entirely through Medicare. The steep price of this effort, and the constraint that we imposed on ourselves to offset it within Medicare, compels difficult choices, including fee-schedule reductions and offsets that we might not otherwise support.

The Commission is also proposing refinements to the accuracy of Medicare's physician fee schedule through targeted data collection and reducing payments for overpriced services. Even with improvements to the fee schedule's pricing, moreover, Medicare must implement payment policies that shift providers away from fee-for-service (FFS) and toward delivery models that reward improvements in quality, efficiency, and care coordination, particularly for chronic conditions. The Commission is also recommending incentives in Medicare's accountable care organization (ACO) program to accelerate this shift because new payment models—distinct from FFS and the SGR—have greater potential to slow volume growth while also improving care quality. Similarly, incentives for physicians and health professionals to participate in the newly established Medicare bundling pilot projects could also improve efficiency across sectors of care.

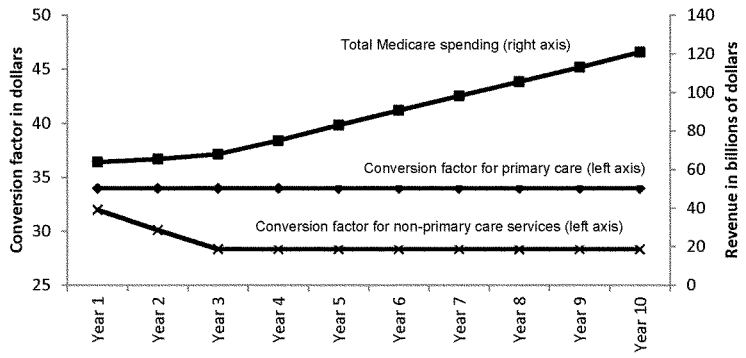
Respectfully, we submit the recommendations described below. Several of them are interrelated. Our willingness to recommend difficult measures underscores the urgency we attach to repealing the SGR. The cost of repealing the SGR, as well as the cost of any short-term reprieves, will only increase. Meanwhile, the opportunities for offsetting that cost by reducing Medicare expenditures will only shrink if Medicare savings are used for other purposes (such as, to help finance coverage for the currently uninsured or for deficit reduction). Our concern is that repealing the SGR will become increasingly difficult unless the Congress acts soon.

Repealing the SGR formula and realigning fee-schedule payments to maintain access to primary care

Repealing the SGR formula ultimately severs the link between future payment updates and cumulative expenditures for services provided by physicians and other health professionals. In place of the SGR, the Commission proposes a 10-year path of legislated updates (Figure 1). This path is consistent with the principles of an affordable repeal of the SGR, continued annual growth in Medicare spending for physician services, and maintaining access to care. For primary care, which we define more specifically later in this section, the Commission recommends that

payments rates be frozen at their current levels. For all other services, there would be reductions in the fee schedule's conversion factor in each of the first three years, and then a freeze in the conversion factor for the subsequent seven years.[1] While there would be decreases in payment rates for most services, projected growth in the volume of services—due to increases in both beneficiary enrollment in Medicare and per beneficiary service use—would lead to continued annual increases in total Medicare expenditures for fee-schedule services. We describe previous spending trends in Appendix Figure A-1.

Figure 1. Potential update path for fee schedule services



Source: MedPAC analysis of Part B fee-for-service spending per beneficiary, enrollment growth, and growth in the volume of fee-schedule services per beneficiary. See text for details.

The rationale for exempting primary care from fee-schedule cuts comes from recent research suggesting that the greatest threat to access over the next decade is concentrated in primary care services.[2] In both patient surveys and physician surveys, access to primary care providers is more

[1]Alternative update paths with the same approximate cost are possible. For example, fees for non-primary care services could receive smaller reductions over more years. Under this alternative, however, by year 10, the conversion factor for non-primary care services would be lower than that proposed in Figure 1.

[2]Medicare Payment Advisory Commission. 2011. *Report to the Congress: Medicare payment policy.* Washington, DC: MedPAC; Friedberg, M. et al. 2010. Primary care: A critical review of the evidence on quality and costs of health care. *Health Affairs* 29, no. 5 (May): 766-772; Vaughn, B. et al. 2010. Can we close the income and wealth

problematic than access to specialists. These findings hold for both Medicare and privately insured patients, magnifying the vulnerability of access to primary care services.

One example of this research comes from MedPAC's annual patient survey that we use to obtain the most timely data possible for analyzing access to physician services. This survey interviews Medicare beneficiaries age 65 and over and privately insured individuals age 50 to 64. (For more details on the survey's methodology, please see Chapter 4 our March 2011 Report to the Congress.) Results from this annual survey consistently find that both Medicare beneficiaries and privately insured individuals are more likely to report problems finding a new primary care physician compared with finding a new specialist (Appendix Table A-2). For instance, in 2010, although only 7 percent of beneficiaries reported looking for a new primary care physician in the past year, among those looking, 79 percent stated that they experienced no problems finding one. In contrast 87 percent of the beneficiaries who were looking for a new specialist reported that they had no problems finding one. Among privately insured individuals looking for a new primary care physician, 69 percent reported no problems finding one compared with 82 percent of those looking for a new specialist.

Consistent with this patient survey, physician surveys have also found that primary care physicians are less likely than specialists to accept new patients. Again, this discrepancy holds for both Medicare and privately insured patients. For example, the 2008 National Ambulatory Medical Care Survey finds that 83 percent of primary care physicians accept new Medicare patients, compared with 95 percent of specialists (Appendix Table A-3). Acceptance rates are lower for patients with other insurance as well. Specifically, 76 percent of primary care physicians accepted new patients with private (non-capitated) insurance compared with 81 percent of specialists. In a 2008 survey conducted by the Center for Studying Health System Change, physicians who classified themselves in surgical or medical specialties were more likely

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gap between specialists and primary care physicians? *Health Affairs* 29, no. 5 (May): 933-940; Bodenheimer, T. et al. 2009. A lifeline for primary care. *New England Journal of Medicine* 360, no. 26 (June 25): 2693-2696; Grumbach, K. and J. Mold. 2009. A health care cooperative extension service. *Journal of the American Medical Association* 301 no. 24 (June 24): 2589-2591; Rittenhouse, D. et al. 2009. Primary care and accountable care—two essential elements of delivery-system reform. *New England Journal of Medicine* 361, no. 24 (December 10): 2301-2303; Colwill, J. et al. 2008. Will generalist physician supply meet demands of an increasing and aging population? *Health Affairs* 27, no. 3 (April 29): w232-w241.

than primary care physicians (classifying themselves as either in internal medicine or family/general practice) to accept all new Medicare, Medicaid, and privately insured patients.[3]

Exempting primary care from the reductions would mean that Medicare payments for those services would not be based entirely on resource-based relative values. Although resources used to furnish a service (e.g., the time and intensity of effort or practice expenses incurred) are appropriately considered in establishing the fee schedule, other considerations may also be important, including ensuring access or recognizing the value of the services in terms of improving health outcomes or avoiding more costly services in the future. Market prices for goods and services outside health care often reflect such factors. The Congress has demonstrated precedent for this approach in the Medicare fee schedule, such as through the primary care and general surgery bonuses included in the Patient Protection and Affordable Care Act of 2010 (PPACA), as well as floors established for work and practice expense values and bonuses for services provided in health professional services shortage areas.

Regarding the proposed updates included in our recommendation to repeal the SGR, we specify a definition of primary care that focuses on protecting the practitioners and services which make up the core of primary care. The Commission limits the primary care update path to physicians and other health professionals who meet both of the following criteria:

- *Practitioner specialty designation*: Physicians who—when enrolling to bill Medicare—designated their specialty as geriatrics, internal medicine, family medicine, or pediatrics. Eligible practitioners would also include nurse practitioners, clinical nurse specialists, and physician assistants.
- *Practice focused on primary care*: Physicians and practitioners who have annual allowed Medicare charges for selected primary care services equal to at least 60 percent of their total allowed charges for fee-schedule services. Primary care services used to determine eligibility are: office visits, home visits, and visits to patients in nursing facilities, domiciliaries, and rest homes.

Under our proposal, the legislated updates for primary care would apply to the following services when provided by eligible primary care practitioners: office visits, home visits, and visits to

[3]Boukus, E. et al. 2009. *A snapshot of U.S. physicians: Key findings from the 2008 Health Tracking Physician Survey*. Data bulletin no. 35. Washington, DC: HSC.

patients in hospitals, nursing facilities, domiciliaries, and rest homes.[4] MedPAC analysis of claims data finds that under these specifications, about 9 percent of fee-schedule spending would be protected from fee reductions each year. For eligible primary care practitioners, these protected services typically account for the vast majority of their Medicare billing. Payment rates for other services—such as laceration repairs and endoscopies—furnished by all fee-schedule providers, including primary care practitioners, would be subject to the fee reductions in the first three years.[5]

Table 1. Potential update path for fee-schedule services

	Primary care		Other services		Annual
Year	Payment rate change	Conversion factor	Payment rate change	Conversion factor	payments (billion)
Y1	0.0%	$33.98	−5.9%	$31.99	$64
Y2	0.0	33.98	−5.9	30.11	66
Y3	0.0	33.98	−5.9	28.34	68
Y4	0.0	33.98	0.0	28.34	75
Y5	0.0	33.98	0.0	28.34	83
Y6	0.0	33.98	0.0	28.34	91
Y7	0.0	33.98	0.0	28.34	98
Y8	0.0	33.98	0.0	28.34	106
Y9	0.0	33.98	0.0	28.34	113
Y10	0.0	33.98	0.0	28.34	121

Note: The current (2011) conversion factor is $33.98.
Source: MedPAC analysis of Part B fee-for-service spending per beneficiary, enrollment growth, and growth in the volume of fee-schedule services per beneficiary 2004-2009.

Medicare fees for non-primary care services would be reduced by 5.9 percent each year for 3 years (Table 1). We arrive at this path after satisfying two requirements: protecting core primary care services that are furnished by primary care providers from payment reductions, and

[4]Expanded definitions of primary care are possible. For example, the range of specialties could be expanded. However, protecting more services from the fee reduction will result in either a higher cost (and the need for more offsets) or a deeper fee reduction for the non-primary care services. Alternative definitions of protected services are also possible, such as using the number of unique diagnosis codes that a provider sees over the course of a year to distinguish between highly specialized providers and those that provide a more comprehensive range of care.
[5]The freeze on payment rates for primary care could be implemented either with a separate conversion factor, or with a claims-based payment modifier. If the freeze is implemented with a claims-based payment modifier, a single, reduced conversion factor would apply to all services; but, for eligible primary care services, the payment modifier would increase the fee and effectively reverse the conversion factor reduction.

achieving a total estimated 10-year cost that is no more than $200 billion. If the update paths depicted in Figure 1 were implemented in 2012, the conversion factor for non-primary care would decrease over a period of three years from the current level of $33.98 to about $28.34. It would then stay at that level for the remaining seven years of the budget window. By contrast, under current law, the conversion factor would be $24.27 at the end of the budget window. Taking into account the increase in the number of Medicare beneficiaries over the next 10 years and growth in the volume of services provided per beneficiary, total practitioner payments from Medicare would rise from $64 billion to $121 billion. On a per beneficiary basis, practitioner payments would continue to rise at an average rate of 2.2 percent per year. The $200 billion estimated cost of this proposed update path accounts for the cost of eliminating the significantly larger SGR cuts and replacing them with the updates specified in Table 1.

A freeze in payment levels for primary care is not sufficient to support a robust system of primary care. Payment approaches that recognize the benefits of non-face-to-face care coordination between visits and among providers may be more appropriate for primary care, particularly for patients with chronic conditions. The Centers for Medicare & Medicaid Services (CMS) is embarking on several projects to examine the results (patient health and total spending outcomes) of monthly per-patient payments to primary care providers for their care coordination activities. These include the Comprehensive Primary Care Initiative, the Multipayer Advanced Primary Care Initiative, and the Federally Qualified Health Center Advanced Primary Care Practice Demonstration. Issues that this work will help to inform include patient involvement in selecting these providers and effective ways for attributing one eligible provider per patient.

Recommendation 1:

The Congress should repeal the sustainable growth rate (SGR) system and replace it with a 10-year path of statutory fee-schedule updates. This path is comprised of a freeze in current payment levels for primary care and, for all other services, annual payment reductions of 5.9 percent for three years, followed by a freeze. The Commission is offering a list of options for the Congress to consider if it decides to offset the cost of repealing the SGR system within the Medicare program.

Collecting data to improve payment accuracy

In addition to a conversion factor, the physician fee schedule includes relative value units (RVUs). These RVUs account for the amount of work required to provide each service, the expenses that practitioners incur related to maintaining a practice, and malpractice insurance costs. To arrive at the payment amount for a given service, its RVUs are adjusted for variations in the input prices in different markets, and then the total of the adjusted RVUs is multiplied by the conversion factor.

The Secretary lacks current, objective data needed to set the fee schedule's RVUs for practitioner work and practice expenses.[6] The fee schedule's time estimates are an example. The RVUs for practitioner work are largely a function of estimates of the time it takes a practitioner to perform each service. However, research for CMS and for the Assistant Secretary for Planning and Evaluation of the Department of Health and Human Services has shown that the time estimates are likely too high for some services. In addition, anecdotal evidence and the experience of clinicians on the Commission suggest problems with the accuracy of the time estimates. Furthermore, under CMS's recent potentially misvalued services initiative, time estimates for a number of services have been revised downward after consultation with the Relative Value Scale Update Committee (RUC). These revisions suggest that current time estimates—which rely primarily on surveys conducted by physician specialty societies that have a financial stake in the process—are subject to bias.

Reliable, objective data are also needed for the fee schedule's practice expense RVUs. CMS's methodology for determining these RVUs relies on various types of data: time estimates for clinical employees who work in practitioners' offices, prices for equipment and supplies used in practitioners' offices, and total practice costs for each physician specialty. The Commission questions the accuracy and timeliness of these data.[7]

The Commission evaluated sources of data the Secretary could consider. Surveys might be an alternative, but they are costly and response rates are likely to be low. Time and motion studies

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[6]Medicare Payment Advisory Commission. 2011. *Report to the Congress: Medicare and the health care delivery system.* Washington, DC: MedPAC.
[7]Medicare Payment Advisory Commission. 2011. *Report to the Congress: Medicare and the health care delivery system.* Washington, DC: MedPAC.

would be costly, too, and they are subject to bias. And mandatory data reporting—analogous to the cost reports submitted by institutional providers—would raise issues of administrative burden on practitioners.

Instead of these approaches, the Secretary could collect data on a recurring basis from a cohort of practitioner offices and other settings where practitioners work. Participating practices and other settings could be recruited through a process that would require participation in data reporting among those selected. The cohort would consist of practices with a range of specialties, practitioner types, patient populations, and furnished services. Further, the cohort should consist of practices with features that make them efficient (e.g., economies of scale, reorganized delivery systems). If necessary, practices could be paid to participate. The Commission is working with contractors to assess the potential of using electronic health records, patient scheduling systems, cost accounting, and other systems as sources of data in physician practices and integrated delivery systems.

Recommendation 2:

The Congress should direct the Secretary to regularly collect data—including service volume and work time—to establish more accurate work and practice expense values. To help assess whether Medicare's fees are adequate for efficient care delivery, the data should be collected from a cohort of efficient practices rather than a sample of all practices. The initial round of data collection should be completed within three years.

Identifying overpriced services

Moving forward from the SGR could also include a change in the process for identifying overpriced services in the physician fee schedule. The current process for identifying potentially misvalued services is time consuming, occurring over several years. In addition, the process has inherent conflicts. The process relies on surveys conducted by physician specialty societies. Those societies and their members have a financial stake in the RVUs assigned to services.

To accelerate the review process, the Secretary should be directed to analyze the data collected under recommendation 2, identify overpriced services, and adjust the RVUs of those services. Further, the Congress should direct the Secretary to achieve an annual numeric goal equivalent to

a percentage of fee-schedule spending. This would be a goal for reducing the RVUs of overpriced services. These adjustments should be implemented in a budget neutral manner. Therefore, while payments could decrease considerably for any given overpriced service, they would increase slightly for all other services.

As mentioned earlier, the RUC and CMS have started a potentially misvalued services initiative, and there is some evidence that this effort has drawn attention to inaccurate pricing. As an example, for fee schedule payments in 2011, CMS received work RVU recommendations from the RUC for 291 billing codes and made decisions after considering all of those recommendations.[8] In some cases, comprehensive billing codes were established that bundled component services, thereby recognizing that efficiencies can arise when multiple services are furnished during a single patient encounter. Other recommendations did not include a change in billing codes. Instead, the RUC had addressed the question of whether current RVUs are too high or too low for certain services because of a change in technology or other factors. The net effect of the increases and decreases in work RVUs—had the changes not been budget neutral, as required by statute—would have been a reduction in spending under the fee schedule of 0.4 percent. Previously, the net effects of work RVU changes had been smaller: 0.1 percent per year in both 2009 and 2010.

The American Medical Association's (AMA's) position is that the process for identifying potentially misvalued services has been broader in scope than that suggested by these budget neutrality adjustments.[9] The AMA reports that in addition to about $400 million that was redistributed for 2011 due to changes in work RVUs, another $40 million was redistributed due to changes in the RVUs for professional liability insurance, and $565 million was redistributed due to changes in practice expense RVUs.

An annual numeric goal for RVU reductions—stated in terms of a percentage of spending for practitioner services—could foster further collaboration between the RUC and CMS in improving

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[8]Centers for Medicare and Medicaid Services, Department of Health and Human Services. 2010. Medicare program; payment policies under the physician fee schedule and other revisions to Part B for CY 2011. Final rule. Federal Register 75, no. 228 (November 29): 73169-73860.

[9]American Medical Association. undated. The RUC Relativity Assessment Workgroup Progress Report. http://www.ama-assn.org/resources/doc/rbrvs/five-year-progress.pdf.

payment accuracy. For example, such a goal should focus the effort on high-expenditure services, thereby making a time-consuming and resource-intensive review process more efficient. In addition, collecting objective data to improve payment accuracy—the data collection addressed by recommendation 2—will make the process more effective. As to the level of the numeric goal, judgment is required. If the AMA's estimates are accurate, RVU changes for 2011 led to a redistribution of payments equaling almost 1.2 percent of total allowed charges.

Recommendation 3:

The Congress should direct the Secretary to identify overpriced fee-schedule services and reduce their relative value units (RVUs) accordingly. To fulfill this requirement, the Secretary could use the data collected under the process in recommendation 2. These reductions should be budget neutral within the fee schedule. Starting in 2015, the Congress should specify that the RVU reductions achieve an annual numeric goal—for each of five consecutive years—of at least 1.0 percent of fee-schedule spending.

Accelerate delivery system changes to emphasize accountability and value over volume

Even with more accurate RVU assignments, the FFS payment system inherently encourages volume over quality and efficiency. Indeed, rapid volume growth in the last decade is due, in large part, to the underlying volume incentives in FFS reimbursement. New payment models, such as the ACO program and new bundled payment initiatives, present an opportunity to correct some of the undesirable incentives in FFS and reward providers who are doing their part to control costs and improve quality.

Repealing the SGR provides an opportunity for Medicare to implement policies that encourage physicians and other health professionals to move toward delivery models with better accountability for quality and value. With this shift, we should see a greater focus on population health and care coordination—thereby improving patient experience and aligning incentives for beneficiaries to become more engaged with their own care management. Through the ACO program and bundled payment approaches, Medicare is taking important steps in this direction—embarking on new payment models that can encourage providers to work together across sectors to maximize quality and efficiency.

Within the ACO program, incentives for these improvements are strongest for ACOs which bear financial risk, often called two-sided risk ACOs. These ACOs are eligible for both rewards and penalties based on their performance on quality and spending measures. In contrast, bonus-only ACOs are not subject to performance-based penalties. Therefore, the Commission recommends aligning policies related to Medicare's fee schedule with incentives for physicians and health professionals to join or lead two-sided risk ACOs.

Specifically, the Commission recommends that physicians and health professionals who join or lead two-sided risk ACOs should be afforded a greater opportunity for shared savings compared to those in bonus-only ACOs and those who do not join any ACO. The greater opportunity for shared savings would come from calculating the two-sided risk ACO's spending benchmark using higher-than-actual fee-schedule growth rates.

More precisely, assuming the initial reduction in fee-schedule rates outlined in our first recommendation, the Commission recommends that the spending benchmarks for assessing the performance of two-sided risk ACOs be calculated using a freeze in fee-schedule rates, rather than the actual fee reductions. Under this circumstance, two-sided risk ACOs would have a greater opportunity to produce spending that is below their benchmark, and thus be more likely to enjoy shared-savings payments from Medicare.[10]

This recommendation might increase the willingness of physicians and other health professionals to join or lead two-sided risk ACOs. In doing so, it would accelerate delivery system reform toward models with greater accountability for health care quality and spending. As ACO models develop and make strides in improving quality and efficiency, the volume-based FFS environment should be made increasingly less attractive for Medicare providers. Accordingly, the advantage offered to the two-sided risk ACOs would increase in the second and third year that the fee-schedule reductions are in place.

[10]One issue to examine under this policy would be to monitor the effect of differential payments for services provided by ACO and non-ACO providers. The differential shared savings opportunities are intended to hasten improvements in our delivery system and shift payments away from FFS. The incentives should be revisited as enrollment increases to ensure that ACOs are having the desired effect of encouraging more organized care delivery and lowering overall spending growth.

Final regulations on the ACO program are not yet completed. Therefore, it is difficult to determine the effects of this recommendation, relative to current law. Theoretically, by offering providers a greater opportunity to share in Medicare savings, the Commission's recommendation could reduce total Medicare savings. However, more importantly, if more providers decided to join two-sided risk ACOs as a result of greater shared savings opportunities in this recommendation, total Medicare savings could increase over the long term.

Recommendation 4:

Under the 10-year update path specified in recommendation 1, the Congress should direct the Secretary to increase the shared savings opportunity for physicians and health professionals who join or lead two-sided risk accountable care organizations (ACOs). The Secretary should compute spending benchmarks for these ACOs using 2011 fee-schedule rates.

The Secretary could also consider developing analogous pricing incentives in Medicare's new bundled payment initiatives. That is, in the context of fee-reductions, bundled pricing would assume a rate freeze across all fee-schedule services. In testing this approach for improvements in quality and efficiency, the Secretary could, at the same time, assess the effect that bundled payments have on growth in the total number of episodes.

Offsetting the cost of the SGR package

The Commission describes a budget-neutral package for repealing the SGR, offsetting the cost within the Medicare program (Appendix Table A-4). Under current law, the SGR calls for a very large fee reduction (30 percent on January 1, 2012) and the budget score associated with repealing the SGR has grown exponentially. Given the high cost of repealing the SGR and the current economic environment, the Commission's proposal must be fiscally responsible.

The list of options offered by the Commission spreads the cost of repealing the SGR across physicians and other practitioners, as well as other providers and Medicare beneficiaries. Under the Commission's approach, physicians and other practitioners who provide non-primary care services will experience a series of Medicare fee reductions, followed by a freeze in payment

rates. Primary care physicians and other primary care practitioners would experience a freeze in rates for the primary care services they provide. Through these reductions and freezes, physicians and other health professionals are shouldering a large part of the cost of repealing the SGR. The cost of repealing the SGR and replacing it with a complete freeze in fee-schedule payment rates would be approximately $300 billion over ten years, but the Commission's approach would cost approximately $200 billion, with most physicians and practitioners absorbing $100 billion in the form of lower payments than they would receive under a freeze.

To offset this $200 billion in higher Medicare spending relative to current law (which applies the SGR fee cuts), the Congress may seek offsets inside or outside of the Medicare program. Because MedPAC was established to advise the Congress on Medicare policies, we are offering a set of savings options that are limited to the Medicare program. We do not necessarily recommend that the Congress offset the repeal of the SGR entirely through Medicare. Also, we offer this set of options with the express purpose of assisting the Congress in evaluating ways to repeal the SGR. The steep price of this effort, and the constraint that we are under to offset it within Medicare, compels difficult choices, including fee-schedule payment reductions and offsets that we might not otherwise support.

The offset options listed in Appendix Table A-4 would spread the impact of the reductions across other providers and Medicare beneficiaries. They are grouped in two categories. Those in Tier I— about $50 billion— are MedPAC recommendations not yet enacted by the Congress. Those in Tier II—about $168 billion—are informed by analyses done by MedPAC, other commissions, and government agencies. Several of the options in Tier II are designed to make changes to Medicare payments to encourage the use of more cost effective care. The estimates of savings are preliminary staff estimates and do not represent official scores.

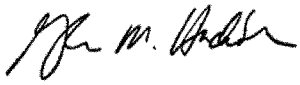
The Commission has not voted on each individual item in the Tier II list, and their inclusion should not be construed as a recommendation. Tier II does not include all of the proposals that have been offered for reducing long-term Medicare spending—e.g., increasing the age of eligibility, or requiring higher contributions from beneficiaries with higher-than-average incomes, or premium support. The exclusion of such policies should not be construed as a

statement of MedPAC's position on these policies. Such policies raise complex issues that are beyond the scope of Tier II offsets.

To reiterate, we offer the list of offset options to assist the Congress in its deliberations on resolving the SGR problem. The Congress could choose different directions to offset the related cost—for example, other spending or revenue offsets, even from outside the Medicare program.

In closing, given the urgency of the need to resolve the SGR policy, the Commission is submitting this letter to the Congress in advance of our usual March and June publication schedule. At a minimum our proposal underscores the exigency of the matter, the complexity of deriving any solution, and the degree of sacrifice a resolution entails. If you have further questions or otherwise wish to discuss this important issue, please feel free to contact me or Mark E. Miller, MedPAC's Executive Director.

Sincerely,



Glenn M. Hackbarth, J.D.
Chairman

Appendix

TABLE A-1

Commissioners' voting on recommendations

1 The Congress should repeal the sustainable growth rate (SGR) system and replace it with a 10-year path of statutory fee-schedule updates. This path is comprised of a freeze in current payment levels for primary care and, for all other services, annual payment reductions of 5.9 percent for three years, followed by a freeze. The Commission is offering a list of options for the Congress to consider if it decides to offset the cost of repealing the SGR system within the Medicare program.

Yes: Armstrong, Baicker, Behroozi, Berenson, Butler, Chernew, Dean, Gradison, Hackbarth, Hall, Kuhn, Miller, Naylor, Stuart, Uccello

No: Borman, Castellanos

2 The Congress should direct the Secretary to regularly collect data—including service volume and work time—to establish more accurate work and practice expense values. To help assess whether Medicare's fees are adequate for efficient care delivery, the data should be collected from a cohort of efficient practices rather than a sample of all practices. The initial round of data collection should be completed within three years.

Yes: Armstrong, Baicker, Behroozi, Berenson, Borman, Butler, Castellanos, Chernew, Dean, Gradison, Hackbarth, Hall, Kuhn, Miller, Naylor, Stuart, Uccello

3 The Congress should direct the Secretary to identify overpriced fee-schedule services and reduce their relative value units (RVUs) accordingly. To fulfill this requirement, the Secretary could use the data collected under the process in recommendation 2. These reductions should be budget neutral within the fee schedule. Starting in 2015, the Congress should specify that the RVU reductions achieve an annual numeric goal—for each of five consecutive years—of at least 1.0 percent of fee-schedule spending.

Yes: Armstrong, Baicker, Behroozi, Berenson, Butler, Castellanos, Chernew, Dean, Gradison, Hackbarth, Hall, Kuhn, Miller, Naylor, Stuart, Uccello

No: Borman

4 Under the 10-year update path specified in recommendation 1, the Congress should direct the Secretary to increase the shared savings opportunity for physicians and health professionals who join or lead two-sided risk accountable care organizations (ACOs). The Secretary should compute spending benchmarks for these ACOs using 2011 fee-schedule rates.

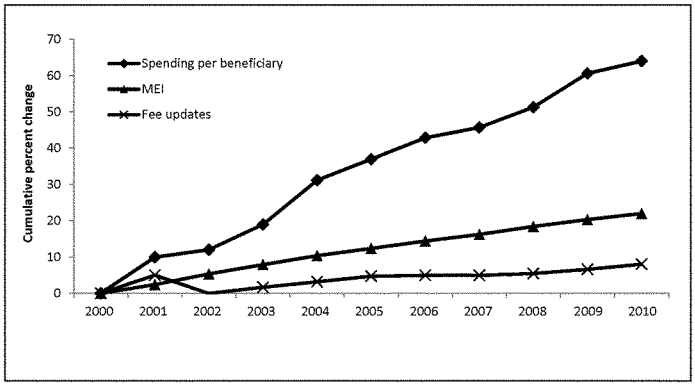
Yes: Armstrong, Baicker, Behroozi, Berenson, Butler, Castellanos, Dean, Gradison, Hackbarth, Hall, Kuhn, Miller, Naylor, Stuart, Uccello

No: Borman

Not voting: Chernew

FIGURE A-1

Growth in spending for fee-schedule services, 2000–2010



- Spending for fee-schedule services grew from $37 billion in 2000 to $64 billion in 2010—an increase of 72 percent.
- On a per beneficiary basis, spending grew over this period from $1,200 to $2,000—an increase of 64 percent. This increase amounts to an average annual spending increase of 5 percent per beneficiary, per year.
- Medicare spending on fee-schedule services grew much more rapidly over this period than both the payment rate updates and the Medicare Economic Index (MEI). The cumulative increase in fee-schedule updates from 2000 to 2010 was 8 percent. The comparable cumulative increase in the MEI was 22 percent.
- The growth in spending per beneficiary was due more to growth in the volume and intensity of services provided than to fee increases. The volume of imaging, tests, and "other procedures" (procedures other than major procedures) grew more rapidly than the volume of major procedures and evaluation and management services.

TABLE A-2

Most aged Medicare beneficiaries and older privately insured individuals have good access to physician care, 2007–2010

Survey question	Medicare (age 65 or older) 2007	2008	2009	2010	Private insurance (age 50–64) 2007	2008	2009	2010
Unwanted delay in getting an appointment: Among those who needed an appointment in the past 12 months, "How often did you have to wait longer than you wanted to get a doctor's appointment?"								
For routine care								
Never	75%*	76%*	77%*	75%*	67%*	69%*	71%*	72%*
Sometimes	18*	17*	17*	17*	24*	24*	22*	21*
Usually	3	3*	2*	3*	4	5*	3*	4*
Always	3	2	2	2	3	2	3	3
For illness or injury								
Never	82*	84*	85*	83*	76*	79*	79*	80*
Sometimes	13*	12*	11*	13*	17*	16*	17*	15*
Usually	3	1	2	2	3	2	2	2
Always	2	1*	1	1*	3	2*	2	2*
Looking for a new primary care physician: "In the past 12 months, have you tried to get a new primary care doctor?"								
Yes	9	6	6	7	10	7	8	7
No	91	93	93	93	90	93	92	93
Looking for a new specialist: "In the past 12 months, have you tried to get a new specialist?"								
Yes	14	14*	14*	13*	15	19*	19*	15*
No	86	85*	86*	87*	84	81*	81*	84*
Getting a new physician: Among those who tried to get an appointment with a new primary care physician or a specialist in the past 12 months, "How much of a problem was it finding a primary care doctor / specialist who would treat you? Was it..."								
Primary care physician								
No problem	70*	71	78	79*	82*	72	71	69*
Small problem	12	10	10	8	7	13	8	12
Big problem	17	18	12*	12	10	13	21*	19
Specialist								
No problem	85	88	88	87*	79	83	84	82*
Small problem	6	7	7	6*	11	9	9	11*
Big problem	9	4	5	5	10	7	7	6
Not accessing a doctor for medical problems: "During the past 12 months, did you have any health problem or condition about which you think you should have seen a doctor or other medical person, but did not?" (Percent answering "Yes")	10*	8*	7*	8*	12*	12*	11*	12*

Note: Numbers may not sum to 100 percent because missing responses ("Don't know" or "Refused") are not presented. Overall sample sizes for each group (Medicare and privately insured) were 2,000 in 2007, 3,000 in 2008, and 4,000 in 2009 and 2010. Sample sizes for individual questions varied.
*Statistically significant difference between the Medicare and privately insured samples in the given year at a 95 percent confidence level.

Source: MedPAC-sponsored telephone survey conducted in 2007, 2008, 2009, and 2010.

TABLE A-3

Acceptance of new patients is lower among primary care physicians, across most insurers

Accepting new patients, type of insurance	Primary care specialties	All other specialties
Any new patients	89.5%	97.8%
Medicare	83.0	95.2
Medicaid	55.1	68.7
Capitated private insurance	58.3	43.7
Non-capitated private insurance	76.4	81.3
Workers' compensation	53.4	61.2
Self-pay	85.7	95.1
No charge	39.7	52.2

Note: Results include office-based physicians with at least 10 percent of practice revenue coming from Medicare.

Source: Centers for Disease Control and Prevention, National Center for Health Statistics, National Ambulatory Medical Care Survey (2008).

TABLE A-4 **Potential Medicare offset options for repealing the SGR system**

- Along with the recommendations included in this letter, the Commission is offering a set of savings options for the purpose of assisting the Congress in offsetting the budgetary cost of repealing the SGR system. The projected savings amounts are unofficial, based on MedPAC staff estimates, and subject to change.

- The options are divided into two tiers. Tier I—about $50 billion—contains proposals that have been recommended by the Commission in previous reports or comment letters. Tier II—about $170 billion—contains options informed by outside (e.g., the Office of Inspector General, Department of Health and Human Services; Congressional Budget Office options) and MedPAC staff analysis. The Commission has not voted on or recommended the items on the Tier II list. The exclusion of policies from this list should not be construed as a statement of MedPAC's position on such policies.

- In the statute creating MedPAC, the Congress charges the Commission with reviewing Medicare policies, including their relationship to access and quality of care for Medicare beneficiaries. Therefore, all of the offset options on this list are Medicare policies; the Congress could choose to employ other savings or revenue offsets including those from outside of Medicare.

TABLE A-4 **Potential Medicare offset options for repealing the SGR system**

Tier I: MedPAC work		5-year savings ($ in billions)	10-year savings ($ in billions)	Reference
1	Copayment for home health episode	2	4	MedPAC March 2011
2	Hospital update of 1 percent for 2012 and DCI recovery	7	14	MedPAC March 2011
3	Dialysis update of 1 percent for 2012	0	1	MedPAC March 2011
4	Hospice update of 1 percent for 2012	1	2	MedPAC March 2011
5	Apply the competitive bidding offset to all competition-eligible DME categories starting in 2013	1	1	MedPAC June 2003
6	Apply the competitive bidding offset to the DME categories never subject to competitive bidding starting in 2013	2	7	MedPAC June 2003
7	Repeal MA quality bonus demonstration	6	6	MedPAC comment letter, 2011
8	Rebase HH in 2013 and no update in 2012	5	10	MedPAC March 2011
9	No IRF update in 2012	0	1	MedPAC March 2011
10	No LTCH update for 2012	0	1	MedPAC March 2011
11	Raise the compliance threshold for IRFs to 75 percent	1	3	MedPAC comment letter, 2003
12	ASC update of 0.5 percent for 2012 and report on cost and quality	0.1	0.1	MedPAC March 2011
13	Program integrity: prior authorization for imaging by outlier physicians	0	0.1	MedPAC June 2011
Subtotal, MedPAC work		***25***	***50***	

Tier II: Other Medicare		5-year savings ($ in billions)	10-year savings ($ in billions)	Reference
14	Part D LIS cost-sharing policy to encourage substitution	6	17	Staff
15	Apply an excise tax to medigap plans (5 percent)	5	12	CBO: Budget Options 2008
16	Program integrity: pre-payment review of power wheelchairs	0.1	0.2	PB 2012, HHS OIG
17	Require manufacturers to provide Medicaid-level rebates for dual eligibles	25	75	CBO: Budget Options 2011
18	Bundled payment for hospital and physician during the admission	0	1	CBO: Budget Options 2008
19	Pay E&M visits in hospital outpatient departments at physician fee schedule rates	5	10	Staff
20	Reduce payments by 10 percent for clinical lab services	4	10	Staff
21	Risk-adjustment validation audits in the MA program	2	3	PB 2012
22	Bring employer group plan bids closer to other MA plan bids	0	1	Staff
23	Hold the trust funds harmless for MA advance capitation payments	2	3	HHS OIG
24	Restore the Secretary's authority to apply a least costly alternative policy	0	1	Staff
25	Additional reductions through competitive bidding or fee schedule reductions to payments for home oxygen	3	5	HHS OIG
26	Rebase payments to SNFs	10	23	Staff
27	Apply readmissions policy to SNFs, HH, LTCHs, and IRFs	1	4	Staff
28	Targeted 3 percent reduction for hospice care provided in nursing homes for hospices with a significant volume of nursing home patients	0.5	1	HHS OIG
29	Program integrity: validate physician orders for high-cost services	0	2	PB 2012
Subtotal, Other Medicare		***64***	***168***	
Total, Tier I and Tier II		***89***	***219***	

Note: ASC (ambulatory surgical centers), CBO (Congressional Budget Office), DCI (documentation and coding improvements), DME (durable medical equipment), E&M (evaluation and management), HH (home health), HHS (Department of Health and Human Services), IRF (inpatient rehabilitation facilities), LTCH (long-term care hospitals), LIS (low-income subsidy), MA (Medicare Advantage),OIG (Office of Inspector General), PB (provider bulletin), SNF (skilled nursing facility).The Commission is offering a set of savings options for the purpose of assisting the Congress in offsetting the budgetary cost of repealing the SGR. The projected savings amounts are unofficial, based on MedPAC staff estimates, and subject to change.

Mr. PITTS. Thank you for your opening statement. Your entire written testimony will be made a part of the record. I will begin the questioning and recognize myself for 5 minutes for that purpose.

Mr. Hackbarth, in your testimony you state that the array of new models for paying physicians and other health professionals is unlikely to change dramatically in the next few years. Yet you advocate rewarding physicians as they shift their practices from open-ended fee-for-service to accountable care organizations. Are you suggesting that ACOs are the only models that physicians should shift to or should physicians be able to choose how they practice from a wide variety of options?

Mr. HACKBARTH. A couple points, Mr. Chairman. First of all, we focus on ACOs because they are the new model that is already a part of the Medicare program. As you know, other models, medical homes, bundling around admissions, are being piloted at this point. ACOs, however, are the only models that are actually operational in the Medicare program.

The second point I would make is that the ACO model is by design a flexible model. It does not dictate a particular form of medical practice or a particular way for money to be distributed within the ACO among clinicians and other types of providers. Let me draw an analogy here. In the Medicare Advantage program, we have private insurers enrolling Medicare beneficiaries, and they deal with physicians in a lot of different practices, some in sole practice, others in small groups, others in large multi-specialty groups, and they manage to deal with physicians in different settings, often with different payment models, depending on the particular location and type of practice. ACOs can have the same sort of flexibility, the principal difference being that ACOs by design are provider-governed organizations as opposed to organizations run by insurance companies. So we think that there is every possibility for the ACO structure to be a flexible one that does accommodate differences in practices and pay physicians in different ways, depending on circumstances.

Mr. PITTS. Now, you suggest that the fee schedule should be rebalanced to preserve access to primary care, and one way you suggest doing this is by giving a primary care bonus similar to the provision in PPACA. However, according to the Association of American Medical College's Center for Workforce Studies, there will be 45,000 too few primary care physicians but also a shortage of 46,000 surgeons and medical specialists in the next decade. If the goal is to increase the primary care workforce by making primary care more attractive to medical school graduates, do you think that a few years of modest payment increases will do this, and how does this address the projected shortage of specialists?

Mr. HACKBARTH. So let me talk about the steps related to primary care first and then come back to other specialties. We actually think that there is a series of things that should be done to improve payment for primary care and increase the likelihood that more young physicians in training choose primary care as a career and also that older physicians who are nearing retirement continue to practice primary care as opposed to elect early retirement. One step is to change how the relative value units are calculated in the

physician fee schedule, and I would be happy to go into detail on any of these, if you wish. Second is to add new codes to the physician fee schedule to pay explicitly for activities that are not now covered like care coordination and management of transitions in care. A third is a bonus of the sort that you referred to in your question, Mr. Chairman. A fourth is moving to new payment models as we are piloting with medical home where part of the payment is on a lump-sum-per-patient basis in addition to the fee-for-service payment. And then the last thing is graduate medical education. There is a lot of talk about shortage of physicians and particularly a shortage of primary care physicians and the need to increase the number of Medicare-funded GME slots. If Congress takes up that issue of expanding GME funding, we would urge it to look in particular at how those physicians are distributed across specialties and ensure that an adequate number are devoted to primary care.

Now, on the issue of other specialties, we are not saying that primary care is the only specialty—or the only—certainly it is not the only specialty that matters to Medicare patients. All of the specialties play an important role in high-quality care. We focus on primary care, however, because the evidence that we see that a robust system of primary care is especially important to a high-performing health care system and so in a time of limited resources, we think that that focus on primary care is justified based on system performance.

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

Mr. PALLONE. Thank you, Mr. Chairman. I want to follow up on what you were discussing there with primary care.

Mr. Hackbarth, tell me what is the problem in primary care. In other words, what kinds of problems are we facing and why are we facing this crisis? Just give me a little idea about what we face and what is causing it.

Mr. HACKBARTH. Well, I think that there are several factors, Mr. Pallone. One is the overall level of compensation. As you well know, it is significantly lower than many of the subspecialties. In fact, if you look at it on an hourly basis under the physician fee schedule, the amount we pay for various specialty services is often two or three or more times what we pay for primary care services on an hourly basis. So there is a significant payment differential there.

In talking to primary care physicians, though, I often hear that that is only a piece of the problem. Another problem is that fee-for-service as a method of payment is not really well suited to primary care because the fee schedule doesn't recognize all of the activities that make primary care important for the care delivery system—education of payments and ongoing contact with patients, coordination of care and the like. And often these days where we have got a relative shortage of primary care physicians, the practices are frankly overwhelmed with the work they need to do and the number of patients they need to see. It is important, therefore, to help primary care practices build some of the infrastructure that would allow them to better manage larger volumes of patients, and

that is where the lump-sum payment and the medical home is particularly important. It allows practices to hire additional staff to work with patients and some of the educational activities allow them to build necessary systems and the like. So we need to make the job more doable as well as to increase the average compensation level.

Mr. PALLONE. All right. Thanks. I wanted to ask about physicians who don't fit in delivery models. As you know, there is a great deal of diversity in the health care system and various specialties and practice patterns, different kinds of markets, some dominated by hospitals, some more dominated by plurality of provider groups or individual practitioners. How do you design a reformed Medicare payment system that works for all physicians? In other words, how do we address the measurement challenges for a myriad of physicians? Are we always going to have some doctors that don't fit into a delivery model? Are we always going to have doctors for whom the quality measurement system just doesn't work? How should we deal with this, essentially?

Mr. HACKBARTH. We may at the end have some physicians that are in unique circumstances, for example, very isolated areas that we will have to treat as a special case. But as I indicated in my response to Chairman Pitts, ideas like the accountable care organization, I don't see as rigid models that dictate a particular form of physician practice. ACOs as defined in the statute and in the regulations are able to accommodate different styles of medical practice—solo practice, group practice and the like. And in fact, if we look around the country in terms of how practices deal with managed care organizations. Again, private insurance plans, you see a lot of variety. So take a State like California where you have got a lot of managed care activity and have for years. Some of the physician practices there are large, multi-specialty groups, but there are also independent practice associations where much smaller practices are hooked together with one another for purposes of contracting, sharing resources and the like and sharing financial responsibility. So I think that there are opportunities for many different styles of practice. It is not a one-style-fits-all model in the ACO.

Mr. PALLONE. Can I just ask—my time is limited now, but I think Medicare needs to make more data available for development of models and care improvement. What is MedPAC's view of CMS's current data policies, and is there some way that the agency and Congress can encourage more data availability.

Mr. HACKBARTH. Well, I don't consider myself expert, Mr. Pallone, on the CMS data systems. Traditionally, it has been a struggle for CMS to provide timely data, for example, to physicians and in the pilots in the prepaid group practice demonstration project. In part, at least, that is a function of resources. The agency in our judgment has been chronically underfunded. The tasks that it has to carry out are increasingly complicated including on the data front and they don't get the resources they need to do those jobs well. And I think we are paying a price. It reduces the appropriation side of the budget but the lack of robust data means that we are going to spend more on the entitlement side of the budget.

Mr. PALLONE. Thank you. Thank you, Mr. Chairman.

Mr. PITTS. The Chair thanks the gentleman and recognizes the vice chairman of the subcommittee, Dr. Burgess, for 5 minutes for questions.

Mr. BURGESS. I thank the chairman for the recognition.

Mr. Hackbarth, it is good to have you back at the committee. You know, the downside of solving the SGR is we won't get to have these visits every couple of years, but I will actually look forward to that as well. Maybe we will both find something better to do with our time.

You were just talking to Mr. Pallone about models. Could you speak for just a minute about what you have learned from the study of Medicare Advantage programs? Some, I understand, have worked well, even with the constraints of the SGR, others maybe not so well. So are there positives that we can take away from the Medicare Advantage experience?

Mr. HACKBARTH. There are positives. In fact, some Medicare Advantage plans, as you know, perform extremely well on both quality of care measures and cost, and among the plans that perform well, there are a variety of different models. Some of them are the prepaid group practice model like Kaiser Permanente but there are other plans that contract with independent practices and don't rest entirely on large multi-specialty groups.

Mr. BURGESS. I would just offer an observation, that it is not just the satisfaction of the agencies and the people who measure those things but it is also satisfaction of patients and satisfaction of physicians, and certainly my experience with a group like Scott and Mike down in Temple, Texas, is that this has worked reasonably well and it may be something that we certainly want to be careful that we don't damage whatever we do going forward.

Can you speak to—everyone this morning is kind of focused on the fact that the CBO put SGR on sale so let us buy this week while it is low. Can you talk just a little bit about why it is low and is there a dark side to it being low right now?

Mr. HACKBARTH. Yes. There are a number of reasons, and understanding all of the magic of the CBO estimation process is not one of my strengths and so——

Mr. BURGESS. Me neither.

Mr. HACKBARTH [continuing]. Any detailed accounting you ought to get directly from CBO, but the most important factor is that the rate of growth in Medicare expenditures, in particular physicians, has slowed significantly in the last several years.

Mr. BURGESS. Let us stay on that for just a minute. Why is that? Is that because of the recession? Is that because of physician ownership of some facilities? Can you drill down on that a little bit?

Mr. HACKBARTH. Well, the short answer is, I don't think any of us really knows. As you well know, there has been some speculation about the effect of the recession, although logically, you would think that that would be less of a factor for the Medicare population which by definition had continuous coverage through the recession. There has been some sort of public health factors. A relatively small flu season in recent years has held down utilization. We have seen significant slowing of the rate of increase in imaging. That could be due in part to changes in payment but also due in part to growing concerns about radiation exposure. And finally, it

could be that some physicians believe the world is changing and are preparing for a new world where total cost of care is more important.

Mr. BURGESS. Yes. Have the new methods of payment been around long enough for them to stake any legitimate claim in these savings?

Mr. HACKBARTH. You know, I think the jury is out on that.

Mr. BURGESS. So the answer is no, the short answer?

Mr. HACKBARTH. Yes.

Mr. BURGESS. OK. I will accept that. Let me just ask you this. I mean, you talked a little bit about decentralization, and I must admit, we have had these discussions before, you hit a nerve with me. It is not decentralization, it is recentralization. I mean, you take the authority from me as a practicing physician and then you are giving it to someone else. It is not that it has gone away and magically just been dissipated out into the ether. So it is not decentralization, it is recentralization, and, you know, I think a lot of physician groups and certainly patient groups fear that that recentralization will occur somewhere, whether it is in an insurance company, whether it is in a hospital, whether it is in the government itself where their interests may not be served. I mean, let us remember, an accountable care organization begs the question, accountable to whom, and if the doctor is employed by the hospital, if the doctor is employed by the government or an insurance company, then they are probably accountable to their employer, are they not?

Mr. HACKBARTH. Well, I know there is widespread, although not universal concern, among physicians about having to work for the hospital in an ACO, but in fact, 50 percent of the ACOs that have been approved and signed contracts with CMS have been physician-sponsored organizations which, as a former CEO of a physician group, I consider to be a very positive sign. I happen to believe that physician-sponsored organizations are the way to go. And so I don't think the ACO model is synonymous with hospital control.

My fear about fee-for-service is that continuation of fee-for-service combined with the inevitable increase in fiscal pressure from the retirement and Baby Boom generation inevitably leads to ratcheting down on the rules around fee-for-service payment, more intrusion from central locations like Washington and Baltimore into clinical decision-making, more detailed rules about what you have to do to qualify for this type of payment and what you are not allowed to do if you quality for that kind of payment.

Mr. BURGESS. So we must be concerned about recentralization then.

Mr. HACKBARTH. Yes, but I believe that the ACO model can push those decisions out where they belong: in the hands of clinicians. Now, the quid pro quo is that the clinician organizations assume accountability for overall quality of care and costs for the defined population. I think that is a good trade for clinicians.

Mr. BURGESS. Thank you, Mr. Chairman. We could go on about this for quite some time, but I appreciate the chairman's indulgence.

Mr. PITTS. The chair thanks the gentleman and now recognizes the gentleman from Michigan, Mr. Dingell, for 5 minutes for questions.

Mr. DINGELL. Mr. Chairman, you are most courteous. I commend you and the committee for this hearing. This is something which very much needs to be addressed, and I would like to welcome our witness.

The point of this question is, how do we balance quality measure development to ensure physicians have a voice in the fixing of fees and so forth but also see to it that we have broad enough participation by the public at large in these matters. Now, physicians are, as we all know, essential partners in improving quality and accountability. At the same time, there are challenging questions that need to be answered regarding their appropriate role. So when it comes to performance measurement, especially as it will be used to drive new payment systems, don't we have to have a broad participation by physicians, by patients, by hospitals and by the other people in the provider chain? Is that right or wrong?

Mr. HACKBARTH. I think, Mr. Dingell——

Mr. DINGELL. Just yes or no.

Mr. HACKBARTH. Yes or no. I think it deserves a more robust response.

Mr. DINGELL. Well, we need broad participation, don't we? I have limited time and I need your cooperation.

Mr. HACKBARTH. I do in general favor broader participation but I really would like the opportunity to——

Mr. DINGELL. So everybody ought to have a say, right?

Mr. HACKBARTH. Pardon me. I am sorry?

Mr. DINGELL. Everybody ought to have a say. The doctors ought to have a say. Their say is going to be very important. Hospitals, patients, insurers, the whole works, they ought to have a say. We ought not rig this device so it favors one particular participant over others.

Mr. HACKBARTH. I think we want a system that does three things. It brings scientific evidence to bear on——

Mr. DINGELL. Well, one of the problems I have is, I get witnesses down there and they just feel they have to make a speech, and all I am really asking for is a yes or no. How many folks do we want in this? Do we want enough that we get a clear picture and we get an honest answer or do we want to have just one group doing it and skewing the result?

Mr. HACKBARTH. I think that we need——

Mr. DINGELL. Help me, quickly.

Mr. HACKBARTH [continuing]. A range of participants. I think we need a range of participants, but the objective——

Mr. DINGELL. Thank you. Now, what is the appropriate role then of physicians in developing performance measurement systems, and how do we ensure an appropriate multi-stakeholder process including, again, consumers, purchasers and providers that avoids conflict in interest and gets us the best possible picture?

Mr. HACKBARTH. The role of physicians is to help bring scientific evidence to bear on establishment of standards but that is not the only step in the process. To have appropriate standards——

Mr. DINGELL. Am I being somewhat unclear? I am just trying to get you to tell me how we set this process up so we get the answers that are best suited to saving us money and full service, seeing to it that everybody participate. How do we do this?

Mr. HACKBARTH. And that is what I am trying to answer, Mr. Dingell. If it were easy and clear, it would have already been done, sir.

Mr. DINGELL. Now, let us go to the next question and hope we have the time to do it. Where are the opportunities to reduce unnecessary care, saved wasted dollars and improve the value in the current FFS while we are transitioning to new payment models? You have 1 minute and 20 seconds.

Mr. HACKBARTH. There are a number of areas where——

Mr. DINGELL. Plead your case. You have a minute and 10 seconds.

Mr. HACKBARTH. There are a number of areas where we can reduce waste and excess utilization. It is a long list not suited to a minute and 10 seconds.

Mr. DINGELL. Would you like to tell us what they are and relieve us of the need to speculate?

Mr. HACKBARTH. One would be, for example, excess readmissions, avoidable readmissions to the hospital. Another would be——

Mr. DINGELL. What are some of the others?

Mr. HACKBARTH. Every time I try to answer, I am interrupted. Another would be——

Mr. DINGELL. You have 22 seconds.

Mr. HACKBARTH. Another would be excess imaging that not only is costly but poses a risk for patients due to radiation exposure. So those would be two examples. I am trying to stay within your limit, sir.

Mr. DINGELL. My time is exhausted, Mr. Chairman. I thank you for your courtesy.

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

Mr. HALL. I thank you, Mr. Chairman. I am a little confused. This is the same John Dingell I learned to ask questions and extract answers from. He hasn't let up at all. Age hasn't bothered him nor lessened his pursuit.

Mr. DINGELL. I thank my old friend.

Mr. HALL. And I am a little concerned because I was on this committee for, I think, almost 30 years. Two years ago I took a leave of absence, and I find the problem exactly the same almost as it was when I left.

And Mr. Hackbarth, you were right when you said we are at a critical juncture for SGR reform, and you pointed out that recently the CBO lowered the cost of repeal by over $100 billion. That ought to help some. And you added a dimension to the problem that every time the pay cut is delayed, the size of the cuts the following year is bigger so it is 2 years bigger from the time I left to this day when I am back.

Let me ask you a question that affects my part of the country some. The current SGR formula based part of its reimbursement on the time it takes to perform a task. Do you believe that this has created the right incentives for beneficiary care or do you believe

a shift away from time and more toward paying for quality would be more appropriate for the delivery of beneficiary care?

Mr. HACKBARTH. We do believe that we need over time to shift away from a fee-for-service system to other payment models that focus on quality and value for patients. However, the fee-for-service system is likely to be with us for still some time, and one of the problems that we see in the existing physician fee schedule is that these time estimates that you referred to we think are often off by a significant amount and that affects the distribution of payments within the fee schedule.

Mr. HALL. We are not lacking for suggestions, and even the Heritage pitched in saying we ought to allow price flexibility among specialties, remove the cap on how much a doctor can change and enforce price transparency, allow private contracting, on and on, but we are here today, and I guess there a number of physician reporting requirements currently in statute. As part of the reform, do you think some sort of streamlining of such reporting similar to what Mr. Dingell was questioning about is absolutely necessary to develop the kind of performance measures that you touched on in your testimony?

Mr. HACKBARTH. Yes, we do think that measures of performance, in particular, measures of quality, are an indispensable part of both the existing fee-for-service system and any new payment models, and I do have some ideas about what such a system should look at to formulate those measures. As I started to say in response to Mr. Dingell, I think it should include scientific input. Specialty societies have a major role to play there. But our measures also ought to be carefully chosen to increase value for Medicare beneficiaries. But anything that is good to do should be rewarded with a bonus payment.

Mr. HALL. I am impressed by the quality of this committee, those that you have selected, Mr. Chairman, and I will yield back my time.

Mr. PITTS. The chair thanks the gentleman and now recognizes the gentlelady from California, Ms. Capps, for 5 minutes for questions.

Mrs. CAPPS. I want to thank all of our witnesses, both panels, for being here today, and thank you, Chairman Pitts and Ranking Member Pallone, for holding this very important hearing.

I have long been a supporter of fixing the SGR. It harms providers and consumers alike, and it keeps us from true innovation in the health care sector. But the conversation often stops at the crisis point—how to make it to the next paycheck—and rarely moves to one where we can discuss our vision for a health care system in the future and how to get there. That is why I am so pleased that we are having this forward-looking hearing today.

There has been a lot of talk about the role of doctors in the health care system, but as I have said before and in some respects I am following on to our distinguished former chairman, I truly believe that if we are going to really move to a more comprehensive prevention-focused system of care, we need to look at the full picture of our health care system.

Mr. Hackbarth, most of the new delivery models like patient-centered medical homes and accountable care organizations emphasize

team-based care, and they recognize the critical role and value of non-physician providers. As such, I think it is important to acknowledge the role of other health care providers such as nurses, nurse practitioners, physician assistants in this conversation as well. While physicians and physician payment has always received a lot of attention, and rightly so, it is important that non-physician providers are also actively engaged in both the development and the implementation of these new systems for health care delivery and payment. So I have a couple questions on this topic for you. First, why do you think there is such a discrepancy, disparity, gap between the importance of non-physician providers and the level of attention they are receiving in the SGR debate?

Mr. HACKBARTH. Well, I am not sure why there is that disparity in attention.

Mrs. CAPPS. I mean, do you acknowledge that it does exist?

Mr. HACKBARTH. I agree, it does exist, and I also agree with your statement that we are not going to get where we want to go in terms of improved health care delivery without an expanded role for other health professionals including advanced practice nurses and physician assistants.

Mrs. CAPPS. Great. So there is no reason, it is just lack of attention?

Mr. HACKBARTH. I think it is lack of attention and, you know, sort of history in terms of how our health care system has evolved. When I look at the growing problems that we have in primary care, I just don't see how that is going to be solved without expanded use of other health professionals.

Mrs. CAPPS. Well, and you are representing MedPAC, which is a group of people. Has this not come up in your discussions? What is your view on the role of non-physician providers in a new value-based delivery and payment system that is focused on outcomes rather than fee-for-service?

Mr. HACKBARTH. It comes up often, I assure you, and I think I speak for the commission as a whole in saying that we think that an expanded role for nurses and other health professionals is essential both to deal with short-term problems like access to primary care but also for long-term improved system performance.

Mrs. CAPPS. Just in your own structure, because you are a spokesperson for MedPAC, do you see yourself expanding the commission members, or how is your discussion?

Mr. HACKBARTH. In fact, over the years, almost always we have had one or more nurses. Currently, Mary Naylor from the University of Pennsylvania School of Nursing is a member of MedPAC and has been very helpful in talking about the role of nurses, for example, in transition care after a hospital admission.

Mrs. CAPPS. That is just one of the many roles that they can play.

Mr. HACKBARTH. Exactly.

Mrs. CAPPS. One could say that this is a little bit like a token representative. Do you have any discussion of ways to expand it to be more inclusive?

Mr. HACKBARTH. Well, we actually don't choose our own members. Under the statute that governs MedPAC, GAO actually appoints the membership of the commission.

Mrs. CAPPS. Do you listen to other organizations, accountable care kind of organizations? Maybe this is just a vacuum that needs now to be addressed.

Mr. HACKBARTH. We do. For example, another member of our commission is Scott Armstrong, the CEO of Group Health of Puget Sound in Seattle, an organization which for many years has made a very extensive use of advanced practice nurses and other non-physician health professionals and team care. So that perspective comes into our discussions not just through people who have RN after their name but also from other commissioners that deal with these systems, that lead these systems.

Mrs. CAPPS. My time is up, but I do want to tell you that as a nurse myself, I guess I am a little bit more sensitive to the fact that nurse organizations, and I am sure physicians assistants would be the same, are eager. They have been doing a great deal of discussion among themselves and ascertaining of patterns that they would like to see in an expanded role for how to reach the goals of—we are really talking about how to reach the goals of the Affordable Care Act, and reimbursement, the fee schedule, is one of those—of course, it is clearly a very important aspect of how that is functioning. So I would urge you to reach out, and we will try to establish some more communications so that this can be a more serious part of your agenda.

Mr. HACKBARTH. I would welcome that.

Mr. PITTS. The Chair thanks the gentlelady and now recognizes the gentleman from Illinois, Mr. Shimkus, for 5 minutes for questions.

Mr. SHIMKUS. Thank you, Mr. Chairman, and welcome, Mr. Hackbarth. I have been interested in the intensity of this first line of questioning. I appreciate the work you do. It is very difficult, so thank you.

I am trying to pull up the Web site and the like. I understand that on March 7th through 8th you have an open public meeting at the Ronald Reagan Building and International Trade Center. I imagine that where is you take comments from anyone who may be involved so all these groups, all these individuals that are involved with that. Isn't that kind of why you do that?

Mr. HACKBARTH. Yes. We have open meetings, but we don't stop there. We reach out to groups that we think have expertise, information to bring to bear on the topics before us. So we don't want for them to come to us. We look for them.

Mr. SHIMKUS. Thank you. To help Mr. Dingell, I can think of one way to address costs, and that is litigation reform, medical liability issues. I am from the State of Illinois. If you are from Illinois, you know the medical liability crisis that we continue to have with high costs. So there is enough, I would consider that low-hanging fruit, to help address the cost of bringing down the cost of care so we could go through—as you said, there is numerous and it would take longer than a 5-minute round of questions.

But there is also the comment that Mr. Dingell mentioned that we do want to make sure a lot of folks are inclusive in these discussions. That is why I focused to the open-meetings aspect. But sometimes there is a feeling that the beneficiary is kind of left out in some of these dollars-and-cents care, procedures and debate. So a

couple of questions that I am going to direct kind of focus on the beneficiary. So do you believe that is important for the overall success of reform efforts to find ways to incentivize the individual beneficiary along the way?

Mr. HACKBARTH. Yes, we do believe that this is a part of what needs to be done.

Mr. SHIMKUS. So if we have new models of care that were developed that involve sharing savings between beneficiaries and government, should the beneficiary share in those savings as well?

Mr. HACKBARTH. In our comment letters on the development of the ACO program, we recommended that in fact beneficiaries had the opportunity to share in any savings. It seems to us odd that all of the focus should be on how the government and providers are going to share and the beneficiary is left out of it.

Mr. SHIMKUS. Yes, it is just—I have been on the committee a long time also, and it is great to have Mr. Hall back because maybe we will get this solved now since he has been gone for a while and now he is back, and maybe we will get this solved with his expertise.

But I am still a capitalist, competitive model folk. I do think people shop around based upon dollars and cents and based upon their return on dollars, they will make decisions. I also believe the public will buy a premium quality if they are given the opportunity to. My frustration with the health care delivery system is, they are kind of left out. I mean, really. They are not incentivized. They are directed. There is no variability in choices, so I am happy to see that.

On the other hand, I believe there are some negative incentives within the Medicare program that might hurt beneficiaries and endanger reform like a catastrophic cap within Medicare, copays that are based upon percentages instead of fixed costs so beneficiaries know what they are liable for, and first-dollar coverage that incentivizes beneficiaries to use more services when the new models encourage providers to be more efficient with the care provided. How important is it for the success of reform that Congress address these issues?

Mr. HACKBARTH. Well, about a year ago, Mr. Shimkus, we made a series of recommendations related to reforming the Medicare benefit package, and you touched on some of the critical elements. We think that the current structure is antiquated and very difficult for Medicare beneficiaries to understand, and so we recommended that it be simplified, use fixed dollar copays as opposed to percentage coinsurance, which is unpredictable, include catastrophic coverage. We also recommended that the Secretary be given broader authority to introduce principles of value-based insurance design by which we mean the Secretary should be able to say the evidence is really strong that if patients have access to this service, it not only improves their health but it lowers long-run costs. And so they want to totally eliminate cost sharing for those really high-value services. On the other hand, there are services that are of lower value based on scientific evidence and we may wish to impose more cost sharing on those. This is an idea that is being used increasingly by private insurers, and we think it makes sense for Medicare as well.

Mr. SHIMKUS. Thank you very much. Thank you, Mr. Chairman.

Mr. PITTS. The Chair thanks the gentleman and now recognizes the gentleman from Texas, Mr. Green, for 5 minutes for questions.

Mr. GREEN. Thank you, Mr. Chairman, and again, Mr. Hackbarth, welcome. I appreciate your work over the years.

The Sustainable Growth Rate formula is broken and must be repealed and replaced with a system that pays doctors fairly for their services and ensures that the quality of coverage for seniors and reduces the financial burden on taxpayers. One of the ways I want to and I understand a lot of folks do want to achieve cost savings is through quality improvements. There is a bipartisan agreement on this issue broadly but there are disagreements on specifics. I want to work toward a bipartisan agreement on measuring quality to increase efficiency and quality of care while decreasing the costs. We owe it to our seniors today and the future generation of seniors to make good on that promise we made for affordable, quality health care through Medicare.

I am going to try to go through a number of questions quickly. What is the most effective quality improvement measure with respect to improving health outcomes?

Mr. HACKBARTH. Well, I would say the single most important thing is to move to new form of payment and care delivery where clinicians accept ultimate accountability for outcomes that matter to patients but also the associated financial responsibility. As I have said in response to Dr. Burgess, we think decentralizing decisions to clinicians and provider organizations with increased accountability is the most important thing to do.

Mr. GREEN. What criteria must be met to realize savings from the quality improvement initiatives?

Mr. HACKBARTH. What criteria must be met? Could you just say a little bit more?

Mr. GREEN. What criteria must be met to realize savings from these quality improvement initiatives?

Mr. HACKBARTH. Well, the most important criteria is that of course we want to protect beneficiary access to care and quality of care, and that is why having affordability for outcomes is really an important part of the system. But while doing that, as I said earlier, what we want to do is not make decisions here in Washington but have clinicians who know the patient, who know local circumstances, have increased decision-making authority.

Mr. GREEN. Is a voluntary adoption of these quality improvements sufficient to yield systemwide savings or does this need to be a required practice? And I know your answers earlier were that there are some private insurers who are already doing some of these.

Mr. HACKBARTH. We think that a wise course for Medicare would be to apply increasing pressure on the fee-for-service system, which for the reasons I described at the outset we fear is not consistent with quality for Medicare beneficiaries, apply pressure on fee-for-service and create incentives and opportunities for people to move into new care delivery models that can deliver higher value.

Mr. GREEN. And what is the best way to address quality improvement when programs serve such a wide variety of people with various health needs, for example, seniors who have disabilities?

And as we know, as we get senior, we are going to take a lot more health care than someone who is not but also low-income earners.

Mr. HACKBARTH. Yes. Well, having a robust system of adjusting payments to reflect the underlying health risk of the patients is really important. We don't want a system where providers avoid those complicated patients because they are not paid appropriately for them. If a provider assumes responsibility for complicated patients, they ought to get the associated resources to do the job well, so what we refer to as risk adjustment is a really important feature.

Mr. GREEN. In developing quality measures, there has quite correctly been a lot of focus on including physicians and physician groups in the discussion, perhaps even having them develop the measures for their own specialties, and I would hope that would be, you know, the input from our specialty societies. What other entities should be at the table? Specifically, shouldn't the beneficiary somehow be represented in some capacity?

Mr. HACKBARTH. Yes. As I said in response to Mr. Dingell, we think that the physician specialty societies can provide critical input but input from others is important as well including from patient organizations.

Mr. GREEN. My last question in 35 seconds is, I know my seniors are worried about changing the SGR and could result in their care being diminished, and this is a scary prospect, but I also want, and I think a lot of us share in a bipartisan way, you want to make sure the system is around for my children and my grandkids. What is the best way to ensure that if SGR is repealed and replaced that the beneficiaries will have a seat at the table and the changes that are made are a positive experience for them?

Mr. HACKBARTH. So the question is, how do we assure that this is a positive experience for Medicare beneficiaries?

Mr. GREEN. So they know that, you know, they are going to be able to have the Medicare that they traditionally feel comfortable with.

Mr. HACKBARTH. Well, we need to take the necessary steps on payment to ensure the system is fiscally stable but we also need to offer choices to Medicare beneficiaries. As I said in response to Mr. Shimkus, having patient choices but also choices that reflect the cost of different options is important.

Mr. GREEN. Thank you, Mr. Chairman.

Mr. PITTS. The chair thanks the gentleman and now recognizes the gentleman from Louisiana, Dr. Cassidy, for 5 minutes for questions.

Mr. CASSIDY. Mr. Hackbarth, I will be more polite than Mr. Dingell, but if you could keep your answers concise, I would appreciate it.

Mr. HACKBARTH. I will try.

Mr. CASSIDY. I understand that, and I think you are doing a fantastic job.

Listen, I think there is evidence that consolidation is actually driving up costs if you look at how hospitals are buying physician services. Is this a premonition of what is to come?

Mr. HACKBARTH. We do worry about a hospital-dominated system. As I said to Dr. Burgess, this is one of the reasons why I think having physician-sponsored organizations is very important.

Mr. CASSIDY. I accept that. I can also see, though, the physician-sponsored Pioneer ACO being purchased by a large hospital, and so it almost seems like if you are really good at it, you may get bought.

Let me ask you, some of this diminution and/or decrease in the amount of care being delivered through Medicare Part B, I have been unable to figure out how much of that is attributable to hospitals purchasing, say, cardiology practices now billing through Part A as opposed to Part B.

Mr. HACKBARTH. Some of it is.

Mr. CASSIDY. When you say "some", is that 1 percent or is that 30 percent?

Mr. HACKBARTH. Well, let us focus on one area where it is a fairly significant factor, the rate of growth in expenditures on imaging services.

Mr. CASSIDY. Did those previously go through B or through A?

Mr. HACKBARTH. When they were provided in independent practices, cardiology imaging in particular, was in Part B. When it moves over to the hospital practice——

Mr. CASSIDY. It's part A. So really, we may not see—this may not be something on sale. It may be part of a larger trend where consolidation is shifting costs to A.

Mr. HACKBARTH. There could be some of that, yes.

Mr. CASSIDY. But then that in turn will further stress the Medicare trust fund.

Mr. HACKBARTH. Although if we look at total Medicare expenditures, the growth there has slowed as well. It is not just on Part B.

Mr. CASSIDY. I think statistics show about 25 percent of Medicare beneficiaries don't have a primary place they go, and the ACO relies upon some sort of retrospective kind of statistical analysis—you belong there even though you got your liver transplant here. Now, Mr. Miller will give testimony suggesting that prospective assignment would be a much more efficient way, better way to approach this as opposed to the retrospective assignment that occurs with the ACO model under statute.

Mr. HACKBARTH. And we favor prospective.

Mr. CASSIDY. Now, that leads us to MA. It really seems as if MA kind of solves this even though there is a prejudice in the Administration against MA.

Mr. HACKBARTH. Well, as I said earlier, there are some similarities between the two but a critical difference is that by definition, the accountable care organizations are controlled by providers as opposed to by insurance companies.

Mr. CASSIDY. Now, we both know of models, you know of models, there is the WellMed model down in Texas in which they go a two-sided risk with the Medicare Advantage program but effectively being a two-sided risk they are now managing. Would you favor such models?

Mr. HACKBARTH. So you are referring to a model where there is a partnership between an insurer and——

Mr. CASSIDY. I think they now they purchased them, but at some point the physician primary care group would contract with whichever MA plan they contracted with, that 85 percent of what the MA plan was getting from CMS, and they in turn would be a two-sided risk relative to the MA plan.

Mr. HACKBARTH. Yes. There are a lot of different varieties that can work, and as I tried to emphasize, we think that is a good thing because the circumstances really differ in places around the country. There are different preferences.

Mr. CASSIDY. Now, let me ask, because again, my concern, as I said in my testimony, is that our bias is towards big, and the ACO has to have a minimum of 5,000 patients. That means inherently it is big. So to what extent can that solo practitioner, how can she survive without being absorbed?

Mr. HACKBARTH. Well, 5,000 patients isn't all that large. That is, several internal medicine practices have 5,000 patients. Well, actually if it is 5,000 Medicare patients, it would have to be a somewhat larger number. But they don't all have to be under one roof and common ownership.

Mr. CASSIDY. But there would be——

Mr. HACKBARTH. You can——

Mr. CASSIDY. But to get the economy of scale in terms of marketing, in terms of billing, in terms of data integration, that suggests that you are going to have a certain bigness, correct?

Mr. HACKBARTH. Well, there is no doubt some scale required, but again, those costs can be shared and spread over a larger number of practices.

Mr. CASSIDY. Now, what do you think about an IPA model that would contract with an MA-type entity, whether it be prospective assignment, and yet you get the advantage of the MA data analysis, et cetera, but nonetheless allow these folks to maintain their autonomy.

Mr. HACKBARTH. It is an entirely legitimate approach that has worked in a lot of areas, but you could also have an ACO that contracts with an MA plan just to provide support services, and to buy reinsurance and spread risk.

Mr. CASSIDY. My concern about that is, that when you start doing statistical analysis, a small practice won't really know whether that outlier, that 25 percent of patients who are going elsewhere, are they getting a square deal from the top dogs or are they not.

Mr. HACKBARTH. Well, in fact, that is the problem when you have small practices and small numbers. As you well know, there is a lot of statistical variation, random variation in the numbers, and that makes assessment more difficult and that is one of the reasons that linking practices together and getting larger populations makes sense.

Mr. CASSIDY. You have given great answers. Again, I thank you for your courtesy, and I yield back.

Mr. PITTS. The Chair thanks the gentleman, excellent line of questioning. The Chair now recognizes the gentlelady from Florida, Ms. Castor, for 5 minutes for questions.

Ms. CASTOR. Well, thank you, Mr. Chairman. Thank you for calling this hearing. Mr. Hackbarth, welcome.

Since coming to Congress, I have to say one of the most nonsensical policies that we deal with is how we patch SGR and treat Medicare physicians and the patching and discussions that go on every year. It is remarkable. It is not reasonable, and colleagues, we have got to do something about it finally. And it should not be lost on us what this recent CBO score is. You said it is like it is on sale now. The CBO score has dropped $107 billion from $243 to $138 billion. Now is the time to act to solve it, to repeal it, to replace it with something that makes better sense for the modern health system, especially with the Affordable Care Act. I concur with Ranking Member Pallone that it is too important for us to just haphazardly steal from other Medicare providers to patch over here, and because of this renewed score that is over $100 billion lower, we have the ability now to really take a hard look and solve this now, and time is of the essence.

I also supported going to the OCO. I thought that was quite reasonable, and now I don't even think this would take up what is left in OCO savings, so we have an opportunity here in the coming months and we should not let it pass.

But we have larger issues as well, and I think that moving forward, solutions on replacing the SGR with different payment models, I think in Dr. Berenson's testimony, he laid out, you know, you are never going to get away entirely from fee-for-service. There will be some medical services that that is how they will have to be compensated, and the difficulty will be carving those out as we move to different integrated models.

So Mr. Hackbarth, I think by this time everyone agrees that we need to move the delivery system away from fee-for-service or something blended toward integrated delivery systems, that is, systems where physicians work together and share responsibility for their patients. While the Centers for Medicare and Medicaid Services has already embarked on a significant testing of these models, how do we incentivize more physicians to join these models?

Mr. HACKBARTH. We think it needs to be a combination of two things: some steadily increasing pressure on fee-for-service that frankly makes staying in fee-for-service increasingly uncomfortable over time while we open the door to new payment models and provide an incentive for physicians to participate in those models. So it is a little bit of push and a little bit of pull.

Ms. CASTOR. And I understand that the popular view is that models like accountable care organizations and medical homes and bundled payments have the potential to save Medicare money and improve patient outcomes but first do we really know yet whether they will be successful or what forms of these models will work best? And second, in the absence of ironclad answers and evidence, how do you recommend we proceed encouraging physicians to embrace new models?

Mr. HACKBARTH. Well, ACOs are now an operational piece of the Medicare program whereas the bundling around hospital admissions and medical homes are still in the pilot phase. We are still collecting information. The reason that ACOs are put into the operational mainstream Medicare program at this point is that in fact we had done a demonstration, a group practice demonstration, testing basically the ACO-type model, and to make a long story short,

that demonstration showed some promise for this model to improve quality while somewhat reducing costs in some cases. The results were not overwhelmingly robust but they were generally positive. In making a policy judgment about this, we need to always say well, what is the alternative. It is our judgment that the results of an ACO were sufficiently strong that when compared to continuing fee-for-service, we thought moving towards ACOs made sense. We know the record of fee-for-service. We have done a 35-, 40-year experiment with that: high cost, uneven quality. And so that is a pretty low standard to beat and we think ACOs can comfortably do that.

Ms. CASTOR. Thank you very much. I yield back.

Mr. PITTS. The Chair thanks the gentlelady and now recognizes the gentleman from Virginia, Mr. Griffith, 5 minutes for questions.

Mr. GRIFFITH. Thank you, Mr. Chairman. I do appreciate that.

Mr. Hackbarth, you encourage physicians to switch from open-ended fee-for-service to accountable care organizations. Do you envision a continued rule for FFS in certain geographic locales? I know you have already talked about certain practice types, but coming from a district that it takes a long time to get from one end to the other and has lots of small, rural communities, do you anticipate that fee-for-service would still be the way to do it there or do you think that they can do an ACO with such a small number of folks?

Mr. HACKBARTH. Well, we are still early in the development of the ACO model but I would note that about 20 percent of the ACOs that have been approved to this point include community health centers, rural health clinics or critical access hospitals so there is at least some development in rural areas of ACOs. We will have to see over time, you know, how well that works and how many more develop. So I wouldn't completely write off the possibility right now that the ACO model, which is a very flexible one, can work in rural areas. There may at the end of, you know, some period of time be some really isolated geographic areas with very long distances where that model simply will not work and we will need to take special steps in those areas.

Mr. GRIFFITH. Where mountains are in the way, because that happens a lot of times. It happens in my district from time to time.

I heard you in one of the other questions, and I apologize, that the ACO would need 5,000 patients?

Mr. HACKBARTH. Yes, that is the minimum, and the reason for that is, again, to have numbers that are statistical meaningful and not full of just random variation.

Mr. GRIFFITH. And I also would ask, even with the progressive payment models such as the bundled payments, what is there that would prevent a delivery system from exploiting a volume-based approach with bundled payments? I mean, can't they still do unnecessary things and run their costs up and overcharge?

Mr. HACKBARTH. Yes, and that is one of the fears, that if we bundle payment around an episode, a hospital admission, for example, one of the fears is well, now that you have aligned physicians, hospitals and other actors, they will say well, let us increase the number of episodes, let us increase the number of admissions, and so that is something to monitor and be careful about. That is less of

an issue in ACOs where there is accountability for total costs, not just episode costs.

Mr. GRIFFITH. I thank you very much and yield back my time, Mr. Chair.

Mr. PITTS. The Chair thanks the gentleman and now recognizes the gentleman from Maryland, Mr. Sarbanes, 5 minutes for questions.

Mr. SARBANES. Thank you, Mr. Chairman. Thank you, Mr. Hackbarth.

So as I understand the SGR formula, basically a number of years ago there was kind of projected percentage increasing payments that we were prepared to pay, and in the early years, we just went ahead and paid it even if it exceeded what that trajectory was supposed to be but the tradeoff was that at some point we had to come back and recover it, and that started to kick in in the out years and that is the fire drill that we have every year.

Mr. HACKBARTH. Right.

Mr. SARBANES. So fixing SGR is really getting rid of SGR. I mean, SGR is a design for trying to keep the costs in a sense after the fact in line with this original trajectory that was established, right?

Mr. HACKBARTH. That is correct.

Mr. SARBANES. So all of these other issues about, you know, rebalancing payments and looking at the methodology and, you know, whether we adjust the relative value units or add codes that better address the needs of primary care and so forth, that discussion can kind of happen alongside of the decision that is being made to get rid of this design.

Mr. HACKBARTH. Correct. Even if we get rid of SGR, we need to have that conversation, yes.

Mr. SARBANES. So just anticipating the kind of legislation that we would need to pass here, it could be pretty simple, right? I mean, could it basically be a one-page bill saying the SGR system is hereby repealed and then these other discussions, which frankly have been initiated through the Affordable Care Act, in large measure, can proceed or do you feel that sort of the—you don't want to lose the moment of casting aside SGR to also embed statutorily some of these new goals that you want to see?

Mr. HACKBARTH. Yes. We think it is important to seize the moment of SGR repeal to do three things: one, get rid of SGR, two, to advance progress in rebalancing the payment, as I said in my opening statement, and third is to create incentives for physicians to move towards new payment models. And if the legislation simply repealed SGR, we think that would be a lost opportunity. Frankly, these other two steps of rebalancing payments and encouraging movement to new payment systems, there will be some people who will oppose those.

Mr. SARBANES. So that is kind of my question is, if we are starting to tied in knots over doing these other things, such that that begins to impede the opportunity to just get rid of the design, where would you come down then?

Mr. HACKBARTH. Yes. Well, you know, our expertise is not on, you know, legislative processes and tactics. We believe that there ought to be this quid pro quo. Physicians want to get rid of SGR.

Mr. SARBANES. OK, so that is fair. So you are saying SGR was designed as a kind of cost containment measure, so we are going to get rid of one cost containment measure, let us replace it with other things that we think are going to help us achieve the same goals.

Mr. HACKBARTH. Yes.

Mr. SARBANES. OK. I understand that. That makes a lot of sense.

I will just saying in closing, and then I will yield back, I am not a physician but I spent 18 years representing hospitals and physician groups, and for some period of time in which I was practicing I managed this fire drill on behalf of clients that was happening at the end of every year. In a sense, we have been fixing SGR every year, right? Or every 30 days or every 90 days or whatever it is. So it is not like not fixing it means we are not going to incur the costs because we are probably come back, do a fire drill, patch it, incur the costs, and we talk about taking advantage of this sale. I mean, it is versus running around on the back end and trying to do it. It is really the equivalent in the health care area, and with respect to physician payment, it is like a sequester thing. It is an arbitrary formula.

Mr. HACKBARTH. You are absolutely right that what we have done is fix it a year at a time or, unfortunately, in some cases, a few months at a time. The price we pay for that is that we are undermining the confidence of both physicians and patients in the Medicare system. We are destabilizing the system. And our fear is that the cumulative effect of these last-minute dramas is now really taking a toll on confidence in Medicare and increasing the risk that Medicare beneficiaries will lose access to needed care. It is time to do away with it.

Mr. PITTS. The chair thanks the gentleman and now recognizes the gentleman from Georgia, Dr. Gingrey, for 5 minutes for questions.

Mr. GINGREY. Mr. Chairman, thank you.

Mr. Hackbarth, you just mentioned in responding to Mr. Sarbanes' line of questioning that three things are important: one, repeal SGR, rebalancing payments I think was the second, and then developing new payment models, and indeed, that is what the hearing is all about, and of course, we will have a second panel. We appreciate your testimony and response to our questions. But I think there is a fourth thing here that you might put in the category, the 800-pound gorilla in the room, and that is IPAB, which is the IPAB creation under the Affordable Care Act. Now, you, as I understand it, have been head of the Independent Payment Advisory Commission ever since its existence, and on a yearly basis or twice a year advise, and we have the ability under this system to mitigate recommended cuts, and we have done that, and that is where we are just today, just as Mr. Sarbanes was saying, and I think that if we do these three things, if we repeal SGR, if we rebalance payments and if we develop new payment models that physicians have the ability to choose from and slowly but surely, hopefully they would do that, but if the Independent payment Advisory Board is still there in the law, what good is all this going to do unless we get rid of that, I am going to say monster, because it seems

like to me it really is a monster because it is not advisory. It is instructional. So would you touch on that a little bit and tell us——

Mr. HACKBARTH. Well, as you indicated, Dr. Gingrey, you know, our model, the one that I have participated in, is advisory and the ultimate decisions are up to you and your colleagues in the Congress, and we hope that works well for you. We work very hard to do our best to advise you on those issues. With regard to IPAB specifically, you know, we haven't taken a position one way or another on IPAB. You know, it is sort of a rival approach to dealing with this, and we thought that was more a matter for the Congress to decide and not really a matter of Medicare policy where we consider ourselves to have some expertise. So right from the outset, we have not taken a position either for or against IPAB.

Mr. GINGREY. Well, let me just interrupt you just for a second and say that this member of the committee, this physician member of the Energy and Commerce Health Subcommittee, feels that it would be better to continue your commission in an advisory capacity and all that institutional knowledge that you have gained over the last 10 years and get rid of the monster that gives us no ability, and indeed, I think it is really unconstitutional to say that Congress doesn't have the ability to mitigate as we do under the good advice that you give us.

Mr. Chairman, the power of the IPAB, we all know, is substantial. Even if the President continues to delay naming members to the board, I don't guess there are any members' names so far. Fifteen is what is called for. The Secretary, this Secretary, the next Secretary, of HHS would have the power to establish these cuts. And as we were saying, you read that real carefully, that IPAB section of the Affordable Care Act, up until 2020 hospitals would be excluded from any cuts. So the proposed cuts made by IPAB would fall particularly on providers during the next 10 years almost, and to me, this seems akin to the cuts that SGR has tried to impose on doctors. These types of cuts haven't worked in SGR and they surely won't work with IPAB. I am encouraged that the committee's proposed framework states that IPAB repeal would be an integral part of SGR reform. So, you know, I think that needs to be an important part of the discussion with you, Mr. Hackbarth, and also with the second panel.

My time is expired and I yield back, and I thank you for your response.

Mr. PITTS. The chair thanks the gentleman and now recognizes the gentlelady, Dr. Christensen, for 5 minutes for questions.

Mrs. CHRISTENSEN. Thank you, Mr. Chairman, and I thank you and the ranking member for this hearing, and welcome again, Mr. Hackbarth, because I hope that this year we can finally fix something that all of us agree needs to be fixed and want to fix. As we know, the SGR has been the wrong methodology for setting physician reimbursement because it doesn't reflect the market basket value of physician services today, and as you said, the uncertainty that we create every year just transfers that uncertainty to the Medicare beneficiaries who wonder whether they are ever going to get the services that they need.

In addition to creating new ways of reimbursement, I think it is important, as one of the AMA reports says, to establish an accurate

definition of health care value, rebuild the technological infrastructure to determine episode length payment attribution, improve data and other parameters, and as a physician who practiced in a fee-for-service model, just for the record, I really don't believe that fee-for-service in and of itself was the problem. It is the way we were incentivized, and I can't say that I was but to utilize certain modalities that were expensive and we weren't paid for other things that you are talking about paying for now, and I believe if we pay for that kind of management and now with CER and other provisions of the ACA, fee-for-service can possibly have a place.

But lastly, as Dr. Patel said last year in her testimony, whatever you do, the path needs to be toward clinician-driven, which you have agreed and said many times here this morning, evidence-based medicine that prescribes the autonomy of the physician-patient relationship, even as we move towards more accountability.

You can imagine what my questions are going to veer towards. My colleague, Mr. Green, sort of asked it because we talked about poor, minority communities and patients who are affected by many of the social determinants of health and lack of access to quality health care and some services are not even available in their area, and so they suffer poor outcomes. So you did say that we have to take that into account and set the baseline and look at—include that in the way we measure performance. I was wondering if the minority health profession schools, the minority health professional organizations, patient advocacy organizations, are they involved in providing input as we move forward? Do you know?

Mr. HACKBARTH. Yes. Well, we work with all of the associations, both within the physician world and beyond. I spend a lot of time with representatives of safety-net institutions which are, you well know, critically important for this population and so absolutely, our door is open. We think paying particular attention to those patients, and many of them are Medicare dual eligibles, eligible for Medicaid as well as Medicare, they are some of the most vulnerable patients in the system, and so we need to take particular care when we develop new models that they are not inadvertently harmed.

Mrs. CHRISTENSEN. And you did mention in responding to Mr. Green also the issue of adverse selection and cherry-picking. Do you see the possibility of setting some kind of incentive payments for taking care of patients that may be sicker and coming from areas with high health disparities?

Mr. HACKBARTH. Absolutely. So we think that the payment to the organization ought to be commensurate with the responsibility that they are taking on, and if you are taking on very high-risk, complicated patients, you ought to be appropriately compensated for that. You know, this is an issue, and the still developing demonstrations run dual eligibles, again, one of our most vulnerable populations, and so it is one we are fixated on. There will be all sorts of bad consequences if we don't pay a lot of attention to that.

Mrs. CHRISTENSEN. I am glad that they are really looking at social determinants and looking at health disparities and that we were able to include in a lot of the research and provisions of the Affordable Care Act that health equity and eliminating health disparities had to be one of the goals.

Thank you, Mr. Chairman. I yield back.

Mr. PITTS. The Chair thanks the gentlelady and now recognizes the gentlelady from North Carolina, Mrs. Ellmers, for 5 minutes for questions.

Mrs. ELLMERS. Thank you, Mr. Chairman, and thank you, Mr. Hackbarth, for being with us today.

I have been a nurse for over 20 years, and obviously very concerned about the SGR system and understand fully that it is broken. You know, physician practices, you know, hang on to those determinations of when we are going to get paid and when we are not, and obviously the breakdown is quality of care for the patients and the accessibility moving forward. So keeping those thoughts in mind, I am a little concerned. I know Mr. Dingell and my colleague, Dr. Christensen, was just talking about some of the patient advocacy groups and patient input. Of course, we want health care to be patient-centered. But when we are talking about standard of practice, clinical practices and standard of care, where do you weight patient satisfaction, so to speak? I know this is going to be part of this system, but are we weighting the satisfaction level, you know, and determining quality of care that way?

Mr. HACKBARTH. Yes. Within the ACO system, patient satisfaction is one of the criteria used in evaluating performance, and we think that that plays a role. Frankly, we don't think it should be given the same weight as outcomes of care that patients really care about.

Mrs. ELLMERS. So on a percentage basis, what would you say, how much are you going to be taking that into consideration?

Mr. HACKBARTH. I am not sure that off the top of my head I could tell you exactly what percentage ought to be given to patient satisfaction but ultimately patients go to their physicians and nurses because they have a medical problem they want fixed, and so the bulk of the focus should be on, are those problems fixed, and if the patient in addition to that has a good experience, that is important as well. Probably the element of patient satisfaction that I would say is most important is effective communication because that also has implications for things like adherence to drug regimens and adherence to follow-up care after hospital admissions and the like. I am less interested in putting a lot of weight on, you know, sort of the hotel experience, you know, what was the check-in and the like. I am not saying those are totally unimportant but less important to me than effective communication and outcomes.

Mrs. ELLMERS. I also, and this is a little bit off of the focus here with this particular question, but I am a little concerned too when we are talking about reimbursement and, you know, the more emphasis on different practices and improvements, and you mentioned the cutbacks in imaging services. Can you give me two reasons why we would consider that, to actually be cutting back on reimbursement to imaging?

Mr. HACKBARTH. Well, one of the things that we do is look at how accurate the level of payment is for individual services and fee schedule, and as we have looked at that work and done that work, what we have concluded is that in many instances, we are overpaying for imaging services.

Mrs. ELLMERS. Is it overpaying or are you concerned that imaging is being overused?

Mr. HACKBARTH. Well, it is some of each, and two are linked. So we believe that for some imaging services, not necessarily all of them but some imaging services, the payment for each service is too high, and it is therefore a very profitable service. That prompts people to go out and buy expensive imaging equipment, that once the imaging equipment is in place it is used because it is inexpensive at that point, and that results in overutilization of services.

Mrs. ELLMERS. Well, one thing I would like, there again, based on my experience, one of those areas too that I think needs to be considered is not so much that the imaging is being overused but maybe ordered more frequently by non-physician practitioners. You know, in our local area, of course, JCAHO, who has just come through and basically one of their determinations where there was too many testing ordered, and unfortunately, that is by your non-physician practitioner, and I think that is an issue that needs to be looked at much more effectively because, you know, we want the best care for our patients ultimately but at the same time if it is just a matter of overutilization, then I think that needs to be looked at much more closely.

Mr. HACKBARTH. I think that may well be an issue. You know, we look at the rates of imaging, and there is huge variation, and so if you look geographically, you see big differences in both rates of imaging and the frequency of reimaging of the same patient, and so it is data like that that we look at that suggests to us that there is a problem there.

Mrs. ELLMERS. Thank you. And again, I think efficiency is one of the areas that we really need to be looking at, so thank you.

I yield back the remainder of my time.

Mr. PITTS. The chair thanks the gentlelady and now recognizes the gentleman from New York, Mr. Engel, 5 minutes for questions.

Mr. ENGEL. Thank you very much, Mr. Chairman.

There is no question that the Sustainable Growth Rate formula is seriously flawed and needs to be permanently replaced. I very strongly believe that physicians deserve to be fairly and appropriately compensated for the important work they do and the current SGR formula is failing our physicians and it is failing our Medicare beneficiaries.

I am pleased that the new CBO score estimates that it will cost dramatically less to repeal the scheduled SGR cuts and freeze payment rates for the next 10 years. I know the cost of $138 billion will be difficult to overcome but now is the time to permanently fix the way we reimburse physicians for the care they provide to our Medicare beneficiaries. The cost of doing so will probably never be lower, so as a Congress, I really believe we must seize the opportunity.

Let me ask you a couple of questions. In MedPAC's October 2011 letter to the chairmen and ranking members of committee with jurisdiction over health care, it was stated, and I quote, "The greatest threat to health care access over the next decade is concentrated in primary care services." Recognizing primary care access is critical, as part of the Affordable Care Act Medicare started paying primary care physicians a 10 percent incentive payment in 2011.

It is my understanding that more than 156,000 primary care providers have benefited from these incentive programs. So my question is, does MedPAC intend to analyze the impact of this 10 percent incentive payment on beneficiary access to primary care? If so, when do you think it will be possible to gauge this particular incentive's impact on Medicare beneficiary access to primary care services?

Mr. HACKBARTH. I am not sure if that is on our near-term analytic agenda. I think it might be a pretty difficult piece of analysis to do. What I would ask, Mr. Engel, is let me talk to my colleagues about it and get back to you on that.

Mr. ENGEL. OK. Thank you. MedPAC's reports and recommendations have consistently recommended moving toward payment models that shift providers away from fee-for-service and its incentives driving greater volume and intensity of services to delivery models that reward quality and efficiency. The Affordable Care Act has a number of provisions supporting new models of care including accountable care organizations, or ACOs, and value-based purchasing. How do we know if these new models are moving or delivering payment in the right direction? I believe they are, but how do we really know?

Mr. HACKBARTH. Well, in the case of ACOs, as I said earlier, that was put into the Medicare program without further demonstration or pilots because there had been a demonstration done known as the group practice demo. The short version of that is that there were some positive but not really robust, strong improvements in that demo but the results were deemed good enough that it made sense to move forward with ACOs. My own belief is that over time with more experience, ACOs will be able to improve performance even more than happened in the group practice demo.

Value-based purchasing has also been evaluated, and there too, the results were not really robust. There was a demonstration done involving hospital value-based purchasing known as the premiere demo, and the short version of the story is that there may have been some positive results but the effects were not very strong, and some of the effects were accomplished by just feeding back information on quality without a payment attached to it.

Mr. ENGEL. All right. Thank you. Let me ask you this. Several of our witnesses in written testimony mention the imperative for more data if Medicaid is going to successfully move from a fee-for-service reimbursement system to more quality-driven models. So what are some of the steps you would recommend CMS and HHS take to ensure our health information technology infrastructure is capturing the right data to provide adequate reimbursement for quality health care services?

Mr. HACKBARTH. Well, I am not at all expert, Mr. Engel, on health IT so I can't answer in any detailed way, but I do believe that as more and more health care organizations adopt computerized medical records, that that can greatly expand our capacity for assessing performance because we will have ready access to clinical information, not just claims-based information but clinical information about how well patients are faring in different organizations. So this is a very important investment the country is making. I am

optimistic that it will pay off in the long run, but as I think you know, getting to that point is an arduous journey.

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

Mr. PITTS. The chair thanks the gentleman. The gentleman from New Jersey, Mr. Lance, is recognized for 5 minutes for questions.

Mr. LANCE. Thank you, Mr. Chairman, and I will not take the full 5 minutes. I apologize for not being here. I was in the Commerce Subcommittee all morning.

One question. One of the common responses to the letter that our committee sent out to physician groups was that they need a period of stable payments, and I don't think anybody disagrees with that. However, if we simply stabilize payments, we may not get movement to the kind of payment system we need. In your view, how might we incentivize physicians to move away from what they are currently doing and toward the payment system based on value and not just the volume of their services?

Mr. HACKBARTH. We take a bit different view on this. It has not been a pretty process with lots of sort of last-minute rescue efforts but, you know, there has been considerable stability in payments in recent years.

Mr. LANCE. With great angst.

Mr. HACKBARTH. Great angst, and the angst has caused problems, which I emphasized before you came in, Mr. Lance, and so I am not advocating what has happened, far from it. We think that if we are going to really accelerate movement to new payment systems, there needs to be some pressure on fee-for-service. Now, exactly how much, how quickly is in part a function of how much money there is in the system after you figure out the pay-fors for SGR repeal. So there is not a right answer to how to structure that, but we do think we need a combination of pressure on fee-for-service and then new opportunities and new payment models.

Mr. LANCE. Thank you very much, Mr. Chairman. I yield back the balance of my time.

Mr. PITTS. The chair thanks the gentleman. That concludes the first panel. Excellent testimony, very thoughtful answers. Thank you, Mr. Hackbarth. We will excuse panel one and call panel two to the witness stand, and I will introduce the second panel as they come.

First of all, I want to thank all of you for agreeing to testify before the subcommittee today and quickly introduce our second expert panel. First, Mr. Howard Miller, Executive Director of the Center for Healthcare Quality and Payment Reform. Secondly, Ms. Elizabeth Mitchell, CEO of Maine Health Management Coalition. Thirdly, Dr. Robert Berenson, Institute Fellow at the Urban Institute. And finally, Dr. Cheryl Damberg, Senior Policy Researcher and Professor at the Pardee RAND Graduate School.

Again, thank you all for coming. We have your prepared statements, which will be entered into the record. And Mr. Miller, we will begin with you. You are recognized for 5 minutes to summarize your testimony.

STATEMENTS OF HAROLD D. MILLER, EXECUTIVE DIRECTOR, CENTER FOR HEALTHCARE QUALITY AND PAYMENT REFORM; ELIZABETH MITCHELL, CEO, MAINE HEALTH MANAGEMENT COALITION; ROBERT BERENSON, M.D., INSTITUTE FELLOW, URBAN INSTITUTE; AND CHERYL L. DAMBERG, PH.D., SENIOR POLICY RESEARCHER, PROFESSOR, PARDEE RAND GRADUATE SCHOOL

STATEMENT OF HAROLD D. MILLER

Mr. MILLER. Thank you, Mr. Chairman. It is a pleasure to be here today.

You have what may seem like an impossible task, to repeal the SGR program and save money for the Medicare program and do that without harming patients or physicians, but I believe that you can do that because of four key facts.

The first fact is that there are tremendous opportunities to save tens of billions of dollars in the Medicare program by helping to prevent avoidable admissions to the hospital, readmissions and to reduce the incredible rate of infections, complications and other kinds of problems that occur to patients, medical errors that exist today, and there is no need to deny beneficiary services or to cut fees in order to reduce spending.

The second fact is that the current fee-for-service system actually makes it difficult for physicians to help Medicare take advantage of those savings opportunities. In fact, under fee-for-service, the most desirable outcome of all, which is keeping you healthy, doesn't get paid for at all.

The third fact is that you can't fix fee-for-service simply by adding more pay-for-performance bonuses or penalties or created shared savings programs. Many current payment reform efforts, I think, will have limited success because they leave the current broken fee-for-service system in place, and particularly they force physicians to lose money when they help Medicare reduce spending.

The fourth fact is that there are better ways of paying physicians that give them the flexibility to both improve patient care and reduce Medicare spending without having to take financial losses themselves. I have outlined these in my testimony, and there are reports available on our Web site that describe these in significant detail.

What I wanted to focus on is how to actually get these accountable payment models in place. I believe that more is needed than the traditional top-down approach where CMS develops all new payment models. Because the specific opportunities and barriers differ from community to community and because different physicians will have different levels of willingness and ability to participate, many different solutions will be needed.

Most payment models today are focused on primary care hospitals and large ACOs but we need to also give every physician specialty the opportunity to improve care and reduce costs within its own sphere of influence. To do this, I recommend that Congress also establish a bottom-up approach whereby physicians, provider organizations, medical specialty societies and regional multi-stakeholder collaboratives are invited to develop payment models that will work well for individual physician specialties and the realities

of their own communities. If any of these groups bring CMS a payment model that is specifically designed to improve patient care and save Medicare money, CMS should not only have the power but the obligation to approve it. CMS should then also make that same payment model available to any physician who wants to participate and has the capabilities to do so. Moreover, if a physician is participating in such a model, they shouldn't be subject to threats of SGR-type payment reductions. This kind of bottom-up approach is not as radical as it might seem. The CMS Innovation Center has been doing something just like this for the past 2 years through programs such as the Innovation Awards and the Bundled Payments for Care Improvement Initiative.

But I think there are five policies that Congress needs to establish if you are going to have a truly successful process for developing and implementing new payment models as quickly as possible.

The first policy is that new payment models should be able to be proposed to CMS at any time and there should be no limit on how many different proposals can be improved as long as they improve care and save Medicare money. Proposals also need to be reviewed quickly, and as I mentioned, CMS should have the obligation to approve a proposal if it improves patient care and saves Medicare money.

The second policy is that there should be frequent opportunities for physicians to apply to participate in the already approved payment models. Every physician should be permitted to participate in an approved accountable payment model whenever they are ready to do so.

The third policy: Physicians need to be given access to Medicare claims data so that they can actually determine where the opportunities for savings are, how care will need to be redesigned to achieve those savings, and how payment will need to change to support better care at a lower cost. I can't even begin to describe to you what a barrier it is moving forward on this because of the lack of information that physicians have available to them.

Fourth policy: Once a physician is participating in an accountable payment model, they should have the ability to continue participating as long as they wish to do so if the data shows the quality of care is high and Medicare spending is being controlled. Most innovative payment models today are explicitly time limited, and no physician or other health care provider is going to make significant changes in the way care is delivered if they might be forced to revert to the traditional fee-for-service system within a few years. We need to stop doing demonstration projects and start implementing broad-based payment reforms.

Fifth policy: Funding should be made available to medical specialty societies and multi-stakeholder regional health improvement collaboratives so that they can provide technical assistance to physicians. Most physicians don't have either the time or the training to determine whether and how a new payment model will work for them. If organizations that they trust, though, can help them analyze data and redesign the way they deliver care, I think physicians are far more likely to both embrace new payment models and to be successful in implementing them.

Finally, I must note that I think that payment reforms will be much easier to implement and far more successful if you also take steps to proactively involve the patients, the beneficiaries. Many of the existing payment models are forced to use complicated statistical attribution methodology to determine which physicians are accountable for which patients. It would make far more sense to simply ask the beneficiaries to designate which physicians they want to be in charge of each of their conditions.

I would be happy to answer questions that you may have.

[The prepared statement of Mr. Miller follows:]

Testimony of Harold D. Miller

Executive Director, Center for Healthcare Quality and Payment Reform
President & CEO, Network for Regional Healthcare Improvement
to the
Subcommittee on Health, Committee on Energy and Commerce, U.S. House of Representatives
February 14, 2013

SUMMARY OF KEY POINTS

- The Sustainable Growth Rate formula should be repealed.
- Fundamental changes in the fee-for-service system are necessary in order to control the growth of Medicare spending and to improve the way care is delivered to Medicare beneficiaries. Congress will have limited success in controlling Medicare spending and providing truly high-quality care to Medicare beneficiaries if it merely uses quality-based pay-for-performance or shared savings programs built on top of the dysfunctional fee-for-service system. Fortunately, there are better ways of paying physicians that can enable them to make more significant improvements in patient care and achieve greater savings for Medicare.
- Accountable payment models need to be designed and implemented as quickly as possible in ways that will work for every specialty and every part of the country. To do this, Congress should establish a new, bottom-up approach to payment reform, whereby physicians, provider organizations, medical specialty societies, and regional multi-stakeholder collaboratives are invited to develop payment models that will work well for individual physician specialties in the realities of their own communities. This process should include the following elements:
  - New payment models should be able to be proposed to CMS at any time, with no limit on how many different proposals can be approved as long as they will improve care and reduce costs. Proposals must be reviewed quickly and CMS should have the obligation to approve a proposal if it is specifically designed to improve patient care and save Medicare money.
  - There should be frequent opportunities for physicians to apply to participate in already-approved payment models. Every physician should be permitted to participate in an accountable payment model whenever they are ready to do so. If a physician is participating in such a model, they shouldn't be subject to threats of SGR-type payment reductions.
  - Physicians need to be given access to Medicare claims data so they can determine where the opportunities for saving are, how care will need to be redesigned to achieve those savings, and how payment will need to change to support better care at a lower cost.
  - Once a physician is participating in an accountable payment model, they should have the ability to continue participating as long as they wish to do so if the data show that the quality of care is high and Medicare spending is being controlled.
  - Funding should be made available to medical specialty societies and multi-stakeholder Regional Health Improvement Collaboratives to provide technical assistance to physicians.
- To help new payment models be as successful as possible, Congress should ask Medicare beneficiaries to designate which physician(s) they want to be in charge of care for each of their conditions, so that there is no need to use complicated, inaccurate statistical attribution methodologies to determine which physicians are accountable for which patients.

Mr. Chairman and Members of the Subcommittee on Health:

I commend you for working to repeal the Sustainable Growth Rate formula and to reform physician payment systems, and I appreciate the opportunity to provide input to your deliberations.

The Need to Repeal the Sustainable Growth Rate

Patients' lives depend on having good doctors who are paid adequately to deliver good quality care. We will not be successful in transforming our healthcare system to deliver higher-quality, more affordable care if physicians have to wonder every year whether the major payment cuts required by the Sustainable Growth Rate formula will go into effect or not.

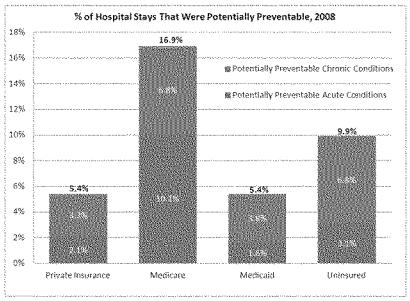
There is no other industry in the U.S. where the key professionals on whom that industry depends are told that their pay will be cut by 27% at the end of the year regardless of whether they are doing a good job or not. We shouldn't do that with physicians in the healthcare industry, either.

Temporary fixes aren't enough. The law has never made sense, and it needs to be repealed.

Controlling Medicare Spending Without Harming Beneficiaries

The broader challenge that Congress faces is controlling the growth in Medicare spending without harming beneficiaries. The way to do this is remarkably simple: tens of billions of dollars in Medicare spending could be saved every year by avoiding unnecessary tests, procedures, emergency room visits, and hospitalizations, and by reducing infections, complications, and errors in the tests and procedures which are performed. For example:

- **Millions of hospital stays, costing billions of dollars, are potentially preventable.** AHRQ data show that 17% of hospitalizations of Medicare beneficiaries are potentially preventable.[1] The frequency of these preventable hospitalizations can be dramatically



Source: *Potentially Preventable Hospitalizations for Acute and Chronic Conditions, 2008.* AHRQ HCUP Statistical Brief #99

reduced; for examples, studies have shown that rates of emergency room visits and hospitalizations for many patients with chronic disease and other ambulatory-sensitive conditions can be reduced by 20-40% or more through improved patient education, self-management support, and access to primary care.[2] If the 2.4 million potentially preventable hospitalizations for Medicare beneficiaries each year were reduced by 25%, Medicare savings would range from $3 billion per year (assuming spending of only $5,000 per hospitalization) to nearly $10 billion per year (based on more typical total spending of $15,000 for an episode of hospitalization for chronic disease, including post-acute care, readmissions, etc.). Bigger reductions in hospitalizations would lead to even greater savings.

- **Hundreds of thousands of infections, complications, and errors occur every day, costing billions of dollars.** On average, in every minute of every day, 3 new avoidable errors, infections, and complications occur somewhere in the U.S. A study a few years ago estimated the cost of those problems at $20 billion per year for all payers.[3] Although progress is being made in reducing the rate of these complications, far more can be done. Work pioneered by the Pittsburgh Regional Health Initiative and replicated in other parts of the country has proven that such events can be dramatically reduced or even eliminated through low-cost techniques.[4]

Medical Error	# Errors (2008)	Cost Per Error	Total U.S. Cost
Pressure Ulcers	374,964	$10,288	$3,857,629,632
Postoperative Infection	252,695	$14,548	$3,676,000,000
Complications of Implanted Device	60,380	$18,771	$1,133,392,980
Infection Following Injection	8,855	$78,083	$691,424,965
Pneumothorax	25,559	$24,132	$616,789,788
Central Venous Catheter Infection	7,062	$83,365	$588,723,630
Others	773,808	$11,640	$9,007,039,005
TOTAL	1,503,323	$13,019	$19,571,000,000

Source: *The Economic Measurement of Medical Errors*, Milliman and the Society of Actuaries, 2010

Reducing avoidable hospitalizations and improving the quality of the remaining hospitalizations not only can save money for Medicare, they improve outcomes for patients, too. Too much time is spent debating whether to deny patients coverage for expensive treatments in order to reduce spending, when our focus should be on how to keep patients healthy, avoid unnecessary hospitalizations, and reduce the infections, complications, and readmissions which harm patients and cost billions of dollars.

The Fee for Service System is a Major Barrier to Higher Value Health Care

A major reason we're still spending tens of billions of dollars on unnecessary and harmful care is because of the way we pay for healthcare today. The current fee-for-service system makes it difficult or impossible for physicians to help Medicare take advantage of these opportunities to improve care for patients and reduce healthcare spending. For example:

- **Many of the types of services that have been shown to prevent emergency room visits and hospitalizations are not paid for adequately or at all**. Medicare does not pay primary care practices for care coordination services for complex patients, to engage in shared decision-making processes with patients facing important choices about tests or procedures, or even to answer a phone call from a patient. Similarly, specialists are only paid for seeing patients in person, not for advising primary care physicians on care management, for time spent coordinating services with the primary care physician, or for responding to patient calls for assistance. A physician who deals with an urgent patient problem over the phone isn't paid even if that call prevented an unnecessary emergency room visit. A physician who hires a nurse to assist with patient education typically cannot be reimbursed for the cost of that nurse, even if the nurse helps the patient avoid a hospitalization. All of these things limit the ability of physicians to flexibly design services to best meet a patient's needs, resulting in unnecessary illnesses, treatments, and spending.
- **Physicians and hospitals can be financially penalized for reducing unnecessary services and providing better quality services.** For example, reducing errors and complications during hospital stays can not only reduce both physicians' and hospitals' revenues, but also reduce hospital profits and their ability to remain financially viable.[5] Physicians lose revenue if they perform fewer tests and procedures, even if their patients are better off without the tests or procedures.
- Perhaps most fundamentally, under the fee-for-service payment system, **physicians don't get paid at all when their patients stay well.**

Pay-for-Performance and Shared Savings Won't Solve the Problem

Although there is widespread agreement now that the fee-for-service system is broken, it is essential to understand the specific problems with fee-for-service payment described above in order to

ensure that payment reforms actually *solve* these problems. In fact, most so-called "payment reforms" don't solve the problems because they don't actually change the fee-for-service system.

For years, health plans and Medicare have been trying to fix the problems of the fee-for-service system by adding bonuses and penalties on top of it. However, most pay-for-performance (P4P) programs have had very little impact, and the reason is simple: a small P4P bonus or penalty can't overcome the significant weaknesses of the underlying fee-for-service payment system. Merely tying payment to a large number of quality measures doesn't necessarily result in better quality care, since you can't expect healthcare providers to measure, report, and improve on a large number of quality measures if the quality measures demand changes in care that aren't paid for under the current payment system.

Although "shared savings" sounds like an innovative new approach to payment, in reality, it is nothing more than a new form of pay-for-performance. Shared savings programs and similar payment reform efforts will likely have limited impact because they leave the current, broken fee-for-service system in place, and in particular, they force physicians and hospitals to lose money when they help Medicare reduce spending. For example:

- Pay-for-performance and shared savings programs don't change the fact that Medicare pays physicians only for office visits, not for phone calls or for hiring a nurse to help patients manage their conditions. If a physician can respond to a patient's health problem over the phone, thereby avoiding the need for the patient to make a visit to the office, the physician will still lose revenue. If the physician hires a nurse to help the patient, the physician's costs will increase but he or she will receive no additional payment. Giving the physician a small bonus or reimbursing the physician for a portion of the lost revenue through a shared savings program still penalizes the physician's practice (recouping only a portion of the loss still results in a loss) and also creates a cash flow problem, since pay-for-performance and shared savings payments typically aren't made until a year or more after the losses occur.
- If better coordination of a patient's care can avoid an emergency room visit or hospital admission, the hospital will lose all of the revenue for that visit or admission, but it will still have to cover the costs of having the emergency room or hospital bed available. Giving the hospital a bonus or shared savings payment for lower admission rates can still penalize the hospital, since the portion of the lost revenues offset through the shared savings payment may be less than the fixed costs the hospital must continue to cover.

Congress will have limited success in improving the quality of healthcare for Medicare beneficiaries and controlling the growth in Medicare spending if it merely adds more pay-for-performance programs, shared savings programs, or "value-based purchasing" programs on top of the current fee-for-service system. The fee-for-service system must be replaced.

Accountable Payment Models Can Help Improve Quality and Lower Costs

Fortunately, there are better ways of paying physicians than fee-for-service that give them the flexibility to both improve patient care and reduce Medicare spending *without* having to take financial losses themselves. *Accountable payment models* can:

- give physicians the *flexibility* to deliver the type of care that patients need without having to worry about whether that particular combination of services is going to be reimbursed adequately.
- give individual physicians *accountability* for the *kinds of costs they can control or influence*, not for things they *cannot* reasonably affect.
- separate insurance risk and performance risk, so that *physicians are not penalized financially for taking care of sicker patients* or those with unusually complex conditions.

Building Blocks of Accountable Payment Models

Accountable Payment Models are created using one or more of the following building blocks:

- **Bundled Payment:** Instead of paying physicians and hospitals separately for each service associated with the hospitalization or procedure, a bundled payment gives them a single amount for the procedure that they can divide up on their own. Under bundled payment, if a physician helps a hospital reduce the cost of a procedure, the physician can share in the savings the hospital achieves, and both the hospital and physician can then offer a lower price to Medicare for the newly redesigned care.
- **Warrantied Payment:** Under a warrantied payment, the physician is paid more for a procedure than they are today, but they are no longer paid more for treating any infections or complications related to the procedure that the patient experiences. The physician is thereby rewarded for providing safer, higher-quality care, and Medicare saves money by not having to pay to treat expensive complications.

- **Condition-Based Payment:** Bundled payments and warrantied payments can help improve the quality and efficiency of care for a particular procedure, but they don't remove the disincentives for reducing unnecessary procedures. A condition-based payment solves that problem by paying for care of the patient's health condition, regardless of what procedure is used.

BUILDING BLOCKS OF PAYMENT REFORM	HOW IT WORKS	HOW PHYSICIANS AND HOSPITALS CAN BENEFIT	EXAMPLE
Bundled Payment	Single payment to two or more providers who are currently paid separately (e.g., hospital + physician)	Higher payment for physicians by reducing costs paid by hospitals	Medicare Acute Care Episode (ACE) Demonstration
Warrantied Payment	Higher payment for quality care, no extra payment for correcting preventable errors and complications	Higher payment for providers with low rates of infections and complications	CMMI BPCI Geisinger ProvenCare
Condition-Based Payment	Payment based on the patient's condition, rather than the procedure used to treat the condition	No loss of payment for providers who use fewer tests and procedures	ACC SMARTCare BCBSMA AQC

The advantage of all of these payment approaches is that they give physicians greater flexibility to decide which services should be provided to a patient (rather than being restricted by the services specifically authorized under a fee-for-service system) and they remove the disincentives to eliminate unnecessary services, so that Medicare or other healthcare payers spend less money to get higher-quality care for their patients.

These approaches – a single payment for a complete product or service, with a warranty to correct defects at no charge – are how most other industries are paid for their products and services, and it makes sense to use them in healthcare, too.

Creating Accountable Payment Models Using Different Combinations of the Building Blocks

Most of the successful payment reforms you typically hear about are simply combinations of these building blocks. "Episode payments" include some combination of bundled payment and warrantied payment. "Risk-adjusted global payment" is, in effect, a broad set of condition-based payments, each with elements of bundling and warranties.

Thinking in terms of the building blocks of payment reform is important because there is no single "best" way to define an episode payment or global payment. The CMS Innovation Center has recognized this, and so its Bundled Payments for Care Improvement (BPCI) Initiative is offering four different payment models for 48 different patient conditions. Each model has a different combination of bundling and warranties; some apply to conditions and others apply to particular procedures.

But despite this diversity – as many as 144 different payment models in total – the BPCI doesn't go nearly far enough, because *all* of the BPCI payment models *are limited to patients who have been hospitalized.* Although we certainly want to improve the quality and efficiency of hospital care and to reduce the high cost of complications, readmissions, and post-acute care for patients who are hospitalized, patients should not have to be hospitalized in order to get better quality care. **We also need to have payment reforms that help to keep patients healthy and avoid needing to go to the hospital in the first place.**

Examples of Successful Accountable Payment Models Using the Building Blocks

Where these building blocks have been used to create appropriate accountable payment models, providers, payers, and patients have all benefited. For example:

- in the Medicare Acute Care Episode (ACE) Demonstration, which "bundles" physician and hospital payments (i.e., it makes a single payment to both providers, rather than separate payments to each), Medicare has saved money, physicians have received higher payments, hospitals have been able to reduce their costs and improve their operating margins, and patients have received better care at lower cost.[6]
- the Geisinger Health System in Pennsylvania, through its ProvenCare℠ system, provides a "warranty" that covers any follow-up care needed for avoidable complications within 90 days at no additional charge. The system was started for coronary artery bypass graft surgery, and has been expanded to hip replacement, cataract surgery, angioplasty, bariatrics, low back pain, perinatal care, and other areas.[7] Offering the warranty led to significant changes in the processes used to deliver care, and Geisinger has reported dramatic improvements on quality measures and outcomes.[8]
- The Alternative Quality Contract implemented by Blue Cross Blue Shield of Massachusetts in 2009 defines a single payment to a physician practice or health system for a group of patients to

cover all care services delivered to those patients (including hospital care, physician services, pharmacy costs, etc.). The payment amount is determined based on the health conditions of the patients, not based on what tests or procedures the providers use. The physician practice or health system can earn a bonus payment for achieving high performance on clinical process, outcome, and patient experience measures. Evaluations of the early results show that participating healthcare providers achieved better quality, better patient outcomes, lower readmission rates, and lower utilization of emergency rooms.[9]

Accountable Payment Models Are Needed for Every Specialty

To date, most payment reform efforts have been focused narrowly on a subset of physicians, particularly primary care physicians and surgeons, or they have required physicians to participate in large health systems or Accountable Care Organizations that are willing to take accountability for the total costs of care for a population of patients. These initiatives are desirable, but insufficient. **If we are going to successfully control healthcare costs and improve the quality of care for all patients, we need to make payment reforms available to every specialty and to independent physicians as well as those who are part of large systems.**

There are many examples of significant improvements in the quality and cost of care that could be achieved by paying individual specialties under accountable payment models. For example:

- **Coronary Artery Disease.** A condition-based payment for coronary artery disease would enable cardiologists (potentially in collaboration with cardiac surgeons and/or primary care physicians) to redesign the way care is delivered to patients with newly diagnosed coronary artery disease, regardless of what type of treatment is used (medical management, PCI, or CABG) or where the treatment is provided (hospital, ambulatory surgery center, or office).
- **Congestive Heart Failure.** A condition-based payment for patients with congestive heart failure (CHF) would enable cardiologists and/or primary care physicians to provide better care management for patients and reduce the rate of emergency room visits and hospitalizations for exacerbations of their CHF.
- **Chronic Obstructive Pulmonary Disease.** A condition-based payment for patients with chronic obstructive pulmonary disease (COPD) would enable pulmonologists and/or primary care physicians to provide better care management for patients with COPD and reduce the rate of ER visits and hospitalizations for exacerbations of their COPD or for pneumonia.
- **Inflammatory Bowel Disease.** A condition-based payment for inflammatory bowel disease would enable gastroenterologists (potentially in collaboration with primary care physicians) to better manage all of the care needs of patients with this condition, reducing unnecessary hospitalizations and emergency room visits.

- **Epilepsy.** A condition-based payment would enable neurologists (potentially in collaboration with primary care physicians) to better manage all of the care needs of patients with epilepsy, including their preventive care.
- **Colon Cancer Prevention.** Gastroenterologists (potentially in collaboration with oncologists) could receive a global payment for colon cancer screening and treatment of colon cancers within a population of patients. More effectively targeted, high quality colon cancer screening would be designed to reduce the frequency of late stage colon cancer treatments, while eliminating unnecessarily frequent colonoscopies.
- **Transient Ischemic Attack and Stroke.** An episode payment would enable neurologists and vascular surgeons to provide the most effective short-term management and treatment of patients who experience a transient ischemic attack (TIA), regardless of what type of treatment is used (e.g., endarterectomy, tPA, antiplatelet therapy). A longer-term condition-based payment could be made to neurologists and cardiologists to support comprehensive strategies to prevent both strokes and myocardial infarction in patients who have experienced a TIA.
- **Childbirth.** A single payment to obstetricians/gynecologists for labor and delivery would enable the mother and physician to choose the best method of delivery (vaginal delivery or cesarean section) and the best location for the delivery (e.g., a hospital or birth center). The payment could be limited to normal pregnancies in low-risk women, or applied to a broader population with the payment amount risk-adjusted based on the mother's characteristics. This could be very helpful to state Medicaid programs.

In order to move away from fee-for-service, each physician specialty will need payment models that are (a) customized to the specific types of patients they care for and (b) focused on the types of costs they can control or significantly influence. **A weakness of many current efforts at payment reform is that they try to make physicians accept accountability for the total costs of all care their patients receive, even though the physician can only expect to have an impact on a subset of those costs.** Physicians and other healthcare providers are far more likely to be willing to accept responsibility for the utilization and cost of services they deliver or prescribe themselves than services chosen by other providers. (For example, primary care physicians can influence the rate at which their patients go to an emergency room, but not the number of tests that are ordered once the patient arrives; emergency room physicians can influence the number of tests ordered in the emergency room, but not how many patients come to the emergency room for conditions that could have been treated by their primary care provider.) To address this, payment to physicians in a particular specialty should be designed to only include the costs of the services that these physicians control or can significantly influence, while *excluding* the costs of other services. (Medicare would continue to pay for the excluded services on either a fee-for-service basis or through separate payment reforms designed for the other specialties).[10]

Accountable Payment Models Can Also Help ACOs Be Successful

Accountable payment models for each specialty not only can help independent physicians improve care and control costs, they can help create more successful Accountable Care Organizations (ACOs). If every specialty participating in the ACO is paid in a way that enables it to achieve savings of 2% within its own sphere of influence, the ACO as a whole will be far more likely to achieve the minimum 2% savings Medicare is seeking from the ACO than if the ACO tries to achieve a similar amount of savings with a few care improvement programs focused on a small number of patients. Although there are many opportunities to save money in healthcare without harming patients, there are no "silver bullets" that can achieve dramatic savings in any one area.

Accountable payment models will even be helpful for health systems with employed physicians, because they will provide a model for improving the compensation structure for physicians inside the health system. Most physician compensation systems today, even for physicians who are "on salary," are based on fee-for-service, i.e., the physician gets paid in part or in whole based on the number of visits they have or the number of procedures they perform. These compensation structures will need to change if a health system wants to be a successful Accountable Care Organization, and accountable payment models can help them do so.

How an Accountable Payment Model Can Improve Patient Care and Save Money Without Harming the Financial Viability of Physicians or Hospitals

Here is an example of how more accountable payment models can improve care for patients and save money for Medicare without financially harming physicians or hospitals. Assume that during the course of a year, a physician practice or health system sees 300 Medicare patients who have a particular health condition (e.g., heart disease). One approach to treating the condition is an expensive hospital procedure (e.g., placement of a stent in a coronary artery) that could help the patients, but the procedure also carries a risk of infection or death, and it is not appropriate for all patients. The physicians in the practice evaluate the patients to determine whether to do the procedure, and they decide to perform the procedure for 200 of the 300 patients who are evaluated. The physicians are paid $150 for the office visit to evaluate each patient and they are paid $850 for each procedure. The hospital is paid $11,000 for each procedure the physicians perform. In total, Medicare is spending $2.4 million per year on these patients.

Now, assume further that a study shows that 10% of the procedures being performed are either inappropriate or unnecessary. If the physician practice simply reduced the number of procedures by 10%, Medicare would save $240,000, but the revenue to the physician practice would decrease by 10% and the hospital's revenue would also decrease by 10%, causing a financial problem for each of them.

	TODAY		
	$/Patient	**# Pts**	**Total $**
Physician Svcs			
Evaluations	$150	300	$45,000
Procedures	$850	200	$170,000
Subtotal			$215,000
Hospital Pmt	$11,000	200	$2,200,000
Total Pmt/Cost	$8,050	300	$2,415,000

But if the physician practice is given a condition-based payment for the 300 patients it is seeing, it can redesign both care and payment in a way that can reduce Medicare spending without financially harming either the practice or the hospital. The payment would no longer depend on what procedures the physicians do or whether they do a procedure at all, so there would be no financial penalty for doing fewer procedures, nor any financial reward for doing more; the focus would be on achieving good outcomes for the patient. Assume that the physician practice works with the hospital and determines that they can jointly give good quality care to the 300 patients with a budget of $2,348,000, which is a 3% savings for Medicare. The physician practice not only redesigns the care for the patients, but it also redesigns the way everyone is paid. The physicians in the practice will now get paid more for the patient evaluation visits, so they have time to spend doing a shared decision-making process with the patients, and as a result, 10% fewer patients decide they want to receive the procedure. The physicians will also get paid more for each procedure, but since they will now be doing fewer procedures, this does not result in a significant increase in revenues for the practice (indeed, they cannot get more revenue than the overall budget allows). The hospital determines what its fixed and variable costs are so that it can be paid enough for each procedure to still cover its costs even with fewer procedures.

CONDITION-BASED PAYMENT:
Ability to Redesign Payment and Care to Save Money
Without Hurting Providers or Patients

	TODAY			TOMORROW			
	$/Patient	# Pts	Total $	$/Patient	# Pts	Total $	Chg
Physician Svcs							
Evaluations	$150	300	$45,000	$200	300	$60,000	
Procedures	$850	200	$170,000	$883	180	$159,000	
Subtotal			$215,000			$219,000	+2%
Hospital Pmt							
Fixed Costs	$6,930	63%	$1,386,000			$1,386,000	-0%
Variable Costs	$3,630	33%	$726,000	$3,630		$653,400	-10%
Margin	$440	4%	$88,000			$89,600	+2%
Subtotal	$11,000	200	$2,200,000	$11,828	180	$2,129,000	-3%
Total Pmt/Cost	$8,050	300	$2,415,000	$7,827	300	$2,348,000	-3%

The net result is that the patients get better care, the physician practice receives slightly more revenue, and the hospital actually sees an increase in its margin, all while saving Medicare money.

Why Shared Savings Won't Achieve the Same Results

This kind of significant redesign of care needs a completely new payment model; it cannot be done under fee-for-service or even in an ACO in the Medicare Shared Savings Program. Under the Medicare Shared Savings Program, the physicians and hospitals are still paid under the fee-for-service system, so they still lose money when they do fewer procedures. The arbitrary formula for awarding shared savings may not provide enough money back to the physicians and hospital to cover their losses, and even if it does, the payment will come a year later, forcing the physicians and hospital to incur losses in the short run. Moreover, there may be no shared savings payment at all if the savings they achieve for this particular set of patients is not enough to allow the ACO to qualify for a shared savings payment.

SHARED SAVINGS:
Shared Savings Payment Is Not Enough To Offset Provider Losses

	Year 0	Year 1	Chg	Year 2	Chg	Cumulative
Physician Svcs						
Evaluations	$45,000	$45,000		$45,000		
Surgeries	$170,000	$153,000		$153,000		
Shared Savings		$0		$17,000		
Subtotal	$215,000	$198,000	-8%	$215,000	-0%	-$17,000
						-4%
Hospital Pmt						
Surgeries	$2,200,000	$1,980,000		$1,980,000		
Shared Savings		$0		$101,500		
Subtotal	$2,200,000	$1,980,000	-10%	$2,081,500	-5%	-$338,500
						-8%
Total Pmt/Cost	$2,415,000	$2,178,000	-10%	$2,296,500	-5%	$355,500
Savings		$237,000		$118,500		-7%

Separating Performance Risk from Insurance Risk

To enable physicians to be successful in accountable payment models and to attract physician participation, the payment models must be structured to ensure that they only require physicians to take accountability for *performance risk*, i.e., for their ability to manage their patients' conditions in a high-quality and efficient manner, but not for *insurance risk*, i.e., whether a patient has an illness or other condition requiring care. In contrast, traditional (non-risk-adjusted) capitation systems transferred *all* cost risk to the provider. Insurance risk is what health insurance is designed to address, and so Medicare needs to retain insurance risk.[11]

There are several ways to structure payment systems to give providers accountability for the costs they can control, without asking them to take on insurance risk that they cannot control:[12]

- **Risk Adjustment:** Higher payments should be made for those patients who have more health conditions or more serious health problems. The payment should only be higher if the patient is sicker, not simply because the provider decides to do more tests or procedures. In the example given earlier, if the physicians and hospital had sicker patients who were more likely to need expensive procedures, then their budget would increase. But this would not mean Medicare

would not still receive savings, because Medicare would have had to pay even more for those patients under the fee-for-service system.

- **Risk Limits:** Since no risk adjustment formula could ever be 100% accurate in predicting legitimate variations in costs, risk adjustment should be supplemented with risk limits, such as outlier payments to cover unusually high costs for specific patients and "risk corridors" that require Medicare to provide additional payments to providers when the total cost of treating a group of patients significantly exceeds the agreed-to payment level. The sizes and cost-sharing parameters for these risk corridors could vary from provider to provider, since larger providers will be better able to manage variation in costs, and the parameters could also be changed over time as providers become more experienced in managing costs.
- **Risk Exclusions:** In some cases, it is clear that certain kinds of costs cannot reasonably be controlled by a provider, and rather than using risk adjustment formulas or other complex calculations to adjust for them, they should simply be excluded from accountability altogether. For example, the costs associated with patients who are seriously injured in accidents could simply be excluded entirely from a global payment model for a small group of physicians, and be paid for separately on an episode-of-care basis or under traditional fee-for-service.
- **Contract Adjustments:** It is impossible for anyone to predict exactly what will happen when Medicare and physicians move to completely different payment models, particularly in the early phases of implementing new payment models. New drugs, new medical devices, and new ways of delivering care are being developed at a rapid pace, and these can either help or hurt providers' ability to control costs and improve quality. Rather than taking years to design and negotiate payment reform contracts that try to anticipate all possible contingencies, CMS should make a commitment to make adjustments to contracts with providers to deal with unexpected events.

Ensuring Quality of Care for Patients

A common concern about payment reforms that are designed to increase incentives for providers to control costs is that they will also create incentives for providers to withhold care that patients need or to deliver lower-quality care in order to reduce costs. It is important to recognize, however, that even fee-for-service payment, with its inherent incentives to deliver more services to patients, does not guarantee the delivery of higher quality care. Implementing the accountable payment models described

earlier will make it easier for physicians and other providers to improve quality because they will remove the barriers and disincentives that exist in the fee-for-service system today. However, no payment system will, in and of itself, guarantee higher quality care unless the quality of care is explicitly measured and mechanisms are established for rewarding higher quality care and/or penalizing lower quality care.

Consequently, accountable payment models should be accompanied by (a) requirements for measurement and public reporting on the quality of care, and (b) bonuses or penalties for the aspects of quality which are not directly encouraged by the payment model itself. Different types of quality measures will be important under accountable payment models than under fee-for-service; for example, if a provider accepts a payment with a warranty for errors, infections, or complications occurring during treatment, there is no need to have a separate quality bonus/penalty for such errors, infections, and complications, because there is a built-in penalty for the provider if such events occur, namely, it has to correct the problems with no additional compensation. In the absence of such a warranty, however, a separate bonus/penalty component would need to be added to the payment system to provide similar incentives. Quality measurement focused on preventive care – where problems will often not manifest themselves until many years in the future – will be important to include in accountable payment models. Fortunately, this is the area where most community-based public reporting programs now focus their efforts.

A more fundamental problem is that most of the measures that are being used by Medicare and other payers today are process measures, not outcome measures, e.g., they measure whether a patient received a specific set of medications, not whether they avoided another heart attack, and they measure whether appropriate surgical procedures were used in the hospital, not whether the patient experienced an infection or was able to walk again. Not only is there evidence that good performance on many types of process measures does not necessarily improve outcomes,[13] process measures could actually impede efforts to reduce costs and improve quality by locking in less-than-optimal approaches to care. **Congress needs to support the development and testing of new quality measures, particularly outcome measures appropriate for the kinds of patient conditions managed by specialty physicians.**

It is desirable to use common, nationally endorsed quality measures and requirements for quality improvement activities wherever possible, but there should also be the flexibility to use different quality

measures and quality improvement programs where appropriate to respond to state and regional priorities. In addition, in selecting national quality measures and requirements for quality improvement strategies, preference should be given to those quality measures and quality improvement strategies that are already being used in multiple regions and states.

How Congress Can Quickly Implement Accountable Payment Models

The nation needs to implement these types of accountable payment models as broadly and quickly as possible, both in the Medicare program and for all types of payers. Every month of delay means that more patients will be harmed, more patients will continue to receive less-than-optimal care, and the federal deficit will be harder to solve.

Weaknesses of the Current Approach for Designing and Implementing Payment Reform

The traditional approach that has been used for payment reform in the Medicare program is a top-down approach, where Congress directs CMS to develop a better payment model, CMS tests one or more alternative approaches, and then it decides on a single approach that has to apply to every physician and every community. This approach is not working as quickly or effectively as we need it to, because it has two fundamental flaws:

- **There cannot be a one-size-fits-all approach to payment reform.** Because the specific opportunities and barriers differ from community to community, and because different physicians have different types of patients and different levels of ability to change care delivery, many different payment reform models will be needed. Any single payment reform model may work for some physicians in some parts of the country, but it will likely not work for others, and that means the impact on cost and quality will be far less than we want or need.
- **We will never be able to "prove" that a payment model works before making it broadly available.** Although it would seem desirable to have "evidence" that a payment reform will be successful before making it broadly available, this will never happen, for two simple reasons. First of all, payment reform itself does not improve quality or reduce costs, physicians do that. Payment reform removes the barriers that fee-for-service payment create for better quality, lower-cost care, but no payment reform will be successful if the physicians being paid that way don't actually use the payment to improve care. Second, because the opportunities and barriers differ dramatically from community to community and provider to provider, the fact that one

physician successfully used a payment reform model to improve care does not guarantee that other physicians will be able to do so. This is particularly true if the payment reform model itself does not incorporate any explicit accountability for cost. For example, even if dozens of studies show that spending is lower for patients who receive care from medical homes that get higher payments, there is no guarantee that future medical home projects will have the same results if they aren't explicitly taking accountability for doing so.

A Bottom-Up Approach for Faster, More Successful Payment Reform

We wouldn't expect centrally-developed solutions in other industries to be the ideal approach, and we can't expect that in healthcare, either. So in addition to the current, "top-down" approach, I recommend that Congress establish a "bottom-up" approach, whereby physicians, provider organizations, medical specialty societies, and multi-stakeholder Regional Health Improvement Collaboratives are invited to develop payment models that will work well for individual physician specialties in the realities of their own communities.

If any of these groups brings CMS a payment model that is *specifically designed to improve patient care and save Medicare money*, CMS should have not only the power, but the *obligation* to approve it and implement it. CMS should then also make that same payment model available to any physician who wants to participate and has the capabilities to do so. Moreover, if a physician is participating in such a model, they shouldn't be subject to threats of SGR-type payment reductions.

This kind of bottom-up approach is not as radical as it might seem:

- For the past two years, the CMS Innovation Center has been inviting providers and other organizations to submit proposals for innovative ways to deliver care and save money, through programs such as the Innovation Awards and the Bundled Payments for Care Improvement Initiative. The fact that CMS received 8,000 applications for the Innovation Awards program demonstrates the broad interest there is around the country in changing care delivery; it also demonstrates the ability of CMS to review large volumes of proposals in a short period of time.
- CMS has implemented significant payment reforms in the past without waiting for evaluation studies to prove that they will work. For example, the Inpatient Prospective Payment System (the DRG payment system for hospitals) was designed and implemented in the fall of 1983, barely a year after it was authorized by Congress, despite the fact that there was no formal

demonstration program to prove it would work. CMS has regularly modified the program to improve it, but it did not wait for the perfect program to be designed before moving ahead to implement it.

There are five things that I believe Congress needs to do to create a truly successful process for developing and implementing new payment models as quickly as possible:

1. **New payment models should be able to be proposed to CMS at any time, and there should be no limit on how many different proposals can be approved as long as they are designed to improve care and save Medicare money. Proposals also need to be reviewed quickly, and CMS should have the obligation to approve a proposal if it demonstrates how it will improve patient care and save Medicare money.**
2. **There should be frequent opportunities for physicians to apply to participate in already-approved payment models. Every physician should be able to participate in an approved accountable payment model whenever they are ready to do so.**
3. **Physicians need to be given access to Medicare claims data so they can determine where the opportunities for saving are, how care will need to be redesigned to achieve those savings, and how payment will need to change to support better care at a lower cost. Specialty societies and Regional Health Improvement Collaboratives should be empowered to assist physicians to do the necessary analyses of these data.**
4. **Once a physician is participating in an accountable payment model, they should have the ability to continue participating as long as they wish to do so if the data show that the quality of care is high and Medicare spending is being controlled. Most innovative payment models today are explicitly time-limited, and no physician or other healthcare provider is going to make significant changes in the way care is delivered if they might be forced to revert to traditional fee-for-service payment within a few years.** ***We need to stop doing demonstration projects and start implementing more broad-based payment reforms.***
5. **Funding should be made available to medical specialty societies and multi-stakeholder Regional Health Improvement Collaboratives so they can provide technical assistance to physicians. Most physicians don't have either the time or training to determine whether and how a new payment model will work for them. If organizations that they trust can**

help them analyze data and redesign the way they deliver care, they are far more likely both to embrace new payment models and to be successful in implementing them.

CMS could give priority to reviewing payment reform proposals from communities that have already developed multi-payer payment reforms involving all or most of the commercial insurance plans in the community and Medicaid programs. The biggest problem the physicians who are participating in these programs have faced is that Medicare does not participate, meaning that 30-40% or more of a physician practice or hospital's patients are not included in the payment reforms. If Congress creates a process through which these communities can bring these payment approaches to CMS and have them approved, the providers in those communities will be better able to change care, and the Medicare program will be able to quickly achieve savings.

The Need to Engage Beneficiaries

Payment reforms will be far easier to implement and far more successful if Congress also takes steps to encourage Medicare beneficiaries to be actively engaged with their physicians in managing their care. One simple change would make a huge difference: asking beneficiaries to designate which physician they want to be in charge of care for each of their conditions.

Most payment reforms that are being implemented in traditional Medicare or in commercial PPO insurance plans are forced to use complicated statistical attribution methodologies to determine which physicians are accountable for which patients. These methodologies are *retrospective*, i.e., Medicare looks back over the claims it paid for the patient over the past year or two to identify which providers the patient actually saw, uses statistical analyses to determine which, if any, physician delivered the majority of the patient's care, and if there is such a physician, assigns the patient to that physician. But using *retrospective* statistical attribution rules to assign patients to providers means that neither the provider nor the patient knows they are part of the new payment system until after the care is delivered, potentially a year a more later.[14] If providers and payers only find out *retrospectively* that they are in a new payment system, it will be difficult for them to work together *prospectively* to change care and prevent unnecessary costs from occurring.

The problems caused by retrospective attribution go far beyond mere uncertainty by providers and patients regarding whether they are in a payment model or not. The attribution models actually reinforce the problems of the fee-for-service system. For example, in various medical home programs,

the primary care physician gets an additional, non-visit-based payment for each patient who is attributed to him or her based on whether the patient made a billable office visit to the PCP. But PCPs who redesign their practices to reduce the emphasis on office visits for healthy patients in favor of phone calls and emails, while providing longer office visits for more complex patients, will be harmed financially under this system, since they will not only lose fee revenue by having fewer office visits, they may also not receive any additional payment for the patients who do not have the recent office visits that are required to trigger the attribution calculation.

Attribution systems also make physicians reluctant to participate because if the attribution rules assign patients whose care the provider cannot influence, the provider can be inappropriately penalized when costs for those patients increase (or inappropriately rewarded if costs decrease). If the attribution rules fail to assign a patient even though the provider was responsible for improving the efficiency of care for that patient, the provider would fail to receive credit for the savings or quality improvements they achieved.[15]

There is an easy solution to this: Simply ask beneficiaries to designate which physician(s) they want to be in charge of care for each of their conditions. Asking patients to designate who their physicians are does *not* mean that the patient has to be "locked in" to those physicians or that any physician must serve as a "gatekeeper" for the patient's care (i.e., that Medicare will not pay for the patient to receive care from any specialist or other provider that is not approved in advance by the physician). It merely means that the patient needs to *choose* their physicians and *notify* both the physicians and Medicare about that; if they wish to change physicians at any point, they would be free to do so, as long as they notify the physicians and Medicare about the change.

Do We Need Incentives or Penalties to Get Physicians to Participate?

Some people have suggested that we need to make the fee-for-service system less attractive, e.g., by cutting payment levels, in order to encourage or force physicians to engage in new payment models. I think this is both unnecessary and inappropriate.

Most physicians will find a properly designed new payment model to be more attractive than the fee-for-service system, because it will give them the flexibility to redesign care for their patients, the opportunity to be rewarded for delivering higher quality care, and the ability to help the nation control healthcare costs in a way that doesn't harm patients or cause financial problems for their practice.

Under the fee-for-service system, physicians typically lose money themselves when they change care in ways that generate savings for Medicare. However, Medicare payments to physicians represent less than 20% of total Medicare spending. Since physicians prescribe, control, or influence most of the remaining 80% of spending, under a properly designed payment model, physicians can help Medicare reduce spending significantly without cutting their own revenues.

Making fee-for-service less attractive in order to get physicians to participate in new payment models implies that the new payment models are *worse* than fee-for-service, which is simply not true. Moreover, since not every specialty or physician will be able to participate in an appropriate payment model right away, making fee-for-service more onerous will penalize physicians who have no other alternative available to them.

I find that most physicians are frustrated with the current fee-for-service system and want to participate in better payment models. However, many physicians have been burned in the past by payment changes that are badly designed, e.g., by shifting unmanageable levels of risk to them, demanding better quality care without giving them the resources or flexibility to deliver it, or cutting payment levels below the achievable cost of care. If Congress and CMS can offer physicians payment models that avoid these problems and provide the help they need to succeed, I believe physicians across the country will not only participate voluntarily, but enthusiastically.

How Congress Can Help Ensure the Success of New Payment Models

Many people believe that the only way that physicians can succeed under accountable payment models is to work for large integrated health systems. Nothing could be further from the truth. Experience has shown that small, independent physician practices can also use better payment models to deliver higher-quality, lower-cost care. For example, the earliest known example of someone offering a warranty in healthcare was not a large health system, but a single physician. In 1987, an orthopedic surgeon in Lansing, Michigan collaborated with his hospital to offer a fixed total price for surgical services for shoulder and knee problems, including a warranty for any subsequent services needed for a 2-year period, including repeat visits, imaging, rehospitalization, and additional surgery. A study found that the payer paid less and the surgeon received more revenue by reducing unnecessary services such as radiography and physical therapy and reducing complications and readmissions.[16]

In many cases, small physician practices may need to join together through Independent Practice Associations (IPAs) or other structures to achieve the necessary economies of scale to manage accountable payment models. However, physicians do not need to be employed by hospitals or join large group practices in order to do so. There are many examples of how physician practices, including very small practices, are successfully managing these new payment models.

Just like in every other industry, where small businesses are often the innovators, small healthcare providers can be more efficient and innovative than large systems, if we give them the opportunity to do so without imposing unnecessary and expensive regulatory requirements.

However, physicians, particularly those in small practices, will need help both to design and implement new payment models. As noted earlier, two kinds of assistance are particularly important:

- Access to Data and Analysis on Cost and Quality
- Training and Coaching in Process Improvement

Access to Data and Analysis on Cost and Quality

It is impossible for physicians, hospitals, and other providers to identify where opportunities for cost reduction exist or how to capitalize on them without access to Medicare claims data. Physicians need information on current utilization patterns and analyses of the likely impact of interventions in order to construct a feasible business case for the investment of resources in new care processes and to evaluate the feasibility of participating in a new payment model.

For example, in order for a physician practice or health system to accept an episode of care payment for the type of treatment it delivers, it needs to know about all of the services that those types of patients have been receiving from the hospital, other physicians, and post-acute care providers, how much all of those providers are being paid, the frequency with which adverse events occur, and the extent to which any of those elements can be changed. Differences in the types of services needed for patients with different types of health conditions need to be identified, and the impacts of risk adjustment and risk limits need to be determined. Medicare will need to have matching data so it can be sure the total episode price is lower than the average amount being paid today.

Once a physician practice is participating in an accountable payment model, timely access to data is critical if the practice is going to be held accountable for costs and quality, particularly if this includes services delivered by hospitals or other providers.

It is not enough simply to have access to data or even to traditional quality measures that are produced by Medicare and commercial health plans; physicians need useful *analyses* of those data to identify where opportunities exist for quality improvement and cost reduction.

Medical specialty societies and Regional Health Improvement Collaboratives can provide this kind of assistance to physician practices, but they will need financial support to do so. In particular, there is currently no federal funding program that provides support for the work that multi-stakeholder Regional Health Improvement Collaboratives do to analyze data or do public reporting of quality measures.

Training and Coaching in Process Improvement

Data can show where opportunities exist to reduce utilization and costs, but physicians also need training and coaching in how to restructure their practices in ways that can take advantage of these opportunities. Not only is this re-engineering not taught in medical school, it is hard for physicians to do it and still keep up with the demands of ongoing patient care. Moreover, it will be challenging for physicians and other healthcare providers who have been operating under the fee-for-service payment system for many years to suddenly switch to operating under accountable payment systems that require greater accountability for cost and quality.

Physicians cannot change the way they deliver care unless payment systems are implemented that support those changes. However, once a better payment model is made available, they will need to change care delivery in order to succeed. Here again, medical specialty societies and Regional Health Improvement Collaboratives can provide assistance to physician practices, but they will need financial assistance to do so. Successfully transforming local healthcare delivery will require many years of persistent effort, and so reliable, multi-year funding will be needed to support these efforts.

Thank you again for the opportunity to testify. I would be pleased to provide any additional detail about these recommendations that would be helpful.

Sincerely,

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[7] For more information, see http://www.geisinger.org/provencare/.

[8] Casale AS, Paulus RA, Selna MJ, Doll MC, Bothe AE, Jr., McKinley KE, et al. "ProvenCareSM": a provider-driven pay-for-performance program for acute episodic cardiac surgical care. Ann Surg. 2007 Oct;246(4):613-21; discussion 21-3.

[9] Chernew ME, Mechanic RE, Landon BE, Safran DG. Private-payer innovation in Massachusetts: The 'Alternative Quality Contract' Health Aff (Millwood). 2011 January, 30(1): 51-61. The Alternative QUALITY Contract: Year One Results, Blue Cross Blue Shield of Massachusetts, 2011, available at http://www.bluecrossma.com/visitor/pdf/aqc-results-white-paper.pdf.

[10] For episode payments, the Integrated Healthcare Association and the Health Care Incentives Improvement Institute have both developed detailed specifications as to which services will be included and which will not, as well as risk adjustments, risk exclusions, etc. For more information, see http://www.iha.org/episodepayment.html and http://www.hci3.org/what_is_prometheus . For global payments, the Integrated Healthcare Association has developed a standardized Division of Financial Responsibility that can be used by providers and payers to clearly define the costs for which the provider will be accountable and those for which the payer will retain accountability. For more information, see http://www.iha.org/dofr.html.

[11] Miller HD. From volume to value: Better ways to pay for health care. Health Aff (Millwood). 2009 Sept-Oct; 28(5): 1418-28.

[12] For a more detailed discussion of methods of controlling provider risk, see Miller HD. Transitioning to Accountable Care [Internet]. Pittsburgh (PA): Center for Healthcare Quality and Payment Reform; 2011. Available from: http://www.chqpr.org/reports.html.

[13] See, for example, Nicholas LH, Osborne NH, Birkmeyer JD, Dimick JB. Hospital process compliance and surgical outcomes in Medicare beneficiaries. Arch Surg 2010 October; 145(10): 999-1004.

[14] For example, under the Medicare Shared Savings Program, a patient is assigned to an Accountable Care Organization (ACO) if the patient had more charges for primary care services in the previous 12 months from physicians associated with the ACO than from physicians not associated with the ACO. Federal Register 76 (212): 67802-67990. Even if attribution calculations are done frequently, a patient who changes physicians may not be assigned to the new physician until they have enough visits with the new physician to represent a majority of the charges over a 12 month period.

[15] For example, if a patient is admitted frequently to the hospital during the year for various problems, but makes his first visit to the PCP near the end of the year, the patient could be attributed to the PCP for the entire year, thereby making the PCP accountable for all of the hospital visits that occurred before the patient first saw the PCP.

[16] Johnson LL, Becker RL. An alternative health-care reimbursement system--application of arthroscopy and financial warranty: results of a 2-year pilot study. Arthroscopy. 1994 Aug;10(4):462-70; discussion 71-2.

Mr. PITTS. Thank you, Mr. Miller.

Ms. Mitchell, you are recognized for 5 minutes for your opening statement.

STATEMENT OF ELIZABETH MITCHELL

Ms. MITCHELL. Thank you, Mr. Chairman and members of the committee. My name is Elizabeth Mitchell. I am the CEO of the Maine Health Management Coalition, and I want to start by thanking you for taking on this issue. As I am sure you well know, employers and State governments can no longer afford cost increases, our employees can't go further years without wage increases, and our providers are increasingly burdened in a system that does not reward high performance and creates daily barriers to improving care for patients, largely due to current payment systems and a lack of data.

Thank you for also hearing from a regional health improvement collaborative. We are an employer-led multi-stakeholder collaborative based in Maine. We have been around for 20 years and we include employers from the State employees to L.L. Bean to the Medicaid program, large multi-specialty groups, academic medical centers and primary care physicians. We work together in a partnership to improve quality and reduce cost.

Maine has been very successful in addressing quality. We have some of the best health care quality in the country. We know that our efforts in data sharing measurement and public reporting have been key to achieving those gains. However, despite these achievements, quality and safety failings continue, and more discouraging is that the quality improvements have not reduced the costs of care for purchasers and patients.

Costs and quality vary by region as do opportunities for improvement. Maine is the birthplace of the Dartmouth Atlas, where Dr. John Wennberg first observed vast differences in maternity care within Maine with no correlation to demographics, patient acuity or patient preference. He also noted that his kids would have received vastly different treatment for their tonsillitis if they lived one county away. Variation in cost is even more pronounced.

Just as there is no single problem facing health care, there is no single one-size-fits-all national solution. I believe with adequate data and support, regions are well positioned to not only identify but help solve their own problems. Data is necessary to identify regional improvement opportunities and to engage stakeholders in improvement. The Dartmouth Atlas would never have been possible without good data. But data is necessary but insufficient. Once opportunities are identified, stakeholders, particularly physicians, must be actively engaged to change current practice. We must now be equally effective using data to engage physicians, purchasers and patients in care improvement. Data is essential for many, many reasons: identifying priority costs and quality improvement opportunities, enabling performance measurement and public reporting, establishing cost and quality performance targets, informing choice by consumers, engaging physicians and managing population health. The premise of medical homes and ACOs is better management of population health but it is both unreasonable

and unfair to ask physicians to assume risk without adequate, timely data.

States and communities face different challenges and physicians need local, timely data to direct their work. To direct physicians to focus improvement efforts on non-priority areas is a sure way to frustrate them when they are not even paid for this improvement work. But they know where care can be improved if you ask. Significant savings are also possible through readmission reduction, through improved C-section rates. There are opportunities around the country if you have the right data to target them.

You rightly recognize the central role of measurement in both improvement and accountability. A key barrier to addressing cost in ways that were equally successful to addressing quality is the lack of nationally endorsed cost measures. Without measures endorsed by the National Quality Forum, we found it impossible to reach consensus on relevant metrics. Regardless of the payment system, appropriate and transparent measurement is required to understand how patients fare in new models. Good outcome and patient experience measures will also support more flexible payment models. New models and incentives to reduce costs must be balanced by ongoing measurement.

You referenced physician-endorsed measures but we would urge you to consider multi-stakeholder-endorsed measures as those who pay for and receive care, purchaser and patient voice, are crucial to identifying the right performance indicators together with physicians. Whether measurement or population health management, none of this work is possible without data.

Unfortunately, multi-payer data is very hard to obtain. Many health plans consider it proprietary. Many provider-run data organizations are reluctant to share it publicly, but as Dr. David Howes, the president of Martin's Point Health Care summed up our challenge, "The age of competing for market share by controlling access to data is over. Transparent all-payer data should be made widely available and competition should be based solely on performance."

Medicare's Qualified Entity program is an important step toward giving communities and providers the information they need to improve care. The Qualified Entity program is a strong signal of partnership and support for local innovation and endorsement for use of integrated data. CMS should not only continue to enable qualified groups to share data but they should accelerate it with financial support and greater flexibility.

Regional health improvement collaboratives are stewards of multi-payer data and experienced leaders using the data for improvement. We may be your innovation infrastructure and partners for implementation on the ground.

[The prepared statement of Ms. Mitchell follows:]

Testimony of Elizabeth Mitchell

CEO, Maine Health Management Coalition and Foundation
and
Board Chair, Network for Regional Health Improvement
to the
Subcommittee on Health, Committee on Energy and Commerce
U.S. House of Representatives
February 14, 2013

Key Points:

1. **Change is urgently needed.** Patients, employers, communities and states face unsustainable healthcare cost increases that are hurting job growth, wages, and siphoning needed funds from other priorities including education and infrastructure. They are unable to continue to absorb increases in costs.
2. **High costs do not correspond to high quality.** Though some care is excellent, our current system is inefficient, ineffective and in many cases makes it more difficult for providers to deliver optimal care. Over 30% of care provided in the US today does not improve patient health or is not provided efficiently. Improvement opportunities must be successfully identified to be addressed.
3. **There is no 'one size fits all' solution.** Quality and costs vary dramatically across the country and across communities. This has been documented for over 30 years. Given regional variation, there is no single solution to improving care and reducing costs- improvement opportunities and priorities vary by region.
4. **Data is essential to improvement.** Data plays many critical roles in healthcare improvement including:
    1. **Identifying priority cost and quality improvement opportunities;**
    2. **Enabling performance measurement and public reporting;**
    3. **Establishing cost and quality performance targets;**
    4. **Informing choice by consumers;**
    5. **Engaging physicians and other stakeholders in care improvement; and**
    6. **Managing population health.**
5. **Multipayer data is very difficult to obtain.**
6. **Medicare's Qualified Entity program is an important step toward giving communities and providers the information they need to improve care and value.** CMS should not only continue to enable qualified groups to share data for improvement, but should consider accelerating that work with financial resources and greater flexibility.
7. **Data is valuable only if it is used effectively.** Despite decades of research on unwarranted variation and failures in care, data has rarely been effectively used for improvement.
8. **Regional Collaboratives should be considered key implementation partners in care improvement.** Regional Health Improvement Collaboratives are capable stewards of multipayor data and are experienced leaders using data with physicians and community stakeholders to improve care.

Testimony of Elizabeth Mitchell
CEO, Maine Health Management Coalition and Foundation
and
Board Chair, Network for Regional Health Improvement
to the
Subcommittee on Health, Committee on Energy and Commerce
U.S. House of Representatives
February 14, 2013

Mr. Chairman and members of the Subcommittee on Health, my name is Elizabeth Mitchell and I am the CEO of the Maine Health Management Coalition and Foundation. Thank you for the opportunity to speak today because, speaking on behalf of my members and my state, the urgency of the problems you have committed to address could not be overstated. State government and employers cannot absorb ever increasing costs without any corresponding increase in quality and value, employees and unions cannot go additional years without pay increases or even jobs, and our provider members are increasingly burdened in a system that does not reward high performance and creates daily barriers to improving care for patients. In short, we need to dramatically transform care and payment. Thank you for taking on this challenge.

Thank you also for soliciting input from a Regional Health Improvement Collaborative. The Maine Health Management Coalition is an employer-led regional health improvement collaborative whose mission is to improve the quality and value of healthcare services for our members. The Maine Health Management Coalition Foundation is a 501©3 public charity whose mission is to bring the purchaser, provider and consumer communities together in a partnership to

measure and publicly report on the quality and cost of health care and to educate the public to use information on cost and quality to make informed decisions. The Coalition, and collaboratives like us around the country, are solely dedicated to improving the quality and value of healthcare and representing all stakeholders in the community- including employers, unions, health plans, patients and providers. Not unlike serving in Congress, representing diverse stakeholders can be challenging, but in my view, may be the best hope to truly change care through coordinated and aligned changes in care delivery, measurement and payment.

Regional collaboratives are not new. The Maine Health Management Coalition was formed in 1993- 20 years ago this year:

> '(1) To assist the Members in the process of sharing and analyzing data ("Health Data"), related to the provision of health and related services to the Members, and their employees and health insurance plan participants ("Health Services")'; and
>
> (2) To foster research, education and coordination among the Members with regard to Health Services, and to act as a forum to promote solutions to Health Services issues'

Our Foundation was established in 2002 to use data to evaluate the quality, safety and cost of health care services. For over a decade we have used a multistakeholder consensus process to publicly report variations in quality and safety across providers and hospitals to the public free of charge. I am here to talk with you today about the role of data and multistakeholder collaboration in transformation- the role that was recognized by my members over 20 years ago at the Coalition's founding and has only proven more critical over time.

Today the Coalition has over 60 members representing the largest public and private employers in Maine including State Employees, the University of Maine System, Bath Iron Works, Delhaize America and LLBean. Our largest member is a union, the Maine Education Association Benefits Trust. Our members also include large health systems such as MaineHealth and Eastern Maine Health Systems (now a Pioneer ACO) and smaller hospitals including Mercy in Portland and St. Joseph's in Bangor as well as primary care and multispecialty groups from Martin's Point Health Care to Penobscot Community Health Center. Collectively we represent over 40% of the commercial market in Maine and spend well over $1 billion per year on healthcare services. Maine's Medicaid program is also a member of the Coalition. The one notable absence at the table is CMS- who would be a welcome partner.

While we are significant in Maine, our real significance lies in the relevance and replicability of our work nationally. There are strong and effective collaboratives around the country using data with employers, patients and physicians and collectively we may be able to partner with national policymakers to implement change on the ground. We have the tools, abilities and relationships with all stakeholders to do the hard work of transforming care. We may be the 'innovation infrastructure' needed to transform US healthcare.

Change is Urgently Needed

The MHMC's 'value equation' is one of improved quality, improved care outcomes, improved population health and reduced costs. After nearly two decades Maine has achieved some of the best healthcare quality in the nation. We are consistently ranked in the top 3-5 states in the country for our quality as measured for Medicare patients. In 2010, the Agency for Healthcare Research and Quality found that Maine showed the biggest improvement in quality in the country. From our own measurement efforts we know that we have gone from poor medication safety practices to some of the most robust medication safety results nationally. The University of Southern Maine conducted an evaluation of practices participating in our measurement and reporting program that showed higher scores across our measures and qualitative evidence of greater commitment to quality improvement among providers.[1] While MHMC in no way takes full credit for these gains, we know that our work on measurement, data sharing and public reporting has been a key driver of these improvements.

Despite significant quality achievements, significant quality and safety failings continue. More discouraging for us is that quality improvement has not reduced the costs paid by purchasers and patients. After 18 years of focusing almost exclusively on quality improvement, cost pressures on our members have forced us to prioritize cost measurement and cost reduction efforts. Maine employers are struggling to

[1] Jablow, P, Studying Maine's Pathways to Excellence Program: Improving the impact of public performance reports and the quality of primary care, Robert Wood Johnson Foundation 05/20/2011

remain competitive with their national counterparts due in part to very high health care costs. Maine employers, public and private, have been clear that they cannot continue to pay the ever-escalating costs of care that are limiting job growth, expansion and business viability. Key examples of the growing challenges include:

- In 2011 the State employee health plan was flat-funded by the Legislature for two years. In Year One (FY2012), the State Employee Health Commission implemented benefit changes requiring employees to absorb over $13 million in cost sharing. For Year Two (FY 2013), the State Employee Health Commission forecast a $22 million gap between projected expenses and flat funding, due primarily to price inflation.
- The University of Maine System was charged with reducing $24 million in health care spending over five years as budget pressure from soaring health care costs forced several years of salary freezes, layoffs, hiring freezes and began to eclipse academic programming in the budget.

Health care cost growth has implications that extend far beyond health care, including impacts on the US debt, wage growth and unemployment. Excessive growth in health care expenditures has serious economic implications for Maine and the country, with the ultimate burden falling on those who use and pay for health care services.[2] Arnie Milstein, MD, of Stanford University, concluded that ten years of wage growth in the US has been effectively eliminated by the increase in health care costs. Effects are particularly felt by workers in industries where wages tend to be low. Some counter these concerns by noting that the health care sector has been an engine of economic growth and job creation. However, recent research from

[2] Haviland AM, Marquis SM, McDevitt RD, Sood N. Growth in consumer directed health plans to one-half of all employer-sponsored insurance could save $57 billion annually. Health Affairs (Millwood) 2012

RAND Corporation shows that every new job added to the health care sector results in .85 fewer jobs in the rest of the economy.[3] For every job created, the costs of running this health care system grow and eventually 'result in layoffs in other sectors unable to manage the growing burden of the cost of health insurance premiums for employees'.[4] To grow Maine's non-health care economy requires us to address health care costs and reduce the burden of these costs on our businesses and families. The burden on private and public employers, patients and state government is now too great to ignore and we need your support to be successful. Given the urgency of the need for change and the challenge of identifying a single national solution, we need to start accelerating transformation by empowering regions with adequate data and effective measures to identify and address their local priorities.

Cost and Quality Vary by Region as Do Opportunities for Improvement

Health care performance and opportunities vary across the country. Maine is the birthplace of the Dartmouth Atlas where Dr. John Wennberg first observed vast differences in maternity care within Maine with no correlation to demographics, patient acuity, or patient preference. He also noted that his kids would have received vastly different treatment for their tonsillitis if they lived one county away.

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[3] Sood N, Ghosh A, Escarce JJ. Employer-sponsored insurance, health care cost growth, and the economic performance of U.S. industries. *Health Serv Res* 2009 Oct; 44:5, Part I: 1449-64.

[4] Murray R and DelBanco S. Provider Market Power in the US Health Care Industry: Assessing its Impact and Looking Ahead, Catalyst for Payment Reform, November 2012

This 'unwarranted variation' in both cost and quality of care is alive and well- and well documented- 30 years later. Just as there is no single problem facing healthcare, there is no one size fits all national solution. I believe regions are well positioned to not only identify but solve their own healthcare problems.

In 2009, using Maine's All-Payer Claims Database analysts replicated the Dartmouth Atlas work and were able to quantify over $350 million in savings if all regions of the state practiced at the best practice level already achieved within Maine. This level of performance was clearly achievable but it was not consistent. Through reductions in potentially avoidable hospital admissions and in high variation-high cost outpatient services, this study identified savings of over $350 million in annual health care expenditures in Maine.[5] The report went on to quantify savings by service type including savings from potentially avoidable admissions in cardiac care, musculoskeletal, gastroenterology and others. These findings not only make a compelling case for change but make the information increasingly actionable. The Dartmouth Atlas and the profound learnings that have come from it would not have been possible without good data. We must now be equally effective ***using*** data to engage physicians, purchasers and patients in care improvement.

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[5] All-Payer Analysis of Variation in Healthcare in Maine *Conducted on behalf of Dirigo Health Agency's Maine Quality Forum and The Advisory Council of Health Systems Development,* Health Dialog, April 2009

Data is Necessary to Identify Regional Improvement Opportunities and Engage all Stakeholders in Improvement

Data plays many critical roles in healthcare improvement:

- **Identifying priority quality improvement opportunities and cost drivers;**
- **Enabling performance measurement and public reporting;**
- **Establishing cost and quality performance targets;**
- **Engaging physicians and other stakeholders in care improvement; and**
- **Managing population health.**

But despite over 30 years of research documenting variations in care, not enough has been done to effect those variations. States and communities face very different challenges related to quality and costs of healthcare. Some states may have much higher rates of readmissions, C-sections or hospitalization for diabetes, or overuse of imaging. To direct physicians to focus their improvement efforts on areas that will not have a significant impact on their patients or the community's costs is not only unnecessary but a sure way to frustrate a physician who is already consumed with patient care and not paid for improvement work. Targeted improvement efforts reflecting population or community need is a much better use of time, energy and resources.

To identify those opportunities in Maine, in 2012 we led a Health Care Cost Workgroup to collectively identify and quantify cost reduction opportunities in the

state. The Workgroup first identified opportunities by soliciting input from members, including clinicians, plans and purchasers. All members had ideas about ways to reduce costs, ranging from reduced administrative costs to improving medication adherence. Providers provided key insights into current practices that are not optimal for patients, are not good uses of resources, but are difficult to change given financial incentives, organizational structures and/or culture. This was reinforced by a separate but related meeting held by the MHMC and the Maine Medical Association with physicians, who identified multiple savings opportunities through practice improvement.

Working with members, Coalition staff then worked to quantify achievable savings related to each area through available data. We then calculated the likely impact of achievable change, keeping in mind that in some cases other costs may increase to reduce unnecessary spending - investment in the medical home pilot to reduce avoidable hospital admissions being an example.

The most notable conclusion of the series was that **significant savings are clearly possible.** As an example:

> **Findings:** Commercially insured people with chronic illness are hospitalized at a rate 3.2 times that of the total commercially insured population in Maine22. According to a recent analysis of MHMC data applying Prometheus algorithms,23 potentially avoidable complication rates for diabetes ranged from 10-40% across providers. These complications should be preventable with optimal care management and if best practice standards are met.
>
> • **Potential Savings Opportunity:** Admission and readmission rates and costs were analyzed for MHMC plan sponsor insured members. The portion

> of the inpatient PMPM attributable to members with chronic conditions ranged from 46-77% in this commercially insured population. The workgroup suggested targeting a 20% reduction in admissions and readmissions. **A 20% reduction of hospital admissions and readmissions for people with chronic illness would result in savings of up to $32 million yearly for Coalition employers/plan sponsors and their members.**

The results begin to identify and quantify significant opportunities for reduced health care costs based on best practice in Maine and nationally.

The results were also notable because the series demonstrated that with transparent data, analytic support and neutral facilitation, parties can come together to collectively identify, understand and address health care cost drivers. This is an approach that is both effective and replicable in other communities.

Further, it was concluded that only with all parties at the table will system transformation be achieved. Doctors and other providers must transform how they deliver care to patients, but they need changes in payment, patient engagement and additional data to better manage population health. Patients need more and better transparent and shared information on their care, and different incentives to better manage utilization. These **improvements require coordinated and aligned change from all parties** so that payment can support optimal care delivery, incentives can support optimal utilization and that reliable information is available for all parties to make improvements. A multistakeholder forum where transparent data can be shared with all stakeholders is an important forum to both identify and understand opportunities for improvement, and to work together effectively for its

achievement.

Using Data for Improvement

Access to data is necessary but insufficient. Once opportunities are identified, stakeholders- particularly physicians- must be actively engaged to change current practice. Data is foundational to that work but analysis, technical assistance, measurement and transformation support are also needed. Mechanisms for transparent accountability will be key for sustained change. Fortunately there are examples of this happening across the country.

In addition to using multipayer data to measure and report on the performance of practices and hospitals, and the use of data by ACOs to manage population health, there are several innovative efforts underway in Maine and nationally to use data for improvement. Here I only cite Maine examples though it is important to know that several Regional Health Improvement Collaboratives including the Pittsburgh Regional Health Initiative, Oregon Health Care Quality Corporation, Puget Sound Health Alliance, Minnesota Community Measurement and Institute for Clinical Systems Improvement and many others have innovative programs driving and supporting improved care.

Using Data for Improvement: Examples:

Multipayer Advanced Primary Care Pilot and Learning Collaborative.

In November 2010, Maine was selected as one of eight states to participate in the Medicare Multi-Payer Advanced Primary Care Practice (MAPCP) demonstration, Medicare's major PCMH demo. In January 2012, Medicare joined the private purchasers and Medicaid as a payer in the Maine Patient Centered Medical Home (PCMH) Pilot. Within this demo, Medicare is providing Maine PCMH Pilot practices with a new care management fee – estimated to a total up to $28 million over the next three years—for providing medical home services to their Medicare patients. Because of Medicare expectations for budget neutrality, CMS has set an expectation that Pilot practices will demonstrate improvements in clinical care and efficiency; to that end, the Maine PCMH Pilot has targeted decreases in several areas of high-cost utilization that could be reduced as a result of improved coordination of care, including 4-5% decreases in avoidable inpatient admissions, 9% decrease in avoidable emergency department visits, and 5% decreases in specialty consultations and imaging. These targets were set using data made available to Maine by Medicare.

As practices seek to transform to become medical homes, significant technical assistance and support is required. Maine Quality Counts, another Regional Health Improvement Collaborative in Maine provides targeted and intensive support to these practices based on their performance against key metrics. Maine Quality Counts offers outreach, support, and collaborative learning methods to PCPs, helping them transform to a more patient-centered model of care and provides IHI model learning collaborative opportunities for PCPs transitioning to PCMH and MaineCare Health Home status.

Community Care Teams and "Hot-Spotting'

The MAPCP demonstration also provided the Pilot with an opportunity to introduce Community Care Teams (CCTs) as a new component of care for high-needs patients. CCTs recognize that many patients have needs and barriers to care that can reach beyond the capacity of even the most robust

primary care physician practice. CCTs are multi-disciplinary, community-based, practice-integrated care management teams that will work closely with PCMH Pilot practices to provide enhanced services for the most complex, most high needs patients in the practice. Maine has worked with Dr. Jeffrey Brenner of New Jersey whose 'hot-spotting' techniques were highlighted in *The New Yorker* by Dr. Atul Gawande. By identifying and targeting high need patients who utilize disproportionate resources, Dr. Brenner and his team were able to make substantial improvements in utilization and costs through intensive and targeted interventions. Early results are showing as much as 40% decline for some patients in the use of hospital services when appropriate supports are provided. The CCT model had been established and found to be highly successful in other communities and states, like North Carolina, New York and Vermont.

Under the MAPCP demo, Medicare, Medicaid, and commercial payers have agreed to provide payment to a set of eight sites_that support the 26 PCMH Pilot practices and patients. CCTs are a vital strategy for improving quality and reducing costs, decreasing avoidable hospital admissions, readmissions and Emergency Department visits.

Practice Reports for Patient Centered Medical Homes and Health Homes

To support the Multipayer Patient Centered Medical Home and Medicaid Health Home pilot practices, the Maine Health Management Coalition has developed practice performance reports using claims based quality, cost and utilization metrics. Not only will the reports be populated with all payer claims data, we intend to integrate clinical data from our Health Information Exchange to track clinical outcomes measures. We developed these reports working directly with physicians to ensure meaningful measurements. After

initial private reporting, a subset of the report will be publicly reported to recognize good performance and facilitate consumer choice.

In 2010 Maine Quality Counts, the Maine Quality Forum and the Maine Health Management Coalition developed and disseminated reports on comparative practice performance across the state and held regional forums with providers to understand and use the data. High levels of participation in the regional meetings and ongoing dialogue with the practices indicate strong demand for this type of information that is otherwise unavailable.

Risk Based Contracts

In some communities across Maine, large public and private purchasers are working directly with practices and health systems to establish risk-based contracts for population health management. The Maine Health Management Coalition and its analytic staff are key participants in these pilots to enable transparent, neutral and reliable data sharing. The MHMC identifies aggregate trends for each employer population and works with the parties to establish appropriate performance benchmarks given demographics and trends. Participating providers can then access identified data on this same population in order to immediately impact areas of care that may need better management. Enabling two parties to use the same data with appropriate, role-based access, enables important transparency and avoids problems of competing, inconsistent data. Even more importantly this enables providers to address priorities by population and enables purchasers to understand- and address – barriers providers face in current payment systems and benefit designs. Purchasers are well positioned to make critical payment and benefit changes to support care redesign when there is common understanding of the need and impact, and there is clear accountability through transparent data sharing.

Assuring that Clinical Coordination is Facilitated by Data

Maine has one of the most robust query-based centralized health information exchanges in the nation (HealthInfoNet). Today, over 90% of all hospital data and 55% of all ambulatory data flows into the exchange. All Maine hospitals will be participating in the exchange by the end of 2013, and 80% of all Maine ambulatory providers will be participating by the end of 2015. This data infrastructure will:

- Make clinical notifications available in real-time when patients enter the health care system;
- Advance the electronic capture of behavioral health and other "high-risk" clinical data
- Give patients access to their statewide clinical information so that they can be better informed when making medical decisions and hold their providers accountable for the care that is delivered

Data and Measurement Must Include Multiple Stakeholders and Reflect Community Priorities

You rightly recognize the central role of measurement in both improvement and accountability. A key barrier to addressing costs in ways similar to our successful work in quality was the lack of cost measures. Until very recently, there were no reliable, nationally endorsed measures of cost and resource use. Without measures endorsed by the National Quality Forum, we found it impossible to identify measures deemed relevant by purchasers and consumers and fair and acceptable to providers. With no ability to measure or report on cost and no visibility into cost drivers, large employers and purchasers have had to accept rates set by providers

and health plans through private negotiations. And we have paid a high price. Maine's commercial premiums are among the highest in the country.

No payment system will be successful without appropriate and transparent measurement. New incentives to reduce costs must be balanced by ongoing measurement of access, patient experience and outcomes to ensure that patients are protected and access is preserved in this transition to new models. Measures that are developed and selected for use in payment systems and programs will drive change. It is essential that this change is towards our collective aims.

While clinician leadership is key to improving care, measurement must also reflect the needs and priorities of consumers, communities and those paying for care- both employers and government. You note that:

- 'physician fee schedule payment updates will be based on performance on meaningful, physician-endorsed measures of care quality and participation in clinical improvement activities (e.g., reporting clinical data to a registry or employing shared- decision making tools).
- Medical specialty societies will develop meaningful quality measures and clinical improvement activities using a standard process.'

Physician input is critical to the measure development and selection process but measures must reflect all of our values. Multi-stakeholder endorsed measures with a clear standard of evidence are the foundation of care and value improvement. A process that includes physicians, purchasers and patients will identify measures of improvement that meet the needs of all stakeholders. As an example, we know from

extensive consumer research that measures of patient experience are most important to patients but, despite having a nationally endorsed valid patient experience measurement tool (CG-CAHPS) available for many years, providers have not prioritized or widely used this survey. Without the 'healthy tension' that results from bringing the parties together it is unlikely that we would have complete and robust measures for patient experience, outcomes, cost or resource use or other areas important to communities. As those who pay for and receive care, the employer and patient voice are crucial to identifying the right indicators of performance together with physicians.

Data is a Resource that is Only Valuable when it is Accessible and Used Effectively. If Available, Data Can Be Used Effectively By Communities

Not unlike out national peers, in order to meet our mission the Coalition and Foundation together have a broad portfolio of initiatives that include performance measurement and public reporting; consumer engagement; value based purchasing and payment reform to support clinical care redesign. While each initiative is important, it is the combination of these data-driven efforts and the active engagement of all stakeholders that is impactful. None of this work is possible without access to data.

Despite our track record and years of experience working with data, obtaining multipayor data is remarkably difficult- and expensive. Many commercial health

plans view the data as proprietary and many provider-based organizations are reluctant to share data publicly. Many state-based all payer claims databases place such onerous restrictions on data use that its value is dramatically diminished. Dr. David Howes, President and CEO of Martin's Point Health Care, summed up our challenge eloquently, 'The age of competing for market share by controlling access to data is over. Transparent all-payer data should be made widely available and competition should be based solely on performance'.

The Qualified Entity Certification Program is an important step to enable improvement in communities. The Maine Health Management Coalition was the fourth organization in the country to receive Qualified Entity status to receive identified Medicare data to measure and report performance to physicians. We will integrate this into our multipayer claims database including data from commercial insurers and soon to include Medicaid. This will enable physicians to better understand their performance relative to peers and to improve care across their entire patient population. It will also facilitate reporting to inform consumers about provider performance, meeting the needs of multiple stakeholders. This program is an important step to empowering physicians and communities to use data effectively. The Qualified Entity Certification Program is a strong signal of partnership and support for local innovation and an endorsement for use of integrated data. As experience grows with the program, it could be even more

effective with fewer restrictions on data use and resources available to communities to support improvement.

Maine is fortunate that it has the improvement resources it does. Our success is entirely replicable if these resources are more widely available. In our view, to transform care and payment and engage providers, employers, and consumers, communities need the following:

- **A common, shared data source of integrated clinical and claims data for all parties to use** – with appropriate privacy, security and legal safeguards and role-based access – to serve as the foundation for system and payment reform. All approved users should have fair, affordable and equitable access to the data for the purposes of care improvement.

- **Timely access to all payer data** is necessary to support system transformation. Data on a subset of patients is insufficient to facilitate population health management. Data that is not current does not allow for effective and timely interventions to change care.

- **Patient identified data must be included but identifiable only at the patient/provider level** to allow providers to effectively improve care for their patients. Identified data enables the combining of different data sources to allow a meaningful and longitudinal understanding of utilization, care patterns, and outcomes.

- **Resources should be used effectively and care should be taken to avoid unnecessary duplication of data systems** and the resources needed to support them. Current duplication of proprietary data systems drive additional costs to employers and patients.

- **Data users- including consumers- should have input into the structure, design, and purpose** of data systems to maximize use for and by all stakeholders, including the public.

- **Integrated clinical data, claims, health risk, and outcomes data is the optimal source** of information for care improvement and high value.

- **Information created from healthcare data should be made transparent and publically available** in aggregate with the appropriate safeguards, processes, and criteria for reliability.

Once this data infrastructure is established, with leadership and support stakeholders can put the information to work improving care and reducing costs.

Regional Collaboratives May Serve as Key Implementation Partners

With the best data and measurement, care will only be improved if providers lead care transformation and are supported by reformed payment. We share your priorities and urgency for a transformed healthcare system that delivers value for our significant investment. As you take on the challenge of care redesign, measurement and payment reform, use regional collaboratives to truly understand which measures are meaningful to communities, to physicians and to improvement. This cannot be done solely from Washington. National organizations can and must respond to community need for measure development but measures can only be implemented at the community level. Providers must use data to change practice, data must be collected and reported, consumers must understand and engage in change- all of which is facilitated by local relationships and support. As you set the national direction, we can serve as implementation partners.

Thank you again for this opportunity and thank you for addressing these urgent issues.

Maine Health
Management
Coalition

Mr. PITTS. Thank you, Ms. Mitchell.

Dr. Berenson, you are recognized for 5 minutes to summarize your testimony.

STATEMENT OF ROBERT BERENSON

Dr. BERENSON. Thank you, Chairman Pitts, Mr. Pallone and members of the committee. I very much appreciate the opportunity to provide testimony as the committee attempts to identify how to achieve higher value of physician services for Medicare beneficiaries and taxpayers. It is a subject that I have been deeply involved with through most of my professional career as a practicing general internist, practicing just a few blocks from here for over a decade, a medical director of managed care plans, a senior official at CMS, and Vice Chair of MedPAC until this past May. As an Institute Fellow at the Urban Institute, I am currently involved in a project to improve how services and the Medicare fee schedule are valued for payment.

While there is broad agreement on the need to move from volume-based to value-based payment, the current emphasis assumes that measuring a few quality measures and somehow attributing costs generated by many providers to an individual physician can produce accurate estimates of a physician's value. Measurement is more difficult than some policymakers assume while the evidence on pay-for-performance for hospitals frankly is not encouraging.

For physicians, behavioral economics suggest that pay-for-performance can crowd out professionals' intrinsic motivation to help their patients and can actually worsen performance. What has been lost in equating value-based payment with pay-for-performance is the recognition that value can be fostered not only by improving how well particular services are performed but also by improving the kind and mix of services beneficiaries receive. The Medicare fee schedule for physicians and other health professionals produces too many technically oriented services including imaging tests and procedures and not enough patient-clinician interaction to diagnose accurately, to develop treatment approaches consistent with the patient's values and preferences and continuing engagement to assure implementation of a mutually agreed-upon treatment plan, nor does the fee schedule emphasize care coordination and other patient-centered activities that would actually improve patient outcomes.

However, the price distortions that plague the current fee schedule are not inevitable. Even in fee-for-service, Medicare can buy a better mix of services by altering the prices paid for services, balancing considerations of beneficiary access to care with reducing overuse of services caused at least in part by inordinately high payment for some services. We can improve the fee schedule over the short term even if the ultimate goal is to reduce its importance or eliminate it altogether. In fact, in my view, it is necessary to improve the fee schedule to be able to successfully implement new payment models.

First, the migration to new payment approaches will take years. Even then, fee-for-service may be part of new payment approaches and also may need to be retained for certain regions and particular specialties. Second, fee schedules are the building blocks for vir-

tually all the new payment models, most notably, bundled episodes. Errors in fee schedules would therefore be carried over into errors in the calculations of the new payments. Third, many prototypical ACOs, which I agree with Chairman Hackbarth is the most promising new delivery model, use relative value units from the Medicare fee schedule as the basis for determining productivity for their member physicians. Again, because fee schedule prices are distorted in relation to resource costs, their assessments can be inaccurate, leading specialists to be valued by the ACOs as more productive than primary care physicians or one kind of specialist more productive than another kind of specialist simply because of errors in relative value units.

As we think about moving to new payment models through the kind of activities that are going on with the Innovation Center at CMS, I would recommend the following immediate agenda for improving Medicare payment to physicians. I would suggest repealing the Sustainable Growth Rate for the reasons that have come up already, especially now that the score is only $138 billion over 10 years. I would not implement a new volume control formula at this time, especially given that volume and intensity of services is remarkably low, at least at this moment, but rather permit CMS to more affirmatively modify prices to try to influence volume and intensity of services. I would consider narrowing or eliminating the in-office ancillary services exception to the Stark self-referral regulations if the volume of particular services grows unabated. I would revise the definitions of evaluation and management service codes to better describe the work physicians perform, especially for patients with chronic conditions and functional limitations, and also to decrease the current epidemic of up-coding that is taking place. And finally, I would reduce or eliminate the site-of-service differential, which pays hospitals much more for physician services than are paid to independent practices, separately recognizing the costs of unique hospital obligations and services hospitals uniquely provide.

Thank you very much.

[The prepared statement of Dr. Berenson follows:]

Testimony of Robert A. Berenson, M.D.

Institute Fellow, the Urban Institute

Before

Energy and Commerce Committee

U.S. House of Representatives

SGR: Data, Measures and Models; Building a Future Medicare Physician Payment System

Thursday, February 14, 2013

Chairman Pitts, Representative Pallone, and members of the Committee:

I very much appreciate the opportunity to provide testimony to the Committee as it attempts to identify how to achieve higher value for physician services for Medicare beneficiaries and taxpayers. It is a subject that I have been deeply involved with through most of my professional career. I have had a diversified career as a general internist, practicing just a few blocks from here, a medical director of a preferred provider organization and two independent practice associations, a senior official at CMS in the Clinton Administration, and Vice-Chair of MedPAC until this past May. As an Institute Fellow at the Urban Institute, I have been studying the effects of the Medicare Physician Fee Schedule and am involved now with colleagues from UI and two other policy research organizations in trying to develop improved methods for improving the valuation of services in the fee schedule.

I understand and support the Committee's interest in moving from volume-based to value-based payment. However, I think in some ways the value-based payment concept has gotten off track. I want to focus my testimony on some misconceptions inherent in current policy discussions and also offer some specific recommendations in this area that in my opinion have not received enough attention by policymakers.

The challenges of performance measurement and pay-for-performance

The current approach to value-based payment basically attempts to measure what all physicians do and provide financial rewards or penalties physicians based on their performance on a few particular clinical activities. The approach assumes we have robust quality measures that are a fair representation of a physician's clinical activities and that providing financial incentives to the physicians based on these measures will improve the quality of their professional activities to benefit their patients. I would point to a number of concerns with this formulation.

First, the available process measures that CMS has adopted in the Physician Quality Reporting System (PQRS) program for most physicians capture very little of their professional activities. To illustrate, MedPAC data show that family physicians, general practitioners, and general internists treat nearly 400 different diagnostic categories in a year, with about 70 categories making up 80 percent of their clinical episodes.[1] Basing a payment modifier on performance on as few as three PQRS measures, the current plan, will therefore not provide a meaningful assessment of the quality of a clinician's care.

[1] Medicare Payment Advisory Commission, "Outlier Alternative," Report to Congress: Assessing Alternatives to Sustainable Growth Rate System (Washington, DC: MedPAC, March 2007).

Further, there are major gaps in available performance measures, some of which are unlikely to be filled, even with information from electronic health records. For example, the core of what we want to measure for many specialties—making correct diagnoses—is not measured now nor easily measurable, even from medical records. Nor, for the most part, can we measure from administrative claims data whether a particular intervention was appropriate based on the patient's clinical circumstances and preferences. Yet, overuse of services remains a major problem in the provision of physician services. Given the inherent lack of face validity for physicians of this particular measurement exercise and the reporting burden created for practices, it is not surprising that participation in the PQRS has attracted fewer than 30 percent of physicians who have billed Medicare since the program was launched in 2007.[2]

The technical issues in assigning a cost measure to physicians are similarly difficult. Physicians not only provide services for which they are paid directly, they are also responsible for ordering services across the continuum of care—care provided by other physicians, hospitals, clinical labs, post-acute care facilities, and so on. Yet, the problems inherent in attributing costs generated by many clinicians and institutional providers to a single physician are daunting in the full freedom-of-provider-choice, traditional Medicare program. In short, while I give CMS great credit for trying to accomplish what Congress has mandated, the mission of creating a physician-specific, value-based payment modifier is too ambitious; the numerator of the value equation—quality—captures too little of any physician's performance on quality, while the denominator—cost—cannot be accurately attributed to an individual physician. CMS has correctly started with valuing the performance of large groups, a more promising approach than focusing on individual physicians.

Rather than attempting to provide a "value-index" for each physician, CMS should focus it use of measures derived from quality and cost data on outlier physicians—those who are overtly abusing the fee-for-service system for personal reward or simply not practicing acceptable quality or reasonably prudent care. Performance against available measures would not be sufficient to make a correct assessment of any physician's performance, but would point the way to those for whom more targeted evaluation, including clinical records review, should be conducted.

Second, recent research studies are finding that pay-for-performance as adopted in Medicare has not been particularly successful. The major demonstration—the Premier Hospital Quality Incentive Demonstration Project—did not actually produce better results than other hospitals, which with a short lag demonstrated comparably improved scores on what were mostly

[2] Iglehart, J.K., and Robert Baron. "Ensuring Physicians' Competence—Is Maintenance of Certification the Answer?," *New England Journal of Medicine* 367:26, 2012.

process measures of quality.[3,4,5] Perhaps most troubling, the evaluations have found little evidence that improving the mostly process measures used in CMS's core measure set actually produce better patient outcomes, which after all is the objective. In responding to incentives to improve their measured performance on a relatively few quality process measures, clinicians and hospital staff may well be diverting their attention from other activities to improve quality, much of which would involve developing detailed work process routines to increase the reliability of service delivery. An example would be adoption and deployment of evidence-based checklists providing straightforward activities that doctors, nurses, and other hospital personnel need to consistently follow to achieve good clinical outcomes. Work process improvements have led to major reductions in hospital infections, yet are activities carried out by quality improvement teams within hospitals and not readily amenable to performance measurement using process measures. Stimulating such quality improvement to actually improve outcomes is best supported by a move from measuring and publicly reporting a relatively few processes of care to reporting important outcomes. In the context of hospital value-based payment, CMS indicates that it needs to strengthen its portfolio of hospital measures, especially outcome measures, such as by emphasizing measures of 30-day mortality, hospital-acquired infections, cost, and patients' experiences with care.

For physicians, we know even less about whether reporting and performing well on a handful of process measures makes much difference to patients. Even in the United Kingdom, which in its Quality and Outcomes Framework provided bonuses of as much as 25 percent to general practitioners based on performance on more than a hundred primary care measures, the evidence is mixed on whether patient outcomes have improved meaningfully despite major improvements on the reported measures.[6,7]

I am not questioning the importance of the goal of improving physician performance on process activities that are clearly associated in clinical research studies with better outcomes. Clearly, control of blood pressure in diabetics would reduce disabling complications, such as renal failure and heart attacks. We know that having patients with cardiovascular disease take a small aspirin tablet daily would decrease subsequent cardiac events. What I am questioning is the

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[3] Werner, R.M. and Dudley Adams, "Medicare's New Hospital Value-Based Purchasing Program Is Likely to Have Only a Small Impact on Hospital Payments," *Health Affairs* 31:1932–40, 2012.
[4] Andrew M. Ryan, "Effects of the Premier Hospital Quality Incentive Demonstration on Medicare Patient Mortality and Cost," *Health Services Research* 44(3):821–42, 2009.
[5] Jha A.K., K.E. Joynt, E.J. Orav, et al., "The Long-Term Effect of Premier Pay for Performance on Patient Outcomes," *New England Journal of Medicine* 366(17):1606–15, 2012.
[6] Sutton M., S. Nikolova, R. Baoden, et al., "Reduced Mortality with Hospital Pay for Performance in England," *New England Journal of Medicine* 367 (19): 1821:28, 2012.
[7] Campbell, S.M., D. Reeves, E. Kontopantelis, et al., "Effects of Pay for Performance on the Quality of Primary Care in England," *New England Journal of Medicine* 361(14): 368–73, 2009.

strategy of burdensome and error-prone reporting and pay-for-performance as the dominant approaches to achieving greater success on fostering evidence-based medicine.

Behavioral economics offers insights into why, despite intuitive appeal, pay-for-performance may have a limited—or even adverse—impact on improving quality of care. Economic incentives seek to change behavior through extrinsic motivation, yet most clinicians want the best outcomes for their patients based on an intrinsic motivation to act in their patient's best interests. And even when motivation is lacking, money may not be the solution, since the behavioral economics literature shows that performance bonuses often backfire, particularly for cognitively challenging activities performed by highly skilled persons needing to muster their skills to manage complexity and creatively solve problems.[8,9] Experimental data demonstrate that financial incentives often "crowd out" intrinsic motivation. If intrinsic motivation is high and crowding out is strong, payment incentives may actually worsen performance.

Value-based payment has been too narrowly conceived

What has been lost in equating value-based payment with pay-for-reporting and pay-for-performance is the recognition that value can be improved not only by improving how well particular services are provided but also by improving the kind and mix of services that beneficiaries are receiving. The Medicare Fee Schedule for physicians and other health professionals produces too many technically oriented services, including imaging, tests, and procedures, and not enough patient-clinician interaction to diagnose and develop treatment approaches consistent with a patient's values and preferences, and continuing engagement to assure implementation of mutually agreed upon treatment plans. Similarly, the fee schedule does not encourage care coordination and other patient-centered activities that would actually improve patient outcomes, including their own sense of well-being.

In urging more attention to modifying payments and payment methods to obtain a better mix of clinician services, I want to emphasize that while I agree with the conventional policy wisdom that fee-for-service as a payment method has substantial, inherent flaws and over time needs to be replaced—mostly—fee-for-service gets an undeservedly bad reputation because of its flawed implementation in Medicare and by private payers, which largely rely on the Medicare Fee Schedule in setting their own fee schedules.

The resource-based relative value schedule that was implemented beginning 20 years ago was a definite improvement over the prior system but has not achieved its intended purpose of reorienting payment—and care—away from technical services toward primary care and what

[8] Cassel, C.K., and J. Jain Sachin, "Assessing Individual Physician Performance: Does Measurement Suppress Motivation?" *Journal of the American Medical Association* 307(24):2595–96, 2012.
[9] Daniel H. Pink, *Drive: The Surprising Truth about What Motivates Us*. New York: Riverhead Books, 2011.

are called evaluation and management services, such as office visits. That objective has not been achieved for a few reasons. Current estimates of the relative resource costs associated with each of the 7,000+ individual services that Medicare pays for are flawed. The resultant payment distortions lead physician practices to emphasize services with remarkably high profit margins, leading to the proliferation of a raft of tests and procedures, while skimping on activities that might actually help patients more, including longer office visits, more frequent communication with patients outside office visits, and better care coordination.

Although fee-for-service payment often is criticized for providing incentives for excessive volume of services, regardless of need, in fact, fee-for-service does not reward all volume equally. It does not reward provision of services that are not on the fee schedule at all nor does it promote volume for services that are not particularly profitable. The policy wisdom that physicians respond to a reduction of fee schedule prices by increasing their volume does not hold for many services, as recent research and natural experiments demonstrate. In short, a "smarter" fee schedule can increase the volume of desired physician activities and depress overproduction of profitable services being provided to excess.

Indeed, one the positive attributes of fee-for-service is that payers and clinicians can identify clinical activities that need financial support, develop the necessary payment codes that describe the activity, and then pay enough so that physicians will perform the services, especially if their intrinsic motivation to help patients is supported. Yet, until very recently, there has been little interest in identifying and paying for activities needed for an aging Medicare population, many of whom now live longer but with multiple chronic conditions and, in many cases, serious functional limitations.

The changing demographics call for much more attention to evaluation and management broadly conceived; it includes attention to shared patient-clinician decisionmaking, teaching patient self-management skills, greater attention to medication management, counseling, care coordination, and other activities that currently do not receive explicit attention in fee schedules. The result is that physicians continue to perform lucrative, but often unneeded, tests and procedures while skimping on various activities that are not able to be done in an occasional 15 or 20 minute office visit. Here, fee-for-service is a problem in that it is hard to pay for some of these desired evaluation and management activities *a la carte*. However, a fee schedule can accommodate monthly care management fees for high-risk patients and can develop and recognize for payment other codes that would alter the current mix of services beneficiaries receive. The result would be more value-based payment in a volume-based payment system.

Price distortions are not inevitable

Or at least they can be reduced significantly. A clear example is the natural experiment that resulted from Congress's reduction in overpriced advanced imaging services in the Deficit Reduction Act of 2005. The policy to pay physician practices no more for advanced imaging services, like CT and MRI, than what is being paid for the same services when provided by a hospital outpatient department produced significant program savings directly from the price reduction. In addition, the rate of increase in the performance of these imaging services declined, although still positive.[10] Now years later, the volume of advanced imaging services are pretty flat, in marked contrast to the double-digit rates of increase that occurred through the first part of the last decade. It is not clear that the significant reductions in prices for many advanced imaging tests led to the moderation in volume growth—volume growth has decreased as well for imaging services whose prices were not reduced. However, the price reductions did not generate volume increases to make up for the price reductions.

Anecdotally, at least some of the decline in the growth of advanced imaging services resulted from mid-sized medical practices no longer finding it fiscally prudent to purchase these scanners as highly profitable ancillary services, given the reduction in fees. What the experience suggests it is that physicians do not necessarily respond to fee reductions by increasing the volume and intensity of the services receiving the cuts. Their behavior is more nuanced and varies by their circumstances and the nature of the particular services under consideration. The clear policy implication is that Medicare can buy a better mix of services by altering the prices paid for services, balancing considerations of assuring good beneficiary access to care and reducing overuse of services produced partly from inordinately high payments.

Fee-for-service: end it or mend it?

I share the broad policy community sentiment for moving away from fee-for-service to new payment models involving some amount of physician risk-taking. Even if the current distortions in the Medicare Fee Schedule were reduced substantially, not an easy achievement, fee-for-service nevertheless retains inherent incentives for raising the volume and intensity of services. Further, separate fee-for-service revenue streams reinforce siloed clinical practice at a time when the current challenges of health care delivery demand much greater cooperation and coordination across the numerous sites of health care services provision and community resources. Nevertheless, there are several reasons to improve the Medicare Fee Schedule over the short to medium term, even if the ultimate goal is to reduce its importance or eliminate it altogether.

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[10] Government Accountability Office, *Trends in Fees, Utilization, and Expenditures for Imaging Services before and after Implementation of the Deficit Reduction Act of 2005* (Washington, DC: Government Accountability Office, 2006) GAO-08-1102R.

In fact, I believe it is necessary, if seemingly paradoxical, to take firm steps to improve the fee schedule in order to implement new and improved payment reform models for a number of reasons. First, the migration to new payment models that better reward prudent care will not be easy or quick. Despite hopes for a fast track to new payment approaches, it will take years for the Medicare payment pilots to be tested, refined, and then scaled up to be implemented on a widespread basis. Second, fee schedule prices are building blocks for virtually all of the payment reform approaches being tested, most notably bundled episodes, but also shared savings and global payments for accountable care organizations (ACOs). Errors in individual fees in the Medicare Fee Schedule would therefore be carried over into the bundled episodes and shared savings calculations.

Third, entities like ACOs will work best when formed around multispecialty group practices and independent practice associations, which would be well positioned to accept care responsibility for a population and to organize needed services across the spectrum of providers. But specialties that continue to be generously rewarded from distorted prices under current public and private fee schedules, such as cardiology and radiology, prefer to continue in large single specialty practices or to cash out and accept hospital employment rather than join with primary care physicians to form and maintain the medical group. Perpetuating the current, nearly 3:1 compensation differences between important specialists and primary care will frustrate the transition to ACO-like delivery systems, even if they are supported by new payment approaches. Narrowing the compensation differentials that the Medicare Fee Schedule produces now would help create the environment in which ACOs can become established and do well.

For better or worse, organizations we consider as prototypical ACOs often use Medicare-determined relative value units as the basis for determining their internal compensation approaches. It is informative that many of these groups take advantage of one of the positive attributes of fee-for-service payment—to reward industriousness. Even if the groups themselves receive global payments, they may turn around and reward physicians for productivity, as measured by "work RVUs" (work relative value units) generated. But again, if the RVU valuations are off, the organization's assessment of productivity will be off as well—and an ACOs may find it unwittingly is perpetuating the income disparities that plague current fee-for-service payment.

Finally, some better functioning payment approaches actually retain an element of fee-for-service because, as I have emphasized, fee-for-service does have certain positive attributes. My personal choice for payment reform would be moving toward global payment approaches to support ACOs, but using risk-sharing with Medicare rather than full risk for many ACOs. One way to moderate risk and protect against stinting on services is through what is called partial

capitation—a combination of fee-for-service and per member per month payment for a population. Mixed payment approaches also work well for supporting individual physicians as well. A few European countries use an approach of mixing fee-for-service for visits with a monthly fee to support primary care physicians, one of the approaches that is being tested in CMS's advanced primary care demonstrations. In short, there are many good reasons to continue and improve the Medicare Fee Schedule as we test improved payment models for future adoption.

Moving to new payment approaches: the role of demonstrations

An important way to obtain higher value for beneficiaries is to adopt new payment approaches with better incentives for prudent use of resources, even if we back off the commitment to measuring and publicly reporting individual physician performance, as I am suggesting. Rather than assuming that a limited and intrusive portfolio of measures will improve value, the new payment methods are promising because they embed the incentives for better care into the payment model itself; then targeted quality measures can complement the new payment method by focusing on particular activities, some of which might be adversely affected by the altered payment incentives. That is the approach CMS is taking under the Shared Savings Program for ACOs. Incentives for more prudent use of resources derive from the fully implemented shared savings payment approach. And the quality of certain activities that might be compromised in the zeal to contain costs are being measured to help guard against stinting on care.

A range of payment methods and new organizational delivery structures are being tested, from Independence at Home practices providing "house calls" for frail seniors and disabled to bundled payments for acute care events around a hospitalization to ACOs responsible for populations' health care. I have my own views on which of these and other approaches offer the greatest potential, but here I want to make some general points about the purpose and nature of demonstrations, based partly on my experience as responsible for many of the demonstrations CMS was running when I was there 10+ years ago.

First, it is important not to draw early—often premature—conclusions from demonstrations, sometimes based on partial information or claims of success by self-interested parties. For example, the declared, early success of the Premier Hospital Demonstration of pay-for-performance was not corroborated in subsequent, careful external evaluations, yet the early claims contributed to Congress's formation of Medicare value-based purchasing program for hospitals.

Currently, some are claiming success for the ACEs (Acute Care Events) demo testing bundled episode payment for joint replacements and cardiac procedures. In this demo, Medicare

obtains a small payment discount off the top, while in early findings the "bundled" hospitals and physicians apparently have saved money by agreeing to combine their bargaining power to obtain substantial discounts on equipment and supplies related to these particular procedures.[11] Further, the bundled payment for a discrete episode of care provides the hospital-physician collaboration a concrete, financial reason to get together to improve quality and efficiency, offering the possibility of savings beyond obtaining lower prices for joint appliances and coronary artery stents.

However, it is also plausible that the new financial alignment could stimulate efforts for the physician-hospital collaboration to brand, market, and otherwise attempt to induce demand for these services, which already are examples of services that research shows are significantly overused.[12] After all, bundled episodes remain a form of volume-based payment, even if the approach varies from traditional fee-for-service. Only a comprehensive, external evaluation of the ACEs demo will reveal whether the likely per case savings attained will be offset by an increase in service volume.

The second caution is that the behavior that is seen in a demonstration may not be the same as what would occur if the payment or organizational innovation is adopted broadly in Medicare. Demonstrations sites usually are not typical providers. They may be "early adopters" of a particular approach that is being tested—with an interest in demonstrating success. Further, in a demonstration the sites are under a spotlight, and their behavior is not necessarily reflective of what would take place once the spotlight is turned off.

I am not raising this concern about generalizability from demonstrations to dismiss the desirability of doing demonstrations to inform policy. Rather, I would emphasize that a major purpose of demonstrations is to test operational feasibility of a new approach to payment or delivery for CMS, its contractors, providers, and beneficiaries. There may be important lessons learned that inform how policy might proceed, even if the overall impact of the demonstration cannot be characterized as a "success" or "failure." For example, the Physicians Group Practice Demonstration was not a success overall,[13,14] yet the operational lessons and observations about medical group behavior importantly led to the Affordable Care Act's adoption of the Shared Savings Program and what has become the Pioneer ACO Demonstration.

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[11] Medicare Payment Advisory Commission, *Report to Congress: Medicare and the Health Care Delivery System* (Washington, DC: MedPAC, June 2011).
[12] Berenson, R.A., and Elizabeth Docteur, *Doing Better by Doing Less: Approaches to Tackle Overuse of Services* (Washington, DC: Urban Institute, January 2013).
[13] Gail Wilensky. "Physician Group Practice Demonstration—A Sobering Reflection," *New England Journal of Medicine* 10(1056): 1–3, October 2011.
[14] Robert A. Berenson, "Sharing Savings Program for Accountable Care Organizations: A Bridge to Nowhere?" *American Journal of Managed Care* 16 (10): 721–26, October 2010.

At some point, the decision on whether to adopt a new payment approach broadly into the Medicare program is a judgment call about which the demonstrations can be informative but not decisive. I believe we are a number of years away from being able to make good policy decisions about which new payment methods to adopt and whether to make them available as options for practices along with a legacy fee schedule available for those who opt to not play or to make them mandatory as an no-choice substitute for fee-for-service.

Fortunately, the remarkable recent moderation in service volume and intensity growth in Medicare generally and for physicians in particular offers the opportunity to take the necessary time to learn from the many demonstrations being tested in Medicare, from the experience with other payers' similar initiatives, and experience from other countries, about how best to proceed to replace or complement a physician fee schedule. My estimate is that five or more years will be needed to achieve some consensus on a major reformulation of payment for physicians. In the meantime, many physicians already have the opportunity to opt into ACOs, which is the most important and far-reaching approach being tested or to participate in some of the other promising demonstrations.

Improving value in the short term

For the short term, I would offer the following list of immediate steps Congress should consider to support an improved physician payment system.

1. With the CBO score for repeal of the Sustainable Growth Rate (SGR) now down to $138 billion, it is time to eliminate it once and for all. MedPAC proposed elimination when the score was $300 billion and produced a balanced portfolio of payment reductions to physicians and other Medicare providers and suppliers to offset the cost. Given the new circumstances, I believe a balanced approach would still be the best way to proceed, with a much smaller, but real, reduction in payments for non-primary care services in the Medicare Fee Schedule. CMS has started more actively to correct misvalued services, as MedPAC has recommended for a few years and as the Affordable Care Act mandated. This activity would redistribute relative value units and dollars to produce a different mix of services, which among other things would help address the current and growing shortage of primary care workforce. I understand that in difficult budget times, it is difficult to find new money for the substantial administrative work to accomplish the needed, major recalibration of the Medicare Fee Schedule. Yet, attention to misvalued codes now would more than pay for itself in reduced health spending in the future.

2. For now, I would not replace the SGR mechanism with a different volume control mechanism to automatically reduce fees for volume growth that exceeds a target amount. Rather, I would aggressively work to improve the accuracy of the fees—that is, payment in relation to the

resource costs of production—to alter the incentives for volume growth rising primarily as a source of windfall profits for certain specialties.

3. I would specifically target services that are provided in accordance with the In-office Ancillary Services (IOAS) Exception to the Stark self-referral regulations to target these for specific fee cuts if analysis shows, as I expect, that many are overvalued. In addition, consideration should be given to narrowing or eliminating the IOAS exception for those services that are rarely performed during the same visit it is ordered. Imaging, pathology, and physical therapy are among the services that have grown inappropriately from self-referral abuse.[15,16] The more general policy guidance is to rely on discrete policy interventions to reduce volume growth for particular services rather than rely on across-the-board fee cuts, as under the SGR.

4. As part of a thorough review of the Medicare Fee Schedule, it is time to redefine the core evaluation and management, visit codes that in aggregate represent almost 45 percent of spending under the fee schedule. Among other problems with the current codes and their definitions, recent research shows there is an epidemic of office visit up-coding—physicians and hospitals providing outpatient services.[17,18] While I argued earlier that there is relative underpayment of evaluation and management services in comparison to tests, imaging, and procedures, that unfortunate reality does not provide an excuse for physicians to abuse the payment system by up-coding to make up for what they consider insufficient payment rates.

Still, the code definitions need to change so that there is less ambiguity about how physician practices should correctly code. We need to explore whether the decision made two decades ago to have a single set of visit codes for all specialties and for all patients needs to be revisited, given growing patient heterogeneity. Further, the current evaluation and management definitions and accompanying documentation guidelines have a highly negative impact on the potential use of electronic health records, which have been developed and implemented more to permit easy compliance with CMS documentation requirements than to promote decision support to physicians to improve their care. Clearly, the current documentation requirements are having a detrimental effect on the value of care beneficiaries receive.

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[15] Government Accountability Office, "Higher Use of Advanced Imagine Services by Providers Who Self-Refer Costing Medicare Millions" (Washington, DC: Government Accountability Office, September 2012) GAO-12-966.
[16] Medicare Payment Advisory Commission, Report to Congress: Aligning Incentives In Medicare, "Chapter 8: Addressing the Growth of Ancillary Services in Physicians' Offices" (Washington, DC: MedPAC, June 2011).
[17] Abelson, R., J. Creswell, and Griff Palmer, "Medicare Bills Rise as Records Turn Electronic." *New York Times,* September 21, 2012.
[18] Shulte, F., and David Donald. "How Doctors and Hospital Have Collected Billions In Questionable Medicare Fees" (Washington, DC: Center for Public Integrity, September 2012), http://www.publicintegrity.org/2012/09/15/10810/how-doctors-and-hospitals-have-collected-billions-questionable-medicare-fees

5. Any overdue correction of misvalued services will be counterproductive unless the current site-of-service differential is corrected. In accordance with that differential, "provider-based payment" pays as much as two times more for physician services when provided in an outpatient department than in an independent physician's practice. There was a reasonable rationale for the site-of-service differential when outpatient departments were appendages of the main hospital, which, in contrast to physician practices, have obligations to have "stand-by capacity" and offer 24/7 access to emergency departments, accompanied by some amount of uncompensated care. However, in recent years, provider-based payment has become a primary reason for hospital employment of physicians. But now, the newly employed physicians usually do not move their practices to the main hospital campus and participate in the broad mission of the hospital related to access to care. Rather, they maintain their established practice locations and rarely change the payer mixes of their patients. Yet, the combined hospital facility fee and physician's professional fee adds up to a doubling of the payment—and a commensurate doubling of the patient's co-insurance obligation.

A few years ago, CMS reasonably reduced the overpayment for cardiac imaging tests performed in physician offices; yet, the correction initiated a hospital employment frenzy of cardiologists to take advantage of the higher outpatient payment rates. The result is that Medicare perversely wound up paying more for the same services to the same patients. Hospitals do have costs that independent practices do not face, but these costs should not be reflected in services that do not reflect hospitals' unique obligations. The site-of-service differential for physician services should be significantly reduced or eliminated, while the costs that hospitals do bear for their unique obligations should be paid for but through other means, possibly through increases in inpatient, emergency department and other unique hospital services.

Mr. PITTS. The chair thanks the gentleman, and Dr. Damberg, you are recognized for 5 minutes to summarize your testimony.

STATEMENT OF CHERYL L. DAMBERG

Ms. DAMBERG. Thank you. I want to thank the committee for inviting me here today. I am a Senior Researcher at the RAND Corporation, and the focus of my work over the past decade has been looking to evaluate pay-for-performance or performance-based payment models.

My remarks today address issues related to measuring the performance of physicians under these new payment models that will incentivize or tie payment to performance, and there are a number of issues or measurement issues that I want to call to your attention.

Issue number one: Existing performance measures are not suitable for newer models that emphasize the delivery of efficient, high-quality care across a continuum of time and health care settings. Current measurement focuses on discrete events in single settings of care or silos rather than looking longitudinally across an entire episode of care. The portfolio of measures that exist today were not developed or envisioned to be used in the types of accountability and payment applications that are emerging nor is the portfolio necessarily focused on the right measures. Measurement needs to migrate away from a siloed approach which further perpetuates a lack of coordination to quality assessment that encompasses all care delivered to patients across an entire episode.

Issue number two: When we ask health care providers to devote resources to measurement, it is critical that we focus on the important aspects of care that matter most to patients and which providers can most readily influence. Patients care most about outcomes such as whether a chronic illness like type 2 diabetes was prevented or for a patient with diabetes whether the physician and his or her care team helped the patient manage the condition to prevent complications and premature death. Patients also care about whether they can access care when they need it, whether their care is coordinated. They also want to know about how well they are treated in the system and whether their preferences are considered in treatment decisions. And lastly, patients care about the cost of treatment. Regardless of the payment model used, the true north and holy grail of performance-based accountability and payment is measurement of outcomes.

Issue number three: Outcome measures are currently lacking in many instances or in a nascent state of development. For example, there are a small number of measures of cost or efficiency and many are poorly constructed and have not been fully tested for their validity or reliability. Measures that assess change over time and important intermediate outcomes such as blood pressure control and that influence long-term outcomes such as heart attack and stroke do not yet exist. The United States could learn from efforts in Great Britain. Since 2009, the United Kingdom's national health system has invited all patients who are having a variety of surgeries to fill in patient-reported outcome questionnaires and has generated comparative statistics to incentivize improvements and

help patients understand performance differences across different sites of care.

Issue number four: As we transition to a performance dashboard with more emphasis on outcomes, there is work that can be done immediately to strengthen the types of measures that are currently used. For example, we can shift away from focusing on discrete clinical services toward longitudinally measuring the management of a patient. In addition, the HIT infrastructure may enable the creation of new, novel measures. For example, EHRs and health information exchange audit trails could be used to construct indirect measures of quality. A specific example is medication reconciliation and hospital discharge. In lieu of a checkbox in the HER, the audit trail could provide an indirect measure to determine whether the physician accessed the patient medication list and made any modifications prior to discharge.

Issue number six: We must focus efforts on strengthening data systems to facilitate delivery of high-quality care by physicians and the construction of performance measures. We cannot expect physicians to coordinate care, avoid duplicative use of services and manage total cost of care when they are flying blind. I commend to you a paper that was written by a colleague of mine, Eric Schneider. It was actually written in 1999 but is still highly relevant, and this paper lays out a roadmap for an integrated health information framework and identifies seven features the framework should possess. I won't go into those. They are in my written testimony.

Issue number seven: We have to enlist physicians as true partners in the process of defining measures for which they will be held accountable as individuals and more broadly as care teams and systems of care. They have a vitally important role to play in the selection of measures and choosing concepts that will be measured weighing the scientific evidence, specifying the measures and assessing the feasibility and practice and then ultimately endorsing the measures that will be used once developed. Lastly, because much of the current measure development is occurring using federal tax dollars, there is a clear need to coordinate these efforts to better deploy scarce resources and minimize burden on providers.

In conclusion, I would like to summarize the actions that could be taken. I think there is more federal leadership that could happen to develop a robust measurement strategy and shift the focus and resources towards a greater emphasis on defining and measuring outcomes. Secondly, support the development of the robust health information framework that is integrated and will allow data sharing across providers and payers. Third, continue efforts to coordinate measurement development within and outside the federal government. Fourth, use a rigorous and transparent and inclusive process to develop measures. And I would just leave you with the thought that in addition to paying providers differentially, it is important to note that public transparency or public reporting can be a powerful incentive.

Thank you very much.

[The prepared statement of Ms. Damberg follows:]

Testimony

Efforts to Reform Physician Payment

Tying Payment to Performance

Cheryl L. Damberg

RAND Office of External Affairs

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February 2013

Testimony presented before the House Energy and Commerce Committee, Subcommittee on Health on February 14, 2013

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The RAND Corporation

Efforts to Reform Physician Payment: Tying Payment to Performance[2]

Before the Committee on Energy and Commerce
Subcommittee on Health

February 14, 2013

Chairman Pitts, Ranking Member Pallone, and distinguished Members of the Subcommittee, thank you for inviting me here today. My name is Cheryl Damberg and I am a senior health policy researcher at the RAND Corporation. I appreciate the opportunity to appear before you to discuss physician payment reform. My remarks today address issues related to measuring the performance of physicians and organizations of providers, which is a core component of new payment models that tie payment to performance. My comments derive from research my colleagues and I have conducted that examines the use of financial incentives tied to performance and my experience working with provider organizations over the past decade to measure health care quality and costs.

Congress is considering ways to revise the physician fee schedule so that payment policy supports the delivery of high quality care and efficient use of resources. Performance-based payment, which refers to a broad class of value-based purchasing models that use financial incentives tied to performance on a set of defined measures, is one reform mechanism that can support achievement of these goals. The application of value-based purchasing (VBP) approaches to physician payment reform is already taking shape as called for under the 2010 Patient Protection and Affordable Care Act (ACA). Examples include the Medicare hospital value-based purchasing program, the Medicare physician value-based payment modifier starting in 2015, the Bundled Payments for Care Improvement demonstrations, and the Accountable Care Organization (ACO) shared savings programs and demonstrations.

Measuring the performance of physicians and provider organizations on their quality and resource use or costs is at the heart of these various reforms to care delivery and payment. It is vitally important to signal to providers what patients and payers expect them to be working

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[2] This testimony is available for free download at http://www.rand.org/pubs/testimonies/CT381.html.

towards, and explicit measures—when tied to payment—help focus and redirect physicians and physician organizations towards redesigning care processes and how they coordinate actions with other care providers in order to deliver better value. Value is defined as the outcomes (outputs) achieved divided by the cost or resources used (inputs) to generate those outcomes.

Value-based payment models are very new to the health system and represent a work in progress. Public and private sector purchasers are actively working to design VBP programs to achieve the stated goals of improved quality and more efficient use of health care resources. How these programs are designed is a complex undertaking and one that will determine the likelihood of their success. Two central design features are the payment structure (i.e., size of incentive, how it is distributed across providers, and whether it rewards absolute levels of performance, relative performance, or improvement) and the measures that are the basis for determining payments (Mehrotra et al., 2010; Stecher et al., 2010; Schneider and Hussey, 2012). The pay-for-performance experiments of the last decade offer some useful lessons (Pearson et al., 2008; Damberg et al., 2009a; Damberg et al., 2011; Stecher et al., 2010). Performance measures are a foundational element of value-based payment models and our ability to advance the implementation of these models requires having a set of measures that will be used to determine differential payments to providers.

(1) What is our current state of readiness to measure physician performance?
Over the past two decades, we have significantly advanced our ability to measure the performance of the health system at various levels—health plan, hospital, nursing home, and physician or physician group. Most available measures assess processes of care that measure whether patients are receiving clinically-indicated care, such as whether a patient who has experienced a heart attack received aspirin at the emergency room. Such measurement focuses on discrete events in a single setting of care or "silo" (e.g., hospital) rather than looking longitudinally across an entire episode of care for a patient (Hussey et al., 2009; Schneider et al., 2011).

The portfolio of measures that exist today were not developed or envisioned to be used in the types of accountability and payment applications that are emerging—such as bundled payments, ACOs, and patient-centered medical homes (PCMHs)—nor are these portfolios necessarily focused on the right measures. Existing measures are not suitable for newer models that emphasize the delivery of efficient, high quality care across a continuum of time and health care settings, aligning the actions of multiple providers to achieve optimal outcomes for the patient. Measurement needs to migrate away from a siloed approach which further perpetuates a lack of coordination, to quality assessment that encompasses all care delivered to patients

within a given health episode. We have much more work to do to define and measure quality in health care (Reinhart, 2013).

Although performance measurement initially focused on evaluating whether patients received evidence-based processes of care, the tide is shifting. Newer value-based payment initiatives, such as the Massachusetts Blue Cross Blue Shield Alternative Quality Contract and the California Integrated Healthcare Association's value-based pay-for-performance (P4P) initiative, include measures that capture outcomes of care. Health outcomes look at the impact of medical interventions on patient's health and well being (e.g., pain, functioning), avoidance of complications from chronic illness, and for some types of interventions like surgery, infection rates, occurrence of other adverse events, and mortality rates. The Massachusetts and California programs are measuring a variety of outcomes including "intermediate" or near-term outcomes that influence longer term outcomes (such as blood pressure control), patient experience with receiving care, avoidance of hospital acquired infections, and total cost of care. Similarly, the Veterans Administration's quality measurement initiative holds physicians in the VA accountable for intermediate outcome measures (e.g., blood pressure control, lipid control, blood sugar control).

Our collective thinking about what is important to measure is evolving, as reflected in the National Quality Strategy (2011), which created national aims and priorities to guide quality improvement efforts. The three aims are better care, better health, and lower cost. These same aims are at the heart of new delivery and payment models. Although the aims have been defined, the measures that will be used to determine whether we have been successful in achieving these aims have not.

When we ask health care providers to devote resources to measurement, it is critical that we focus on the important aspects of care—those that matter most to patients and that providers can most readily influence. Patients care most about outcomes—such as whether a chronic illness like Type 2 diabetes was prevented or, for a patient with diabetes, whether the physician and his/her care team helped the patient manage the condition (i.e., by keeping lipids, blood sugar, and blood pressure under control) to prevent complications and premature death. Patients also care about whether they can access care when they need it and whether their care is coordinated across the many providers who treat them. They also care about how they are treated, whether they feel heard, whether their preferences are considered, and whether they are treated with respect. Lastly, patients care about the cost of treatment. How physicians deploy resources drives costs that are borne not only by patients and their families, but by society more broadly.

Regardless of the payment model used, the "true North" and Holy Grail of performance-based accountability and payment is measurement of outcomes. A focus on outcomes applies whether you are measuring individual providers or models of care—such as ACOs, PCMHs, or bundled payments.

The 2011 National Quality Strategy provides an important framework for the nation, but it is now time to get specific and define exactly what should be measured in terms of outcomes and then have physicians and other health care providers focus their energies on working to achieve those outcomes. Outcome measures employed under the National Quality Strategy to measure provider performance should:

- adequately adjust for differences across physicians in the patients they treat that influence the outcome (i.e., risk adjustment) in order to create a level playing field in comparing performance and to avoid unintended consequences (such as avoidance of high risk patients).
- be near-term or proximate events (such as within one year of treatment) such that the actions taken or not taken by the physician are likely to have had some influence in determining the outcome. For example, it is preferable to hold physicians accountable for blood pressure control, not stroke (which may have involved the actions of many physicians over many years).
- aggregate processes or outcomes to a level (physician, practice site, medical group or integrated delivery system) to ensure that there are an adequate number of patient events to reliably measure performance.

Unfortunately, outcome measures are currently lacking in many instances or are in a nascent state of development. For example, there are a small number of measures of cost or efficiency, however many are poorly constructed and have not been fully tested for their validity or reliability. Measures that assess change over time in important intermediate outcomes (such as blood pressure control) and that influence longer-term outcomes (e.g., heart attack and stroke) do not yet exist. Functional status measures or patient-reported outcomes measures (PROMs) were developed in the context of research studies but have not been widely implemented in the context of performance-based accountability and payment programs. However, it is interesting to note that since 2009, the United Kingdom's National Health System has invited all patients who are having hip or knee replacements, varicose vein surgery or groin hernia surgery to fill in patient-reported outcome (PROMs) questionnaires and has generated comparative statistics to incentivize improvements and help patients understand performance differences across different sites of care.

(2) How to advance measure development moving forward?

In the foreseeable future, the dashboard of measures that are used will likely continue to be a mix of measures that address structural elements that influence the delivery of care (e.g., HIT capabilities), care processes, and outcomes. As we transition to a performance dashboard with more emphasis on outcomes, there is work that can be done immediately to strengthen the types of measures that are currently used. For example, a shift away from focusing on delivering discrete clinical services towards longitudinally measuring the management of a patient can shift the focus towards a more integrated, patient-centered way of providing care (Hussey et al., 2009; Schneider et al., 2011). In addition, the HIT infrastructure that the federal government has been developing through the Office of the National Coordinator for Health Information Technology (ONC), and incentivizing through the Medicare program, may enable the creation of new, novel measures. For example, new measures could be developed in the context of ONC's efforts to identifying high priority quality improvement targets that clinical decision support features in EHRs could address (Damberg et al., 2012) or through leveraging electronic health records (EHR) or health information exchange (HIE) audit trails (i.e., access logs) to construct "indirect" measures of quality. A specific example is medication reconciliation at hospital discharge. In lieu of a check box in the EHR (which could be easily "gamed" by physicians), the EHR audit trail data could provide an indirect measure to determine whether the physician accessed the patient's medication list and made any modifications to it on the day of discharge. The current measurement dashboard also could be enhanced through the development of measures of care coordination (care transitions), patient and caregiver engagement, structure (management, health IT utilization), efficiency, and composite measures that combine outcome, process, patient experience, and cost measures (Schneider et al., 2011). Composite measures will be critical for evaluating the performance of individual physicians, where a small number of patient events can lead to measures that do not provide a reliable signal on a provider's performance. As new measures are developed and implemented, we can rebalance the portfolio of measures and eliminate many of the process measures that physicians currently are asked to report. The federal government (AHRQ, CMS, and ONC) has an opportunity to lead through choice of measures to fund for development and specifying outcome measures as the priority for performance programs in Medicare.

(3) What is the process for measure development?

Development of measures needs to occur using a scientifically rigorous process that is transparent, inclusive of physicians and other stakeholders, and ensures the reliability and validity of measures that become the basis of payment. To engage providers to achieve the three aims of the National Quality Strategy, we must enlist them as true partners in defining the measures for which they will be held accountable as individuals, and more broadly, as care teams and systems

of care. Physicians have a vitally important role to play in the selection of measure concepts, weighing the scientific evidence related to specific actions providers can take to influence the process or outcome, specifying measures (including how to adjust for differences in the patient populations they treat and which patients to exclude), assessing the feasibility of a measure in practice, and ultimately endorsing the measures once developed. Some physician specialty organizations have taken steps to identify measures and create registries containing process and outcome measures. These measures and data sources could provide a starting point. For example, the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP®) generates validated, risk-adjusted, outcome measures to help surgeons improve the quality of surgical care.

Although value as a metric is intrinsically appealing, the challenge before us is defining and constructing the measures that comprise the value equation (defined earlier in my statement) and ensuring that the measures deployed in high stakes applications (such as payment and public reporting) are valid and reliable.

- A valid measure is one that measures what it claims to measure (e.g., mortality resulting from how a surgical procedure was performed) rather than something else (e.g., how sick the patient undergoing the procedure was). Valid measures are those over which the provider has some control and, in the case of outcomes, account for differences across provider in the patients being treated in order to provide fair comparisons (i.e., by adjusting for different patient risk factors that affect the outcome).
- A reliable measure is one that allows you to accurately differentiate performance between providers. The baseball analogy is if you only observe a batter at bat 3 times and they hit a home run all 3 times, would you say that batter's batting average was 1.00 (100%)? Likely not—you'd need to observe many more attempts at bat before you could reliably say whether that batter's average is .250, .333, or .500.
    - In health care, it is hard to get a reliable estimate of a single physician's performance if only looking at a few events, which commonly occurs at the level of the individual physician. The reliability of the estimate of performance can be improved by aggregating data across multiple providers, such as the practice site or physician group, aggregating a physician's data over multiple years, or by constructing a composite measure that aggregates a physician's data over multiple measures. Reliability is important because if the measure is not reliable, you increase the chance of making incentive payments based on noise or random variation in performance rather than true signal.

The National Quality Measures Clearinghouse underscores that the requirements for validity and reliability are higher when using measures for payment and public reporting, necessitating that each provider collects data in the exact same way through standardized and detailed specifications (NQMC, 2012).

Finally, if the approach to performance-based payment embodies quality improvement, then physicians and other health care providers are more likely to engage. To improve, physicians need to see comparative data on performance variation. Federal efforts to measure providers' performance should include real-time feedback outside any annual reporting and payment adjustment activities to support providers in their work to achieve the specified targets.

(4) **How do we improve efficiencies in measure development efforts?**
Numerous public and private sector entities are engaged in measure development, including the Joint Commission, the National Committee for Quality Assurance (NCQA), employer coalitions, community collaboratives, federal agencies (CMS, AHRQ, HRSA, CDC), state agencies, private/commercial firms, health plans, and consumer groups. The Centers for Medicare and Medicaid Services (CMS) alone uses approximately 800 measures across its various programs, of which 300 were developed and are now being maintained by the agency. With the passage of the ACA, measurement development efforts have intensified and there is little to no coordination of this activity.

Historically, there has been poor coordination among the measure developers and those who finance measure development. The net result has been overlapping investments and development efforts that generate duplicative or very similar ("me too") measures. Additionally, there is a lack of coordination in the application of measures, with multiple parties measuring the same provider on similar concepts with slightly different measure specifications or thresholds—creating undue provider burden and confusion. Because much of the current measure development is occurring using federal tax dollars, there is a clear need to coordinate these efforts to better deploy scarce resources and minimize burden on providers.

Aware of the need for alignment and coordination, the U.S. Department of Health and Human Services and the Center for Medicare and Medicaid Services (CMS) have recently begun work to coordinate efforts within and across the federal agencies that are engaged in measure development and implementation (i.e., the HHS Measures Policy Council, the HHS Measures Coordination Work Group, the CMS Quality Measures Task Force, and the CMS Measures Coordination Work Group). Additional steps should be taken to coordinate federal measure development with measure developers outside the federal government. Many state

collaboratives and physician professional societies that are actively engaged in performance measurement and federal efforts should seek to coordinate with these efforts. To that end, CMS recently released a request for information (RFI) on the use of clinical quality measure data reported to specialty boards, specialty societies, regional health care quality organizations and other non-federal reporting programs. The focus of this inquiry is to understand how such data might be used to report for the Physician Quality Reporting System (PQRS) and the Electronic Health Record (EHR) incentive program. These are much needed and welcome first steps.

(5) How do we advance our data systems to enable performance measurement and quality improvement?

To enable the construction of performance measures that new payment and delivery models emphasize, we must focus efforts on strengthening data systems. How can we expect physicians to coordinate care, avoid duplicative use of services/procedures, and manage total cost of care when they are flying blind? In most cases, physicians only see the care they themselves provide, given the lack of interconnectivity and information exchange with other providers, such as hospital, or with the payers, who often have data that the providers need. One example is pharmacy data that capture whether a patient filled a prescription based on a physician's order—data that resides with the payer and not the physician. If a patient is admitted to a hospital or emergency department, their physician generally does not know this absent a health information exchange (HIE) or data sharing arrangement with the hospital. In addition to the lack of information exchange, there are other deficits in our data systems that will continue to hinder our ability to measure performance unless they are addressed.

A must read paper regarding what we can do to strengthen data systems to enable performance measurement, and more importantly enable providers to manage care delivery was published in 1999 by my RAND colleague Eric Schneider (1999). This paper lays out a road map for an integrated health information framework, and identifies seven features that an integrated health information framework should possess:

1. specified data elements;
2. established linkage capability among data elements and records;
3. standard data element definitions;
4. automated data capture;
5. procedures for continually assessing data quality;
6. strict controls for protecting security and confidentiality of the data; and
7. protocols for sharing data across institutions under appropriate and well-defined circumstances.

CMS, as one of the nation's most influential health care payers, has an important role to play in strengthening our nation's health data systems. Implementation of an integrated health information framework can be catalyzed if the federal government leads by (1) requiring its provider partners to capture detailed, accurate data and to share data across providers, (2) defining the data elements that should be captured and standardizing data definitions, and (3) setting policies that allow for sharing of data across institutions in ways that protect the security and confidentiality of the data.

Conclusion

In summary, revising physician payment is a daunting challenge, but one that is absolutely necessary. Performance-based payment reform is vital to driving improvements in health care delivery. The ability to move forward with new performance-based payment models is predicated on having (1) a robust set of measures and (2) an integrated health information infrastructure that supports physicians in their quality improvement efforts and performance measurement.

As Congress considers policy changes to provider payment, there are several areas where federal leadership and investment could facilitate and support the transition to value-based payment models.

1. ***Provide federal investment in and leadership related to developing a robust measurement strategy by***:
    - defining the performance measure concepts that should be the focus of accountability and payment,
    - developing the concepts into actual performance measures using a rigorous development and testing process that ensures that measures are valid, reliable, and represent important areas for physicians to focus their attention and resources on, and
    - providing resources to update measures (or retire them) to incorporate changes in the scientific evidence.

2. ***Shift the focus and resources towards a greater emphasis on defining and measuring outcomes.*** The federal government can lead through the types of measures it chooses to fund for development. Work to specify and develop outcome measures should be a top priority for CMS and AHRQ, and physicians should be strategic partners in this work.

3. ***Support the development of a robust integrated health IT framework for quality improvement and reporting.*** Federal investment in the national health information infrastructure can contribute substantially to our ability to assess the performance of physicians, and, more importantly enable physicians to improve quality and be more efficient in how they use resources. The ONC, working in coordination with CMS and AHRQ, should focus on standardizing data elements and definitions and facilitating data sharing across providers and payers to enable better management and coordination of patient care and the ability to track longitudinal outcomes. Enhancing requirements that providers move to report on certain types of measures (such as PROMs) will drive delivery organizations to invest in the information infrastructure that will support quality improvement.

4. ***Continue efforts to coordinate measurement development within the federal government and expand those efforts to coordinate with measure development parties outside government.*** The federal government should continue to coordinate its measure development and measure applications across the various federal agencies, and actively work to engage in coordination with the external community of measure developers.
   - To reduce redundancy of federal investments, federal agencies should be required to search existing measure databases (the National Quality Measures Clearinghouse, National Quality Forum) before letting contracts for new measure development to assess whether measures already exist.
   - Coordination should also occur between measure development work at AHRQ and CMS and ONC's efforts to advance the HIT infrastructure in order to support the development of new, novel measures that HIT may enable. New measures could occur in the context of identifying high priority targets for clinical decision support (Damberg et al., 2012) or through leveraging EHR or HIE audit trails (i.e., access logs) to construct "indirect" measures of quality.

5. ***Use a rigorous, transparent and inclusive process to develop measures.*** Because performance measurement will affect the behavior of physicians and the organizations in which they work, it is important that what we ask them to focus on is based on scientific evidence related to actions they can take to influence the outcomes of interest. While CMS may fund or lead efforts to develop measures, physicians should be actively involved in these efforts, could lead such efforts, and existing physician-led data registries that track processes and outcomes could be leveraged. The development

process should ensure that the measures that will be applied in high stakes applications are valid and reliable. Results from testing of measures should be publicly available for physicians to review; such transparency will build confidence in the measurement system.

6. ***Support providers in their efforts to improve.*** Medicare can work collaboratively with physicians to support improvement by making performance results available in a timely fashion and showing them comparative statistics on their performance.

7. ***Recognize that in addition to paying differentially for performance, public reporting of comparative performance scores (i.e., transparency) is a powerful incentive*** to prompt physicians and the organizations in which they work to improve quality (Lindenauer et al, 2007).

8. ***Guard against unintended consequences.*** Paying providers differentially based on a set of performance measures can potentially lead providers to respond in unintended ways.
    - First, physicians may seek to avoid more challenging patients who will bring their scores down. Measures need to be designed (such as adjusting for differences in the mix of patients) to minimize the likelihood that physicians will avoid sicker patients. VBP programs can also use other adjustments, such as holding the mean incentive payout to be equal across pre-defined groups of providers (e.g., defined by the socioeconomic status of their patients) to avoid redistribution of payment in ways that harm disadvantaged providers and patient populations (Damberg and Elliott, 2010). To mitigate these effects, Medicare will need clinical and sociodemographic information on the patients cared for by each physician to enable front-end risk adjustment or post-measurement adjustments, as well as access and other measures to determine whether providers are avoiding high-risk patients (Schneider et al., 2011).
    - Second, measures dictate the things that providers will focus their attention on—"what gets measured is what gets done." Incentive programs often address only a narrow portion of a physician's outputs or the processes that contribute to outputs. To avoid encouraging physicians to focus on a narrow set of items that are measured and neglecting other important outputs that are not being measured, it will be important to apply a broad dashboard of performance measures.

RAND researchers have developed performance measures (McGlynn et al., 1995; Wenger et al., 2003; Asch et al., 2004), evaluated the impact of pay-for-performance (Damberg et al., 2009), and more recently value-based purchasing programs, helped to define alternative measurement approaches that can support new payment models (Hussey et al., 2009), and assessed the implications of alternative incentive designs and scoring systems to reward performance (Schneider et al., 2012; Mehrotra et al., 2010; Damberg et al., 2009; Stecher et al., 2010; Friedberg and Damberg, 2012). We are happy to work with Committee members to share the work we have done in this area to inform policy making.

Again, let me thank you Mr. Chairman, Mr. Ranking Member, and members of the Subcommittee for allowing me to appear before you today to discuss this important issue. I would be happy to take your questions.

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Mr. PITTS. The chair thanks the gentlewoman, and that completes the opening statements of the second panel. I will now begin questioning and recognize myself for 5 minutes for that purpose.

Dr. Damberg, we will start with you. You state that the single most important factor in facilitating or impeding the use of measures was the availability of data to construct performance measures. Can you describe a strategy for bridging this data gap? Is the current HIT legislative and regulatory climate facilitating or impeding this effort? If the latter, what changes do you suggest to remedy the current shortcomings?

Ms. DAMBERG. While there have been significant investments in the health information structure, I don't think that what is occurring currently is going to help us ultimately with performance measurements, and that is in part because we have not identified the specific data elements, come up with standardized data definitions for those, and I think we are still a significant ways off from data sharing among the different partners, in part because of issues around security, privacy issues and confidentiality of the data. So I think those are several areas where attention needs to be focused.

Mr. PITTS. Thank you.

Ms. Mitchell, can physicians in smaller practices be adequately measured for quality and efficiency? I understand that one problem in terms of measuring smaller-sized practices is the limitations of small sample sizes. Is there a way to aggregate data from a number of smaller practices to overcome this barrier?

Ms. MITCHELL. I think it is incredibly important that we ensure that all measures are reliable and valid, and there will be sample-size challenges to that. We could also look to patient-reported outcomes, however, functional status measures, patient experience measures. There are measures that can be used for smaller practices that are very relevant to other consumers but it will be critical that all measures, especially if they are publicly reported or used for payment, are valid and reliable.

Mr. PITTS. Mr. Miller, there are a number of new payment reform models being developed, and as policymakers, we obviously can't incorporate all current possible future models into one piece of legislation. Yet one lesson from the ACO experience is that if you make the model too prescriptive, it may preclude many providers from participating. Have you given thought as to how you might develop a policy to approve new payment reform models that has the proper balance of detail and flexibility?

Mr. MILLER. As I outlined in my testimony, I think that if we have both a top-down and a bottom-up approach, we will be able to get a much richer set of models that are workable much more quickly than we do today. The problem that you saw with the ACO regulations was, it was designed to be a one-size-fits-all approach, and so naturally there were a lot of concerns about how well it was going to work in all circumstances but basically in the end it was one approach. And I think that what you need to distinguish is that it was one approach to payment called the Shared Savings program. There are many different ways that you could create an accountable care organization, which I think is a very important

model to think about, but you don't necessarily—the best model is not to do it through a Shared Savings program.

So for example, there are many physician groups and IPAs around the country that did not want to participate in that particular program because they felt they were still being paid by fee-for-service with simply a Shared Savings add-on but they did want to participate in the Pioneer ACO model because they had the capability to actually accept a risk-adjusted global payment and be able to significantly change care that way. So I think that is an example where if you actually let the providers come forward and define what they are willing and able to do, you will be able to get a set of models, not in theory that you would say we have to create a dozen models that maybe nobody wants but you would actually have people coming forward saying I know that I can improve care for beneficiaries and I can save money if you change the payment model in the following way.

Mr. PITTS. Thank you.

Dr. Berenson, given the fact that fee-for-service will be around and may even play a prominent role in future payment systems, at least for the foreseeable future, how do we deal with spending in the fee-for-service segment of the system? In other words, how do we control for increases in the volume and intensity of services? Will we still need a system of spending targets and possible cuts, and if so, how should the targets be structured.

Dr. BERENSON. Yes, that is a very interesting question. I would point to the results of what happened when the Congress in the Deficit Reduction Act of 2005 correctly, in my opinion, reduced dramatically the spending for advanced imaging services like MRIs and CTs and PET scans. For reasons I don't quite understand, we were actually paying physician practices more than we were paying outpatient departments for those services. As part of the doc fix for that year, those payments were reduced, and what happened in addition to the savings from the prices coming down significantly, volume of those services over the subsequent years has actually moderated, and what I hear anecdotally is a lot of midsized practices that really had no business purchasing their own MRI machines and were doing so because of its profitably suddenly decided this was no longer a profitable thing to do.

So what I have suggested in my testimony is that the Secretary should have somewhat greater authority to affect prices where they also affect volume of services. I mean, physicians do respond. There is this notion that physicians simply respond to price reductions by increasing volume. That is too simplistic a notion. It varies by the service. I think we need to be much more sophisticated about seeing the relationship between price and volume.

Mr. PITTS. The chair thanks the gentleman and now yields to the ranking member 5 minutes for questions. Mr. Pallone.

Mr. PALLONE. Thank you, Mr. Chairman.

My question is to Dr. Berenson. While there is a consensus regarding the need to move to more value-based payment systems, no one seems to have a clear idea how far or, you know, how we got from our current fee-for-service system or how we go from our current fee-for-service system to some of the new payment reform models like the accountable care organizations, and as you point

out in your written testimony, fee-for-service is actually the foundation for many of these new payment models. So I wanted to ask, if we want to improve the way we pay for fee-for-service at the same time we are creating incentives for providers to move into new delivery and payment models, what would this transitional period look like?

Dr. BERENSON. Well, I pretty much think we are in the transitional period now, even if we can't recognize it, because of all of the experimentation that is now going on. As Mr. Miller pointed out, we have both shared savings ACOs and risk-bearing ACOs that are being tested. We have got various models for bundled episodes being tested, the Independence at Home, which I think is a very important aspect, which would emphasize home care for frail, elderly, medical homes, et cetera. I think what I said in my testimony is that it is going to take us a number of years to sort it out. I think we should be doing robust experimentation now. I support Harold's notion of having some bottom-up approaches that we would test. I also would endorse Chairman Hackbarth's notion that as we go through this transition, we need to make it very—we need to put pressure on the fee-for-service reimbursements, and part of what I suggested is in shifting more reimbursement to primary care or away from tests and procedures, we would be putting that pressure. Ultimately, we want to be in a place where physicians find it is in their own interest to want to move into a new organizational structure or accept new payments rather than stay in fee-for-service.

I think most docs know that sort of unfettered fee-for-service with no incentives for collaboration and coordination probably is not the right payment model. So I think we are in the transition now and happily the volume and intensity of services and therefore CBO's estimates of future spending in Medicare has moderated significantly, so I think we can take the time to really do what is necessary to understand where we want to go at some point. I don't know if that is 5 years from now, 7 years from now. We would have to at least on a regional basis, possibly on a national basis, say we now have enough confidence in an alternative payment model that we are really going to expect doctors to move to that with the fee-for-service as sort of a legacy system for those who can't make the adjustment.

Mr. PALLONE. All right. Thanks. I am going to try to get one more question in here for you and also for Ms. Mitchell, and Mr. Chairman, for this purpose I wanted to ask unanimous consent to introduce into the record this letter from the National Partnership for Women and Families, which I think you have.

Mr. PITTS. Without objection, so ordered.

[The information appears at the conclusion of the hearing.]

Mr. PALLONE. Thank you, Mr. Chairman.

There has been a significant movement over the past decade towards the establishment of multi-stakeholder consensus processes for health care quality and performance measurement, and Mr. Chairman, this letter references the SGR proposal being circulated by the Republican Ways and Means as well as Energy and Commerce staff, and in that letter, the National Partnership raises a number of concerns about the role medical specialty societies are

being given to develop and select quality and performance measures that would be the basis of their payment and the apparent exclusion of other stakeholders including consumers. They are concerned that this appears to reverse the positive trend over a number of years towards including a broader group of stakeholders in the process.

So Dr. Berenson and Ms. Mitchell, over recent years there has been a lot of work developing consensus processes for development of quality and performance measures. What are your views regarding the appropriate roles for physicians, and how important is it to have consumers and other stakeholders involved in this process? And you have got 28 seconds.

Dr. BERENSON. Twenty-eight seconds? I will be very quick. I am a believer in multi-stakeholder participation but ultimately I think Dr. Damberg would agree that the measures that we come up with need to be valid and reliable and need to pass sort of scientific muster from an organization like the National Quality Forum. So I would have consumers at the table and I wouldn't simply defer to what the specialty societies would prefer in terms of how they would be measured.

Mr. PALLONE. Ms. Mitchell, quickly.

Ms. MITCHELL. Well, having run a multi-stakeholder process for over a decade in Maine to include physicians, unions, employers and consumers at the table to select measures, I can tell you it is possible, and it is very important. We have measurements now available that would not be if it were just for one stakeholder group. So it is challenging but it is extremely important, and I think it absolutely can be done and I think the National Quality Forum and their multi-stakeholder approach is very important.

Mr. PALLONE. Thank you. Thank you, Mr. Chairman.

Mr. PITTS. The chair thanks the gentleman and now recognizes the vice chairman, Dr. Burgess, for 5 minutes for questions.

Mr. BURGESS. Thank you, Mr. Chairman. I want to thank our panelists for sticking with us through what has been a long but important hearing.

Dr. Berenson, I was hoping you could help me with a couple of the points that you made, specifically point three and point five, point three being the in-office ancillary services where you said you would target those. I presume that means reduce those, and you would target those for fee reductions.

Dr. BERENSON. I would want to see whether the reason that a lot of—there is abuse in the in-office ancillary exception. We now have physicians like dermatologists and gastroenterologists who used to send their specimens out to an independent pathology lab that are now doing those in-house under this exception, but at least some articles have described instead of doing the specimen to confirm that the biopsy is not malignant, they are now doing multiple slices, getting multiple payments, clearly abusing the opportunity to do those services themselves. Imaging has been a major concern about the in-office exception with practices that are buying machines and then supplying them. So what we learned with the imaging example if we reduce the overgenerous payment, we reduce the incentive to do some of these services. So that is what I had in mind.

Mr. BURGESS. I appreciate you paying attention when we were doing the Deficit Reduction Act in 2005 because that was the work of this committee that led to that. But then point five, the counterproductive nature of the correction of misvalued services, and this one based on the site-of-service differential, which really has led to almost the destruction of office-based cardiology in favor of hospital-based cardiology, and we literally watched that happen over the last 3 or 4 years, and I really think it is to the detriment of patient service. But nobody is getting a better deal because those services are now performed in the hospital. In fact, it was probably a better deal for the patient regardless of the pricing structure. It was a better deal for the patient to be seen in the cardiologist's office, have the tests done, have it read and treatment rendered and judgment rendered at that point rather than multiple trips back and forth to the hospital to have the procedure done and then the consultation with the cardiologist. Can you speak to that?

Dr. BERENSON. Yes. There may be reasons for hospitals to employ physicians if they have a commitment to become an integrated delivery system and potentially an ACO but a good reason is not to take advantage of the provider-based payments that provide, I would call windfall revenues for the hospital. It raises the cost to Medicare, raises the cost-sharing obligations to beneficiaries, does, as you point out, sometimes lead to greater inconvenience. The hospitals say that they do have obligations that practices don't have—stand-by capacity, 24/7 stand-by capacity, running emergency departments, seeing uninsured. I want to recognize those costs but I want to recognize those costs and services, inpatient services or ED services, not in an outpatient service that can be done just as well at roughly the same cost in a doctor's office.

So I agree with you. I think it is unfortunate that we have had a huge migration of cardiologists out of office to become hospital employees, not to be providing higher quality or efficiency but to take advantage of this site-of-service payment anomaly.

Mr. BURGESS. Well, we have come to an unfortunate place in our country where it is prohibited for a doctor to own a hospital but hospitals can own doctors, and that to me has put entirely the wrong incentives out there.

Dr. BERENSON. Well, we do have some multi-specialty group practices that own the hospital so——

Mr. BURGESS. But under the Affordable Care Act, as far as generating and developing a new facility, that can't happen, which really seems unfortunate because of the fact that you and I hold a professional degree, we are precluded from entering a business practice.

Dr. BERENSON. The issues there relate to whether the physician-owned hospitals were in a position to cherry-pick the patients and, you know, MedPAC and others provided reports. It is a difficult issue.

Mr. BURGESS. It is not as clear-cut as that. I read a very clear article on that written in Health Affairs in March of 2008 by me which said the most valuable thing I have is my time, and if I have got an uninsured patient and I can take care of them at an outpatient surgery site and my time is valued by that outpatient surgery site, I am actually ahead even though I didn't make any

money that day and the facility didn't make any money. It didn't cost me the vast investment of time that it would cost me to wait in line behind a hospital surgery schedule. A separate point. I didn't mean to bring that up but you forced me.

Dr. Damberg, let me ask you a quick question. You just referenced that patients care about the cost of care. Did I hear you right when you said that?

Ms. DAMBERG. That is correct.

Mr. BURGESS. Well, now, the Commonwealth folks came out just earlier this month and said that activated patients cared about the cost of their care, and while I don't really want to get into the nuances of what an activated patient is, certainly that patient who has a financial interest, a health savings account owner, for example, in my estimation would be an activated patient. So that would be a patient who cared about the cost of care. In my experience as a physician, when someone came in and I recommended a test or procedure, the next question was, doctor, is it really necessary; doctor, is it safe. The next question was, doctor, does my insurance cover it. If the answer to that question was yes, there was very little other curiosity about anything else. So am I wrong in thinking that way?

Ms. DAMBERG. So let me give you a little story from California from where I hail. So——

Mr. BURGESS. Let us do real life, not California.

Ms. DAMBERG. Well, I think the example holds the rest of the country. So someone that I know needed to have cataract surgery, and he looked within a particular zip code and found variation in terms of the amount of money it would cost to do this procedure ranging from $3,500 to $11,000, and given that he is financially at risk for a portion of that payment——

Mr. BURGESS. Correct.

Ms. DAMBERG [continuing]. That starts to have significant implications.

Mr. BURGESS. And it is the activated-patient concept.

Ms. DAMBERG. Right, and I think what you see on the private sector side now is movement toward what is called referenced-based pricing, and so what health plans are doing on behalf of employers is going out and doing that work to try to understand these pricing differentials, make that available to consumers——

Mr. BURGESS. And it is probably better if the patient is involved in that, not the employer, and perhaps I will generate a written question for the record that I will ask you on that. Thank you.

Mr. CASSIDY [presiding]. The chair recognizes Mr. Sarbanes.

Mr. SARBANES. Thank you, Mr. Chairman.

Dr. Berenson, when do you think we realized, had this epiphany or it has been a slow process of gaining realization that we needed to start moving from this fee-for-service system to something different? I mean, how long have been kind of trapped in this old system even though we have been able to see that we have to move in a different direction?

Dr. BERENSON. Well, what is interesting is in fact two decades ago, it didn't have the label value-based payment but the system, when I was practicing medicine in the 1980s and into the 1990s, we had global payments as a common payment method. The U.S.

health care model that HMOs were paying doctors on the East Coast basically had pay-for-performance but with shared savings. Twenty-five percent of my capitation was withheld and I got it back only if the costs of my patients, all of their costs, were below a certain amount. So in fact, we have been doing these new payment models. I think it came a cropper because of the managed-care backlash and some problems. We then reverted back, I think, to the early part of the last decade to sort of traditional fee-for-service, traditional freedom of choice, and then once we got over that backlash and began to look again and said costs are really going up, there were a couple of seminal articles suggesting that quality wasn't terrific, I think we came back to those models.

Mr. SARBANES. I mean, one difference now is that the better management that you are trying to incentivize is going into the hands of the providers, or at least that is the hope and expectation here.

Dr. BERENSON. Well, I think that is right, although I would point to the California delegated capitation model has been alive and reasonably well—it had problems in the 1990s—for over two decades where providers, doctors, mostly, in control. That is what we are now trying to do in Medicare with ACOs, and I think that is a good idea. What is new, I think, in the last couple of decades is, we have much better data systems now to track performance and we actually do have the beginnings of quality measurement and beginning to focus on outcomes, which we did not have. One of the reasons for the managed-care backlash was the perception that at-risk medical groups had an incentive to stint on care and patients, members of health plans were concerned that they would get short-changed. We now have some ability to monitor that that is not going on. So I think we are in a better position to do what was tried a couple of decades ago.

Mr. SARBANES. Let me ask you this question. Obviously this transition is going to be a heavy lift and there is going to have to be a lot of research behind it in terms of changing these RVUs and coming up with new codes and everything, but if we could snap our fingers and know tomorrow what that new methodology would be based on all the research and everything, so you said we know what it is, now we have to deploy it, how long do you think it is going to take for that phase just to kind of—as a practical matter implement something if you already knew what it was today?

Dr. BERENSON. I see. I guess one of the decisions—there are a couple of sort of core decisions that would have to be made. One is, do we put in a payment system nationally that everybody is going to participate in or can we roll this out by region as different regions demonstrate an ability to move. If we have the flexibility to do the latter, I think then it is much easier to do. Some States and areas within States are really ready, I would argue, for really new payment models and new delivery. Other places are not. So that is one issue.

Another is the threshold question of whether we are providing options for physicians to opt into or whether we are going to make it mandatory. I think the different payment models probably call for a different answer to that one and maybe—in fact, I don't think ACOs should be required to have every physician in the commu-

nity. They would have credentialing criteria as to who really meets the expectations of the ACO. Maybe some docs would not be in. Other payment models like a bundled episode, I have trouble imagining that that would be sort of voluntary. I think if we find that it works, we are going to implement it. I don't know, 3 to 5 years would be my guess. If we knew today that this is where we wanted to go, I would say something like 3 to 5 years to put it in with—I would much prefer to do it on a regional rollout basis than on a national all at once.

Mr. SARBANES. That is helpful. Thank you. I yield back.

Mr. CASSIDY. Thank you, Mr. Sarbanes. The chair yields to Mr. Hall.

Mr. HALL. Mr. Chairman, thank you. I have been in another meeting and I don't know what questions have been asked, but I understand you usually allow us to write questions to them and ask them to answer them at a reasonable time.

Mr. CASSIDY. Yes, sir.

Mr. HALL. Two or three weeks?

Mr. CASSIDY. Correct.

Mr. HALL. Thank you, Mr. Chairman.

Mr. CASSIDY. The chair yields to Dr. Gingrey.

Mr. GINGREY. Mr. Chairman, thank you. I also have had to step out, and I apologize for that, but in the last panel with Mr. Hackbarth, I asked him about burdens to real reform, specifically IPAB, and I look to engage this panel on the same question. What administrative and legislative burdens are in place today, IPAB obviously a legislative burden as I see it, hinder the development of lasting reform and how can we proactively work to remove these barriers to achieve better patient outcomes at a lower cost? Let me start from right to left. Dr. Damberg, would you start? And then each one of you can respond to that in regard to specifically IPAB. I want you to address that.

Ms. DAMBERG. I am not sure I am qualified to talk about IPAB but in terms of other areas where I think federal regulations are getting in the way, I do think going back to the health information infrastructure, issues around privacy security, data sharing, having standardized data elements including a patient identifier are really handicapping our ability to measure patient care across providers longitudinally in the system.

Mr. GINGREY. Yes?

Dr. BERENSON. Well, I have—I am not quite sure I agree with you on IPAB. I agree to the extent that I don't think we need 15——

Mr. GINGREY. You heard my conversation with Mr. Hackbarth on the first panel?

Dr. BERENSON. Right. I don't think we need 15 experts from the outside who bring some special wisdom, but the concept of having the Secretary have the authority to—it is essentially putting Medicare on a budget and giving somebody the authority to recommend how to—where to cut mostly payment rates to accommodate those limits for some action, and I think more discrete action than just across-the-board arbitrary cuts, which will occur if a sequester goes in or which would have occurred under an SGR implementation, just we are going to whack all prices equally. Part of my testimony

was to make the point that I believe there are areas in the physician fee schedule to take that specific example where the prices far exceed the resource costs of production. I think there is an opportunity to do that. I think as a matter of normal business, CMS should be doing that, but if in fact we had to live within a budget limitation, I think it is not unreasonable that the Secretary would have the authority to——

Mr. GINGREY. Thank you. I didn't mean to cut you off, but Ms. Miller, did you have a response on that? Ms. Mitchell. I am sorry. Ms. Mitchell.

Ms. MITCHELL. I am also not prepared to comment on IPAB but I will tell you that what we——

Mr. GINGREY. Pull your mike a little closer, if you don't mind.

Ms. MITCHELL. Well, what we need most, I think, on the ground are resources, resources to actually support a data and measurement infrastructure and to support multi-stakeholder work, and the easy ability to integrate multi-payer, all-payer claims data with clinical data to give that feedback to physicians and to share that information with——

Mr. GINGREY. Well, I think you kind of avoided my question in regard to IPAB. I will let Mr. Miller have a shot at it.

Mr. MILLER. Well, I will not avoid your question, Dr. Gingrey. I think the fundamental fact that you have to keep in mind is that only 17 percent of Medicare spending actually goes to physicians. You can cut physician spending by 27 percent as was proposed to do in the SGR and you would only save a few percent for Medicare. But if you can actually have the physicians helping you save the rest of the other 83 percent, you can save an extraordinary amount of money in Medicare, and that is where I talked about at the beginning is all of those preventable hospitalizations, unnecessary procedures and tests can be saved. And I think the problem is, we continue to try to fix a broken system by trying to either we have—Congress has two choices. If spending is controlled by utilization times price, then you say, oK, we can either take things away from beneficiaries—we don't want to do that—or somehow we are going to cut the amount we pay to providers. Neither of those is a desirable approach, but if you can actually change the way that you pay physicians and ask them to come forward and say where can we save money without hurting patients, I think you can find tremendous opportunities.

When I go around and talk around the country, I give talks to physicians, and when I ask them, I say can you tell me where you can save money in Medicare, and I brought along examples. They all give me examples. I have pages and pages of examples from Maine, from Virginia, from Seattle telling me, and I can give you examples from other States where physicians tell me all the places where there are opportunities to be able to save money, and then I say and why aren't we taking advantage of those now, and they describe the barriers in the current payment system. So there are physicians I have found all over the country who would actually come forward and be able to significantly reduce Medicare spending if we give them the opportunity to do that. We are not going to achieve that by cutting their payment rates. If you thought that

a price of an airline ticket was too high, would you solve that by cutting the salary for the pilot? I don't think so.

Mr. GINGREY. Thank you, and thank you, Mr. Chairman, for your patience.

Mr. CASSIDY. The chair recognizes Mr. Griffith.

Mr. GRIFFITH. Thank you, Mr. Chairman. I like that point, Mr. Miller, that you made about bringing forward the physicians because oftentimes the people in the system can tell you how to solve those problems, and so I forward to working on that as one of the solutions.

I am going to switch to you, Ms. Mitchell. You described geographic disparities in quality and cost of care within your own State of Maine with vast potential for qualitative gains and cost savings if best practices are widely adopted, and I guess I am curious, how do you describe or how would you suggest that we achieve this geographic parity, and keeping in mind that I am also looking not just at specialties but the fact that I have a large rural district with lots of small communities. Some of my counties, you know, have less than the 5,000 people necessary to do one of those new bundling formats that we were talking about with the previous speaker.

Ms. MITCHELL. Well, I think the good news is that you don't need a lot of people to do this. Maine is equally rural, as I am sure you know, and what we were able to do was bring physicians, employers, patients together to look at the data and really look at the variation. We found opportunities to reduce, for instance, cardiac spending by $35 million just by getting to current best-practice levels within the State. This is not unattainable. It is actually being done. So when you facilitate not only that information being shared but then bringing those best practices to the other areas, there is a lot of learning. You need technical support. You need information. You need feedback loops. All of those can be done at the local level. We also found massive variation in early induction, and just by sharing that data statewide, we saw up to a 20 percent reduction in those rates because they understood that that needed to change and that what best-practice targets were. So sharing information in and of itself is a very powerful practice. It does not require an ACO to do that. It requires engagement and data with the physicians.

Mr. GRIFFITH. Which would be an amplification of what Mr. Miller was saying.

Ms. MITCHELL. Absolutely.

Mr. GRIFFITH. OK. And Mr. Miller, how do you encourage the physician buy-in, particularly in rural areas where you may not have sufficient numbers of docs to begin with?

Mr. MILLER. Well, I think there is two ways. First of all, you have to spend the time to help physicians understand the model and to be able to get the data that they need to understand how this will work for them. I found when I have done programs—and I did a program last fall for the Medical Society of Virginia. We had physicians from all over the State that came in and spent a day actually working through the payment models, episode payments, comprehensive care payments for chronic disease, and after they had a chance to work through them, we took a little straw poll at

the end and said so which model would you rather be in, the current model or this model, and almost unanimously they said the new model.

But then the question is, how will that work for me because it does come down to what is the price, and nobody actually knows today. They don't have the data to be able to do that. So if we can get them the data—and it is not just the data, it is actually turning it in to information. So simply handing a physician, you know, seven multimillion claim record files from Medicare is not the answer. They are going to need help and they need to get that help from some trusted local entity. The kind of thing that Elizabeth Mitchell runs in Maine is a place where physicians have a seat at the table and have the access to technical assistance that they trust, and then some assistance in being able to transform the way they deliver care.

And I think that if you then go to a rural area and you say, well, how will this work here and what tweaks do we need to be able to make in that model to make sure that it does work here, given that patients may have longer travel time, etc., but the flexibility of the model means that you can actually design a different system in a different place. You may say in a rural area we need to be able to do more telemedicine to be able to bring resources into unpopulated areas, then we can do something different in urban areas. So I think that is the real advantage of these flexible payment models is, they would actually give physicians the flexibility to design different care delivery systems that work in different communities.

Mr. GRIFFITH. Well, I appreciate that, and I would have to tell you that I am not surprised that if you went to talk with the Medical Society of Virginia that you got some interesting ideas. I served in the State legislature for 17 years and worked with them on a regular basis on a number of issues, and it is a good group of people who are out to solve problems, not just—they are looking out for their territory but they are also out to solve problems and they have always been that way. I appreciate it very much, and I yield back, Mr. Chairman.

Mr. CASSIDY. Thank you, Mr. Griffith, and the chair recognizes Ms. Capps.

Mrs. CAPPS. Thank you, Mr. Chairman.

I am going to pose my first question to Ms. Mitchell. Maybe there is time to have others weigh in on it because this topic has come up today with the previous person on the panel. Delivering high-value patient- or person-centered health care seems to be moving away from the traditional physician-based model to one involving a health care team including both physicians and non-physician providers. Arguably, too much of our discussion tends to be focused on doctors and SGR topics and not enough on the other professionals, and we know how critical they are to achieving high-value care. As we debate what comes next after SGR—I think we are all in agreement that we need to focus on what will come after it—their voices, the voices of these other providers I believe are critical to ensuring an efficient and effective model of care or models of care that take care of the whole person with that being our focus.

So my question is—and I can see others nodding so if you could go quickly and each make a short response to this, I would like to

have you all be on the record on this topic if possible. So the question is, how do we ensure that non-physician providers are appropriately engaged and appropriately valued as we move forward with new delivery and payment systems? I will start with you, Ms. Mitchell, because I had directed it to you, and then Mr. Miller, Dr. Berenson and Dr. Damberg if you would like to comment too.

Ms. MITCHELL. I think one of the most promising developments in any of these new models is the patient-centered medical home, as I am sure you know.

Mrs. CAPPS. Yes, I am a big champion of it.

Ms. MITCHELL. That is absolutely about team-based care.

Mrs. CAPPS. In fact, some have said it should not be a medical home, it should be a health home because it is positive.

Ms. MITCHELL. I like that. And I will say that one of the most effective members of that team is the care manager based in the practice, not a physician, usually a nurse but another key team member who actually makes sure care is coordinated and managed. We are also——

Mrs. CAPPS. Over time, you mean?

Ms. MITCHELL. Over time, absolutely, and in the community. We are also implementing community care teams for high-needs patients. We work with Dr. Brenner on hot-spotting. Who are these people? What supports do they need? Early, early anecdotal evidence, well, actually data-driven evidence is showing 40 percent reductions in some of their spend if they get the right care at the right time. These are not physicians. These are community-based multi——

Mrs. CAPPS. I can only imagine there might be some resistance from some, so let me hear a quick comment from Mr. Miller.

Mr. MILLER. Congresswoman, I ran a project in Pittsburgh to try to reduce readmissions for chronic-disease patients, and we made a variety of changes in the hospital and physician practices but the most critical change by far was, we hired a nurse who could actually follow the patients and go and make home visits to them, and we had a 44 percent reduction in chronic-disease readmissions to the hospital.

Mrs. CAPPS. I am so glad we are getting this on the record.

Mr. MILLER. But the only way we were able to actually hire those nurses is, we got a grant from a local foundation to pay for them, and at the end of the project we had to lay off one of the nurses because no health plan would pay for it. Medicare does not pay for it. We were fortunate enough that in one case, the hospital was willing to pick up that nurse to be able to continue to work with the PCPs and the patients. That is the issue, flexibility of the models. I think when I talk to physicians all over the country, they would love to be able to hire a nurse to be able to do this work. They are not reimbursed for it.

Mrs. CAPPS. Mr. Chairman, in response to this, I surely hope this is a topic that we can continue to engage in. I don't pretend to have the answers, and just because I am a nurse and certainly do appreciate your comment, Mr. Miller, it isn't just about nurses, and you being a doctor, I know you can understand that it is really about who we are focusing on in this kind of model.

Mr. MILLER. I would also just add quickly, the nurse worked with the physician.

Mrs. CAPPS. Of course.

Mr. MILLER. The nurse did not work for a health plan, was not working on some disconnected basis. They were working as part of a team with the physician so they added that critical element that the physicians could not do on their own.

Mrs. CAPPS. And reduce the cost that much. Wow. Dr. Berenson?

Dr. BERENSON. Three quick points. One is that fee-for-service is really a problem because if somebody has to make a rule as to a nurse practitioner working incident to or independently and they are arbitrary and they don't work.

Mrs. CAPPS. There is a lot to work out. That is why this is going to take even from us, and there are other people who will want to weigh in, a lot of discussion, many hearings hopefully on this topic.

Dr. BERENSON. Secondly, I have just completed doing a number of interviews around advanced primary care. Some people prefer that term to either health home or medical home. There was a focus group that said—a woman said let's see, medical home, funeral home, is that what you are talking about? Nursing home, funeral home. So there is a labeling issue I don't think we have to get into, but the docs all said the real advantage that they have gotten as part of the multi-payer advance primary care was being able to hire a care manager/nurse to work with the really frail seniors and keep them out of the hospital. And the final thing, very simply is if we have a global payment to an organization, they can decide who the personnel should be, and I think nurses and other non-physicians will do very well in that calculation. It is not somebody in Baltimore or Washington telling them what their mix of staffing would be.

Ms. CAPPS. And I might even say maybe that person is the right one to decide it but there might be somebody else too, but certainly local rather than some other place.

And I know I am out of time but because I think I might be the last person to ask questions, would you mind? I would just love to get the fourth viewpoint on this. Thank you.

Ms. DAMBERG. I would echo Mr. Miller's comments. One of the things that I have seen in California, there is the Center for Medicare and Medicaid Services Innovation Grants going on.

Mrs. CAPPS. Yes.

Ms. DAMBERG. Some of those involve the use of nurse case managers and other personnel, and one of the things—those models are supposed to be kind of self-sustaining over time.

Mrs. CAPPS. That is the challenge.

Ms. DAMBERG. I think the focus right now in those projects is, you know, is Medicare going to change its payment policy such that we can continue to hire these personnel beyond the life of this project.

Mrs. CAPPS. That might be the very next subject for a hearing, not that it would be my decision but it might be a suggestion that is coming apparently from this team, so I yield back my time. Thank you.

Mr. CASSIDY. Dr. Gingrey has a quick question or comment.

Mr. GINGREY. Mr. Chairman, a unanimous consent request to briefly ask of Mr. Miller. At the end of my line of questioning, you had indicated there were some barriers to these multitude of ideas that you have showed us in your legal papers in regard to physicians not being able to share that information that you have gleaned. If you would submit to the committee maybe a list of some of those impediments to them being able to share that information because I think it would be very, very helpful to us as we go forward?

Mr. MILLER. Well, the barriers are for them to actually implement the changes that would be necessary but I would be happy to share those. I think you would find it very insightful to see the range of different opportunities for savings the physicians identify, but it all comes back in many cases to the payment system that does not actually allow that to happen. It is not an issue of incentives, it is the fact that there are genuine barriers and restrictions like the fact that a nurse does not get paid for today. That is a barrier.

Mr. GINGREY. Yes, and so within a week or two if you could do that, I would appreciate it.

Mr. Chairman, thank you very much.

Mr. CASSIDY. Thank you. The chair recognizes Mr. Bilirakis.

Mr. BILIRAKIS. Mr. Chairman, I appreciate it very much, and I want to thank Chairman Pitts and Chairman Upton for giving me the opportunity to serve on this very important committee.

I have a couple questions. The first one would be for Mr. Miller. I know you touched on this somewhat, but discuss the importance of defining special, specific outcome-based quality measures. What strategies do you propose to determine these measures?

Mr. MILLER. You are directing that to me?

Mr. BILIRAKIS. Yes.

Mr. MILLER. So I think that as the committee has recommended, I think that physicians are in the first, best position to be able to identify what some of those outcome measures should be. I think then there should be a multi-stakeholder process for looking at that and saying are those the right things to ask consumers whether that deals with the kind of things that they are looking at. I do think that what we have to do is to start moving more to outcome measures and particularly to patient-reported outcome measures. Dr. Damberg talked about that in her testimony. But in order to be able to do that, you have to have some infrastructure in a local community to be able to actually survey the consumers and ask them, and that is where is having a trusted entity, a multi-stakeholder collaborative in the community that can actually do that work, to be able to do the surveying of the patients, to be able to do it reliably and then be able to report that in an accurate and objective fashion I think is critical to being able to assure everybody that in fact the care is improving and that you are getting the value for what you are paying for.

Mr. BILIRAKIS. Thank you very much.

Next question for Ms. Mitchell. Can you discuss the opportunities for better care and financial savings through use of the community care teams and the hot-spotting that you mentioned in your testimony? Is this a strategy that you foresee being scalable to different

community demographics such as rural, urban and suburban, et cetera?

Ms. MITCHELL. Certainly, I think it is imminently scalable and it is probably not even that expensive because these are teams of nurses or even laypeople at some times. But what we are finding is that the key drivers for the heavy, heavy utilization are often mental health issues and substance abuse issues and other social determinants of health. So to be in the community and understand what the barriers are to these people actually getting better and not having to return to the hospital over and over again, it is not high tech, it is really working with the individuals, and I think it is not only scalable but really urgent to do exactly that.

Mr. BILIRAKIS. Very good. Thank you.

Thank you, Mr. Chairman, I yield back the balance of my time.

Mr. CASSIDY. The chair recognizes Mr. Green.

Mr. GREEN. Thank you, Mr. Chairman. Again, I want to thank the entire panel for being here today, and some of you may have heard my questions earlier of our first panel, and I would like to hear both from Ms. Mitchell and Dr. Berenson if there would be anything different. How do we measure the quality accurately in a way that avoids a one-size-fits-all approach and put the patients first and avoids the endless complexity that could develop if we build too much flexibility into a system?

Ms. MITCHELL. Thank you. I think you have heard repeatedly, and I certainly concur that outcome measures are the holy grail, but also we really need to think about functional status measures: is someone healthy, can they participate in their daily life effectively. So functional status measurement absolutely needs to be further developed and disseminated. Patients really care about patient experience, and that is somewhat different than patient satisfaction. It is really, did they get the care they needed, did they understand their role in continuing to manage their own health. So patient experience is equally important. I really have to say, though, that cost and resource use are equally important. We need to understand, are resources being used effectively for patients and for communities. So I think it is a combination of all of those different types of measures that really get a view at an accountable system.

Mr. GREEN. Dr. Berenson?

Dr. BERENSON. I would make a different point, which was in my testimony. I was emphasizing that there are some major gaps in what we measure and what I would argue that we can potentially measure in terms of at the individual physician level of what we want to measure. So, for example, for a surgeon, I think what we really care about is technical skill and judgment in deciding when a patient needs to go to the OR and what procedure they might need. I mean, we don't have measures of that so what we do measure is relatively small stuff—did the hospital give antibiotic prophylaxis before surgery. I think we have to recognize that there are some very important things we can't measure. We will get a much better job if we move towards outcomes rather than just relying on these kinds of processes.

And the other point I would make, I think in agreement with everybody here, is the one thing that is ubiquitous in all physician

or hospital experiences is the patient's experience with care, and I think we can be—I think while we have these large gaps in what we can measure and while we are working on an outcomes agenda, I think patient-reported outcomes and patient experience is really the one thing that applies across the whole system, and that is where I would be putting my emphasis at this point.

Mr. GREEN. It seems like, you know, I know we have discussed this for a number of years and we have some almost laboratories in certain areas, whether it be in Pennsylvania where the chair of the subcommittee is from and Geisinger and Kaiser Permanente in California, are we actually learning now from their experiences on moving to that outcome-based in some of those? I know there are other ones in the country. Those are the two that come to mind. Seeing some of those indicators that we would need to do, what Congress needs to do, you know, to put into law so we could do it with that experience we are hearing, is that positive or negative or——

Mr. MILLER. Well, I would just say, you mentioned Geisinger, for example. There is a perfect example of a provider organization that agreed to take accountability for outcomes and said that we will have a single price for all the costs of care associated with a particular procedure or condition including maternity care. What they did was, they developed themselves a whole series of quality measures internally to look at, but they controlled them because they were accountable for the outcome. It wasn't some external entity saying here is what you should do to make the cardiac bypass surgery work well, and because they were in control of them, they could manage them, they could decide which of them did not work and did work and adapt them.

The problem that we have and one of my great fears is that when we start to create more and more and more quality measures, particularly process measures that are imposed by payers or by Medicare or whatever as part of pay-for-performance, we are locking in the old style of practice, and in fact what we want to do is to be able to unleash the creativity and the judgment of physicians to be able to say if it isn't working, what do we need to change to be able to make it better. People talk about evidence-based medicine but where did the evidence come from in the first place but some physician who actually figured out how to be able to make it work, and we shouldn't then say that whatever they discovered 10 years ago is as best as it is ever going to be. We should say if you can continue to improve, and I think that is what these different kind of payment models will allow is the flexibility to actually continue to improve rather than being locked into the old way of doing things.

Mr. GREEN. Thank you, Mr. Chairman.

Mr. CASSIDY. Thank you, and the chair now recognizes himself.

I have incredibly enjoyed this testimony. Mr. Miller, we are intellectual brothers from a different mother, and so I just want to tell you——

Mr. MILLER. I am delighted to hear that.

Mr. CASSIDY [continuing]. Each of you have a standing invitation to call me for dinner and I will treat because I would just love to pick your brain.

Let me go a little bit. I couldn't find it in your testimony but I think I recall you saying that these models that we should allow to bubble up should also include specialty societies. Frankly, the paradigm most speak of is primary care. It is a little bit threatening, though, to the neurosurgeon that thinks that she may be doing a great job but maybe iced out because of whatever reason. How in your thinking could a specialty society evolve into one of these models?

Mr. MILLER. Well, I did not say that the primary care should be threatening. I think that the issue is that we are in fact putting excessive burden on primary care physicians to somehow fix everything about the cost and quality of health care when we do these models. I have talked to specialty physicians all over the country in a variety of different specialties and these examples that I cited have examples from every specialty—gastroenterology, infectious disease——

Mr. CASSIDY. Let me ask you, if there is going to be a global payment for population, then that almost implies that there has got to be somebody——

Mr. MILLER. I think you are jumping too quickly to saying it is only global payment. My point is in fact that I think that there should be different payment models that are specialty specific so if a gastroenterologist says I can do a better job of managing inflammatory bowel disease, they should be able to do that if they can improve quality and reduce costs.

Mr. CASSIDY. And they would in turn contract with either the primary care or with someone——

Mr. MILLER. With whoever would be appropriate. I mean, in many cases I think gastroenterologists, to take the inflammatory bowel disease example, would be ones they would actually serve as the medical home for those patients because that is such a dominant condition.

Mr. CASSIDY. Yes, I understand that.

Mr. MILLER. Then what you can do is, you can——

Mr. CASSIDY. Let me pause you for a second because I get that, and you may know I am a gastroenterologist, so you just hit my sweet spot.

So next, now, Dr. Damberg, you mentioned that there is difficulty coming up with meaningful measures, and both you and Mr. Miller comment on how we are currently measuring processes, but it really seems to me that if you give somebody a global payment, as an example, and they know that in order to improve outcomes and increase profit, they should reduce hospitalizations, as long as you have the kind of quality measures Dr. Berenson spoke of which keeps them from skimping on care almost by judging them on that outcome, you are going to get a better product. Does that make sense? Will it take care of itself if we go to the correct payment model?

Ms. DAMBERG. So my remarks, if you look at my longer testimony, really focus on getting to a set of defined outcome measures, that that should be the focus to the extent that you are going to devise a new system of payment for providers that holds some portion of it at risk for performance on a set of indicators. Outcome measures are going to be more stable over time but it is going to

be critical to get physicians at the table to define what those outcome measures are.

Mr. CASSIDY. I accept that, but on the other hand, if you know that the hemodialysis patient who doesn't crash into dialysis but glides past down, who gets their thrombosis removed as an outpatient as opposed to an inpatient—we could go through other examples—is actually going to have better care and is going to be lower-cost care, as long as we know that they are actually getting dialyzed, they are not skimping and we have some audit—Dr. Berenson, you had mentioned this—it seems as if by judging that outcome, you almost take care of the processes.

Ms. DAMBERG. I think that that is right because what you are letting the system do is self-correct. So one of the things that I have observed under the Medicare Advantage program because they are getting ready for 2015, the quality bonus payments that are kicking in, that will only reward health plans that have four or five stars, there is a huge amount of what I am calling anticipatory behavior going on where the health plans and the physician groups are working very proactively to ensure——

Mr. CASSIDY. To get their stars up.

Ms. DAMBERG. Exactly. And so——

Mr. CASSIDY. I get that. Can I move on?

Ms. DAMBERG. It is to that north star. They will work toward it.

Mr. CASSIDY. Now, let me ask Miller or Mitchell, if you will, you mentioned this regional coordinating thing, which really seems really good but it is going to take—you all took a lot of effort to put that together. I keep on thinking that you have this MA set of systems and the MA plans actually have all this data—they know how to market, they know how to bill, they know how to coordinate care, and they know from what bundle of care somebody is going to give you a certain quality and cost. It almost seems like you could allow that small group to contract with them to provide those services, not in a traditional MA plan but rather mainly as, you know, a management program, if you will, a data management program and perhaps a provider of reinsurance. Any thoughts on that?

Mr. MILLER. I think what you will see increasingly in the future is a complete flip. You will not have doctors being subcontractors to health plans but health plans being subcontractors to physicians to provide the services that they need. In fact, if you look around the country, there is only 11 Medicare Advantage plans in the country that are five stars, 10 of them are provider owned, and most of the 4.5- star plans are also provider owner. So I think there is that opportunity to do that, and I would say that the Louisiana Health Care Quality Forum is a multi-stakeholder collaborative in Louisiana that is working on trying to do this. What all the collaboratives have is the problem of getting any recognition from the federal government that they exist and to be able to give them the support to be able to work with physicians.

Mr. CASSIDY. Now, if you do the subcontracting with the MA plan, it almost seems as if you supplant the need for a public entity but rather you have a private entity that can then take that role.

Mr. MILLER. You could conceivably have a situation in the future where you have provider-driven plans selling policies to patients

and you would not have a traditional Medicare fee-for-service at all anymore.

Mr. CASSIDY. OK. You all have been very helpful. Let me dig out and say what I am supposed to say at the very end.

Thank you all. At this time I would like to ask unanimous consent to have a statement from the American Medical Association and the American College of Physicians included in the record. Without objection, so ordered.

[The information appears at the conclusion of the hearing.]

Mr. CASSIDY. I remind members that they have 10 business days to submit questions for the record, and I ask the witnesses to respond to the questions promptly. Members should submit their questions by the close of business on Thursday, February 28.

Without objection, the subcommittee hearing is adjourned. Thank you again.

[Whereupon, at 1:32 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

February 13, 2013

The Honorable Joe Pitts
Chair
House Energy and Commerce Health Subcommittee
U.S. House of Representatives
Washington, DC 20510

Dear Chairman Pitts:

On behalf of the National Partnership for Women & Families I am writing to express concern about the provision in the SGR replacement proposal being circulated by the Committee that would base Medicare performance payment on physician-endorsed measures of quality without any role for a multi-stakeholder consensus process. The National Partnership represents women across the country who are the health care decision-makers for their families and as such want to ensure that the care they and their families receive is of the highest quality. Key to achieving this is ensuring that quality measures are developed with input from a broad array of stakeholders – including consumers.

The National Partnership, along with a number of other consumer organizations, has been consistently engaged in multi-stakeholder collaborative processes to develop, evaluate, endorse, and recommend performance measures for use in CMS quality reporting and payment programs. We have worked tirelessly with purchasers, payers, providers, consumers and other stakeholders to support efforts to improve health care quality and outcomes while at the same time getting better value for the health care dollar. The goals and priorities outlined in the National Quality Strategy reflect the multi-stakeholder consensus that a patient-centered health care system will lead to improved health, improved care delivery, and lower costs.

We support a number of elements in the Committee's SGR reform proposal, including 1) rewarding physicians who deliver high quality and efficient care, rather than continuing the current system that encourages volume and unnecessary spending; and 2) providing timely feedback and data to physicians to allow for quality improvement. We are extremely concerned, however, that the proposal would give sole responsibility to medical specialty societies to develop and select quality measures, and base payment on measures of performance that do not reflect the concerns and needs of patients for whom we need to improve care and outcomes. This reliance on specialty societies would be a huge step backwards in our efforts to engage consumers in making effective decisions and supporting high value care. It also places a significant burden on the medical community, given the expensive and time-consuming nature of measure development. Currently both the Medicare

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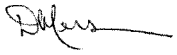
and Medicaid programs use measures that have been developed by a range of entities – NCQA, the VA, the CDC, the Joint Commission, AMA-PCPI, various physician and health professional organizations, research institutions and others. Limiting the measures CMS can use in the Medicare program only to those developed by the medical societies would reduce our ability to foster alignment between the public and private health care sectors.

Rather than create more consistency of measurement across providers and settings, this approach will likely result in other payers, plans and purchasers implementing their own measures, thereby creating a cacophony of measurement that increases the burden for clinicians, increases the cost of data collection, impedes systemic improvement in quality and resource use, and increases confusion for consumers.

It is critical that the process for creating, evaluating, recommending, and implementing quality metrics for the purposes of improving care and tying payment to quality include a broad range of health care stakeholders, including consumers. The National Quality Forum consensus development process for evaluating and endorsing quality measures, and the pre-rulemaking advisory process enabled by the Measure Applications Partnership, reflect strong multi-stakeholder efforts and consensus building. These processes permit wide vetting of the measures by multiple stakeholders based on criteria for importance, validity, solid evidentiary base, and usability. Involving these multiple stakeholders in the approval process helps assure the broad acceptance of the measures for use by both public and private payers and by consumers.

We believe there is a way to include all stakeholders in this process and I would be happy to talk with you further. Thank you for the opportunity to provide input on this proposal.

Sincerely,



Debra L. Ness
President
National Partnership for Women & Families

STATEMENT

of the

American Medical Association

for the Record

House Energy and Commerce Committee
Subcommittee on Health

RE: SGR: Data, Measures and Models;
Building a Future Medicare Physician Payment System

February 14, 2013

Division of Legislative Counsel
202 789-7426

Statement of the

American Medical Association

for the Record

House Energy and Commerce Committee
Subcommittee on Health

RE: SGR: Data, Measures and Models;
Building a Future Medicare Physician Payment System

February 14, 2013

The American Medical Association (AMA) is thankful to Chairman Pitts, Ranking Member Pallone, and all of the Members of the Subcommittee for holding this hearing today on *SGR: Data, Measures and Models; Building a Future Medicare Physician Payment System*. We applaud your leadership in advancing Medicare physician payment and delivery reform efforts.

The AMA also appreciates the opportunity to present our views to the Subcommittee today. We now have a unique opportunity to improve and restructure care delivery and payment policy for patients across the country. Many ground-breaking innovations are already underway, and it is critical that we continue on this path. Yet, successful reforms must rest on a strong Medicare physician payment foundation. Therefore, it is imperative that the flawed Medicare physician payment formula, known as the sustainable growth rate (SGR), be repealed and replaced with an alternative, more viable system. The SGR has been plaguing patients and physicians in Medicare and the TRICARE military health program for over a decade, and its repeal is long past overdue. Now is the time to end this failed policy once and for all and protect access to care for seniors now and in the future. The Congressional Budget Office (CBO) recently estimated that the cost of permanently replacing the SGR has decreased dramatically. The new cost of freezing payments for ten years is $138 billion, more than $100 billion less than the previous projection. The rate of Medicare spending growth declined compared to historical trends, and spending for physician services affected by the SGR is projected to be far less than previously estimated. **We urge the Subcommittee and Congress to take advantage of the fact that the cost of repealing the SGR is lower than it has been in many years and move promptly to replace the formula with a new system that encourages quality care while reducing costs.**

As the Subcommittee explores effective options for new payment and delivery reform models that can form the basis for a new Medicare physician payment system, the AMA is pleased to submit to the Subcommittee the attached white papers developed by the AMA's Innovators Committee. Formed in June 2011, the Innovators Committee is a group of innovative physicians tasked with developing resources to help their colleagues from various specialties implement effective delivery and payment reforms that are applicable to their practice setting and service mix. Two early resources developed by the Innovators Committee to facilitate payment and delivery reform models include:

- *The Case for Delivery Reform—Implementing Innovative Strategies in Your Practice*, which offers practical guidance to physicians on how to implement delivery reforms by describing their own experiences in the form of case studies.

- *Physician Payment Reform—Early Innovators Share What They Have Learned*, which assesses the strengths and weaknesses of various payment models and offers practical implementation guidance for physicians.

The Innovators Committee will continue its important work and outreach to physicians across the country by sponsoring a series of seven webinars (see below) that will offer practical guidance to physicians on how to implement payment and delivery reforms. These webinars, the first two of which were held in 2012, will continue through the first half of 2013.

1. Here It Comes…Delivery Reform, Payment Reform, and Everything In between (November 27, 2012). Archived at https://cme.ama-assn.org/Activity/1263282/Detail.aspx
2. You Can't Do It All So Don't Try: Optimizing Practice Workflow to Increase Value (December 11, 2012). Archived at https://cme.ama-assn.org/Activity/1284669/Detail.aspx
3. Is Employment the Only Alternative? Improving Care Coordination through Clinical Integration (January 31, 2013)
4. Do I Need a Statistician? Benchmarking Practice Performance to Achieve Value (February 27, 2013)
5. Delivery Reform Implemented? Payment Models that Reward Your Performance (April 2, 2013)
6. Building New Payment Models and Getting Paid (TBD)
7. The Final Piece of the Puzzle: Customizing the Payment Model to Fit Your Practice (TBD)

The AMA appreciates the opportunity to provide our comments on these critical matters, and we look forward to working with the Subcommittee to repeal the flawed SGR formula and assist in the transition to a new health care payment and delivery system that provides more coordinated care, improves health outcomes, and slows the growth of costs in the Medicare program.

Summary of Statement for the Record
American College of Physicians
Hearing before the House Energy & Commerce Subcommittee on Health
"SGR: Data, Measures and Models; Building a Future Medicare Physician Payment System"
February 14, 2013

A FRAMEWORK TO REPEAL THE SGR AND PROGRESS TO BETTER MODELS
ACP supports a two-phased approach to eliminate the SGR and transition to better payment and delivery systems that are aligned with value. During phase one, repeal the SGR formula, provide at least 5 years of stable physician payments, with positive increases for all physician services, and higher payments for primary care, preventive and care coordination services; and in phase two establish a process for practices to transition to new, more effective, models of care by a date certain. ACP is encouraged that this committee's SGR proposal, as released jointly with the Ways & Means Committee on February 7th, is largely consistent with this approach.

REFORMING FEE FOR SERVICE AND TRANSITIONING TO VALUE-BASED PAYMENT
ACP supports shorter term reforms to start more physicians on the road to better payment models, and reward "early adapters" who already have taken the leadership to participate in payment programs focused on higher quality, improved patient experience, and greater value. This includes development and recognition under Medicare fee-for-service payment polices of two new sets of CPT codes for transition care following a facility-based discharge and for chronic, complex care. These code sets are designed to allow physicians to report their non-face-to-face time, and the clinical staff (team) time spent on patient cases.

Create opportunities for performance based payment updates based on successful participation in an approved transitional value-based payment program initiative that meets standards relating to the effectiveness of each program, building on successful models in the public and private sectors.

THE ROLE OF PERFORMANCE ASSESSMENT IN A REFORMED HEALTH CARE SYSTEM
Existing Quality Improvement (QI) programs such as Medicare PQRS, e-RX, and meaningful use programs must be better aligned with each other, with private payer initiatives, or with specialty boards' maintenance of certification programs. While strides have been made in aligning the measures, at a high level, the technical requirements within each of the programs are different enough that dual processes must be undertaken.

Improve CMS's ability to provide timely data to participating physicians and practices, which is critical to enable physicians to make adjustments to improve patient care.

In 2012, ACP released a paper titled, *The Role of Performance Assessment in a Reformed Health Care System*,[1] in which we laid out a series of policy statements focused on the evolving roles of performance assessment efforts within the realm of medical care, including programs linking payments to reporting and performance on specific quality measures.

SPECIFIC PAYMENT AND DELIVERY REFORMS THAT CAN SERVE AS THE BASIS FOR A NEW MEDICARE PAYMENT SYSTEM
The patient-centered medical home (PCMH) should be scaled up for broad adoption within Medicare. The PCMH model 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 though all stages of life. Other promising care coordination models include: medical home "neighborhoods," Accountable Care Organizations (ACOs), and bundled payments.

A LEGISLATIVE PATHWAY TO ACHIEVING COMPREHENSIVE PAYMENT AND DELIVERY SYSTEM REFORMS
ACP supports bipartisan legislation, the Medicare Physician Payment Innovation Act (H.R. 574), that has been introduced in the 113th Congress that provides a reasonable pathway toward achieving a phased-in approached to repealing and reforming the SGR, permanently.

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[1] This paper can be accessed at: http://www.acponline.org/advocacy/where_we_stand/policy/performance_assessment.pdf.

FRED UPTON, MICHIGAN
CHAIRMAN

HENRY A. WAXMAN, CALIFORNIA
RANKING MEMBER

ONE HUNDRED THIRTEENTH CONGRESS

Congress of the United States
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March 13, 2013

Mr. Glenn M. Hackbarth
Chairman
Medicare Payment Advisory Commission
425 Eye Street, N.W., Suite 701
Washington, D.C. 20001

Dear Mr. Hackbarth:

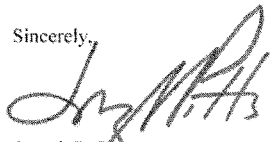
Thank you for appearing at the Subcommittee on Health hearing entitled "SGR: Data, Measures, and Models; Building a Future Medicare Physician Payment System."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for 10 business days to permit Members to submit additional questions to witnesses, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please e-mail your responses, in Word or PDF format, to carly.mcwilliams@mail.house.gov by the close of business on Wednesday, March 27, 2013.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,



Joseph R. Pitts
Chairman
Subcommittee on Health

cc: Frank Pallone, Jr., Ranking Member, Subcommittee on Health

Attachment

Responses to Questions for the Record
Committee on Energy and Commerce—Health Subcommittee
Hearing on "SGR: Data, Measures, and Models; Building a Future Medicare Physician Payment System."
February 14, 2013

Question from the Honorable Joseph R. Pitts

We understand that in developing the Medicare Advantage (MA) rates each year, CMS assumes that the SGR will produce a physician fee cliff in the coming year. The agency does not take into consideration that the Congress takes action every year to eliminate the cliff. This policy has negatively impacted MA rates and the benefits and premiums plans can offer to beneficiaries. From your understanding, is there a statutory reason that compels CMS to make this assumption?

MedPAC does not have expertise in interpreting legal language, and thus we cannot opine on the statutory requirements that CMS must follow in setting the Medicare Advantage (MA) rates each year.

Along with physicians and other health professionals, MA plans experience great uncertainty in their payment rates as a result of the SGR formula. This uncertainty of rates is yet another reason that the Congress should immediately repeal the SGR.

Questions from the Honorable Renee Ellmers

1. **During the question posed to you by Representative John Dingell (D-MI), you indicated that curbing excessive imaging is one of short-term ways to improve care and reduce waste in the Medicare system. In light of the fact that advanced diagnostic imaging services have been cut 12 times since 2006, what further imaging reimbursement policies would you reduce to curb "unnecessary imaging procedures?" What specific data (please include line-by-line or specific code analyses) can you provide in support of such policies? Would MedPAC consult with practicing radiologists and include their input when developing these policies?**

Despite decreases in 2011 and 2010, the use of imaging services remains much higher than a decade ago.[1] Cumulative growth in the volume of imaging from 2000 through 2009 totaled 85 percent, compared with a cumulative decrease in imaging volume in 2010 and 2011 of less than 4 percent. From 2000 through 2009, imaging volume grew more than twice as fast as evaluation and management (E&M) services and major procedures. Meanwhile, physicians and others continue to raise concerns about overuse of imaging[2,3,4,5,6,7,8], and the risks associated with unnecessary imaging.[9,10,11,12]

The Commission believes that reducing waste in Medicare requires implementing delivery system reforms that move away from fee for service (FFS) and encourage high quality, and more efficient provision of care. These reforms include medical homes, bundling, and accountable care organizations (ACOs) under which provider organizations assume clinical and financial responsibility to care for a defined population.

Recognizing that Medicare is likely to continue using its current flawed FFS payment system for some years in the future, the Commission has also made several recommendations to improve payment accuracy for imaging services and ensure that they are used appropriately. Some of these recommendations—discussed below—have not yet been implemented.

First, CMS should work with the American Medical Association/Specialty Society Relative Value Scale Update Committee to accelerate and expand ongoing efforts to combine into a single payment rate multiple discrete services often furnished together during the same encounter.[13] This recommendation applies to the physician fee schedule (PFS). For example, radiopharmaceuticals could be combined with their associated imaging services into a single code, as is done in the outpatient prospective payment system. The payment rate for these comprehensive codes should reflect efficiencies that occur when two or more services are provided together. In 2011, for example, CMS adopted relative value units (RVUs) for new comprehensive computed tomography (CT) codes that included CT of the abdomen and CT of the pelvis. The RVUs for the comprehensive codes accounted for efficiencies in physician work and practice expenses that occur when the component CT studies are performed at the same time.

Second, the Commission recommended that the multiple procedure payment reduction (MPPR) policy under the PFS apply to both the technical component and professional component of all imaging services.[14] The MPPR accounts for efficiencies in practice expense and physician work that occur when multiple services (such as MRI of the head and MRI of the neck) are performed in the same session. In response to our recommendations, CMS has developed MPPR policies for the technical and professional components of CT, MRI, certain ultrasound, and nuclear medicine studies. The analyses conducted by CMS to support these payment reductions are discussed in the proposed and final rules for the physician fee schedule for 2006 and 2012. The Commission supports expanding the MPPR to additional imaging services to account for efficiencies that occur when multiple studies are performed in the same session. Given that there are efficiencies when CT, MRI, certain ultrasound, and nuclear medicine studies are provided together, it is reasonable to expect that similar efficiencies occur when other imaging services (e.g., other ultrasound, X-rays, and fluoroscopy) are furnished in the same session.

Third, Medicare should reduce payment rates for imaging and other diagnostic tests paid under the PFS when the same practitioner orders and performs the test because there are some efficiencies that occur in these cases.[15] The work involved in interpreting a test may duplicate activities that have already been performed by the referring practitioner, such as reviewing the patient's history, medical records, symptoms, medications, and the indications for the test. If the physician who performs the test is the same one who ordered it, the physician should have already obtained and reviewed much of this information during an E&M service. Accounting for these efficiencies should reduce the financial incentive for physicians to self-refer for imaging.

Fourth, Medicare should establish a prior authorization program for practitioners who order substantially more advanced diagnostic imaging services than other physicians who treat similar patients.[16] The rapid volume growth of advanced imaging services (MRI, CT, and nuclear medicine) over the past decade and questions about appropriate use justify the development of a targeted prior authorization program in Medicare. Such an approach would ensure that outlier physicians are using advanced imaging services appropriately without subjecting all practitioners to prior authorization. A prior authorization program should target advanced imaging services that account for a significant share of spending and volume, have evidence-based standards for appropriate use, and exhibit variations in utilization among providers and geographic areas.

Finally, we frequently meet with associations representing radiologists and other physicians who use imaging services, such as the American College of Radiology and the American College of Cardiology. We consider their input in developing our recommendations.

2. **You consistently cite that the primary reason behind high imaging utilization rates is that these services are overpriced. How could advanced imaging services still be overpriced when these services have been cut 12 times since 2006 through such policies as the Deficit Reduction Act of 2005, the CMS Physician Practice Information Survey (PPIS), the professional component multiple procedure payment reduction, and the increase in the equipment utilization assumption rate as stipulated by the recently enacted American Taxpayer Relief Act? Is the ultimate goal of MedPAC to eliminate in-office imaging, thus forcing all Medicare patients to receive imaging services in the hospital setting?**

In addition to mispricing of services, many factors appear to be driving the growth of imaging:

- technological innovation and new clinical applications,
- changes in the population and disease prevalence,
- incentives in Medicare's fee-for-service payment system to increase volume,
- defensive medicine,
- consumer demand,
- physician self-referral, and
- the increase in hospital employment of physicians, which has contributed to the growth of imaging in hospital outpatient departments (OPDs).[17]

Between 2005 and 2012, the Congress and CMS made several changes to PFS payment rates for imaging services. Nevertheless, the Commission believes there are still opportunities to improve payment accuracy for several reasons. For example, the PFS does not account for certain efficiencies that occur when certain imaging services are provided during the same encounter or when the same practitioner orders and performs an imaging study. Payment rates should be adjusted to reflect these efficiencies (see the recommendations discussed in response to question 1 above). MedPAC's goal is not to eliminate in-office imaging. Rather, our goal is to improve the overall accuracy and equity of the PFS, and reduce financial incentives for physicians to order imaging inappropriately.

We are also concerned about the migration of cardiac imaging services from physicians' offices to the higher-paid OPD setting, caused in part by the growth in hospital employment of cardiologists. This shift towards OPDs results in higher program spending and beneficiary cost sharing without significant changes in patient care. From 2010 to 2011, for example, the share of echocardiograms provided in OPDs increased by about 13 percent and the share of nuclear cardiology tests provided in OPDs increased by about 15 percent. If these services continue to migrate to OPDs at the same rate from 2011 to 2021, Medicare spending would be $1.1 billion higher per year by 2021 and beneficiary cost sharing would be $290 million higher per year.

3. You mentioned numerous times in your oral and written testimony that the relative value units (RVUs) for physician work within the Medicare Physician Fee Schedule are incorrect and, in direct response to a question posed by Representative Ralph Hall (R-TX), that the time estimates are "off by a significant amount." What specific data can you provide to justify this statement (please include line-by-line or multiple code analyses)?

The Secretary of Health and Human Services lacks current, objective data needed to set the fee schedule's RVUs for practitioner work and practice expenses.[18] The fee schedule's time estimates are an example. The RVUs for practitioner work are largely a function of estimates of the time it takes a practitioner to perform each service. However, research for CMS and for the Assistant Secretary for Planning and Evaluation of the Department of Health and Human Services has shown that the time estimates are likely too high for some services.[19] In addition, anecdotal evidence and the experience of clinicians on the Commission suggest problems with the accuracy of the time estimates.

Other evidence of errors in the time estimates comes from CMS's potentially misvalued services initiative. Without direction on the number of services to review or the level of savings to achieve, the initiative in 2011 led to revaluation of a number of services and a redistribution of payments equivalent to 0.4% of fee schedule spending (about $260 million). As part of the initiative, the time estimates for services have been revised downward. These revisions suggest that current time estimates—which rely primarily on surveys conducted by physician specialty societies that have a financial stake in the process—are often incorrect.

4. In the past, MedPAC has recommended Congress and CMS apply multiple procedure payment reductions (MPPR) to the professional and technical components (PC/TC) of advanced diagnostic imaging services. Do you believe these MPPR policies should be based on detailed data analyses indicating what efficiencies exist when interpreting multiple imaging studies on the same patient? Do you believe that random application of 25 or 50% reductions are justified especially in light of the fact that a line-by-line analysis to determine efficiencies within the professional component hasn't been released for public review, to date?

The MPPR's percent reduction should be based on an analysis of the average efficiencies that occur when multiple services are performed in the same session. This reduction could vary for different types of services, such as surgical procedures, imaging, and outpatient therapy, depending on the extent of the efficiencies associated with each type of service. CMS has conducted analyses to support the MPPR reductions for the technical and professional components of certain imaging studies, which are discussed in the proposed and final rules for the physician fee schedule for 2006 and 2012. For example, when developing the MPPR policy for the professional component of imaging, CMS analyzed 12 pairs of high volume advanced imaging codes and found duplications in the pre-service work, intra-service work, and post-service work components (this analysis is described in the proposed and final rules for the physician fee schedule for 2012). These efficiencies justified work RVU reductions ranging from 27 to 43 percent for the lower-paid code within the pair. CMS adopted a 25 percent reduction for all of the imaging services included in the policy, which is below the bottom end of this range.

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FRED UPTON, MICHIGAN
CHAIRMAN

HENRY A. WAXMAN, CALIFORNIA
RANKING MEMBER

ONE HUNDRED THIRTEENTH CONGRESS

Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515–6115
Majority (202) 225-2927
Minority (202) 225-3641

March 13, 2013

Mr. Harold D. Miller
Executive Director
Center for Healthcare Quality and Payment Reform
320 Fort Duquesne Boulevard, Suite 20-J
Pittsburgh, PA 15222

Dear Mr. Miller:

Thank you for appearing at the Subcommittee on Health hearing entitled "SGR: Data, Measures, and Models; Building a Future Medicare Physician Payment System."

During the hearing, you were asked to provide information for the record, and those requests are attached. The format of your responses to these requests should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please e-mail your responses, in Word or PDF format, to early.mcwilliams@mail.house.gov by the close of business on Wednesday, March 27, 2013.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Joseph R. Pitts
Chairman
Subcommittee on Health

cc: Frank Pallone, Jr., Ranking Member, Subcommittee on Health

Attachment

320 Ft. Duquesne Boulevard
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Pittsburgh, PA 15222
Voice: (412) 803-3650
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www.CHQPR.org

March 24, 2013

The Honorable Joseph R. Pitts, Chairman
Subcommittee on Health
Committee on Energy and Commerce
House of Representatives
Congress of the United States
2125 Rayburn House Office Building
Washington, DC 20515-6115

Dear Representative Pitts:

Thank you for the opportunity to appear at the Subcommittee on Health's February 14 hearing on "SGR: Data, Measures, and Models: Building a Future Medicare Physician Payment System."

Attached is my response to the question that Representative Gingrey asked during the hearing.

Please let me know if you or Representative Gingrey need any additional information or if I can be of further assistance to the Subcommittee Members or staff.

Sincerely,

Harold D. Miller
President and CEO

Attachment

320 Ft. Duquesne Boulevard
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Fax (412) 803-3651
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Response to the Honorable Phil Gingrey's question: "You had indicated there were some barriers to this multitude of ideas that you have shown us in your legal papers in regard to physicians not being able to share that information that you have gleaned. If you would submit to the committee maybe a list of some of those impediments to them being able to glean that information because I think it would be very, very helpful to us as we go forward?"

In meetings and workshops around the country, I ask physicians "In your practice, how could healthcare costs be reduced without harming patients, if current barriers were removed?" In response, hundreds of physicians from dozens of specialties have given me specific examples of savings opportunities as well as the barriers they face in pursuing those opportunities on behalf of their patients and payers. For example:

- A radiologist said "I have zero control over utilization or studies ordered. I don't get paid for calling a referring doctor and telling him/her the imaging test is worthless."
- An orthopedist said "Patients often need to be in extended care to receive antibiotics because Medicare doesn't pay for home IV therapy. The patient has to stay in the hospital for 3 days to justify a nursing home/rehab stay."
- An internist said "I strongly suspect overutilization of abdominal CT scans in the ER and in the hospital; CT scans lead to further CT scans to follow up lung and adrenal nodules. The hospital focuses on length of stay, but never looks at appropriateness of radiologic studies."
- A gastroenterologist said "I do many unnecessary colonoscopies on young men, because primary care physicians don't have time to allow diagnosis of bleeding hemorrhoids in the office."

In the attached table, I've summarized a sampling of the specific opportunities that physicians have identified as well as the kinds of barriers that prevent them from being pursued. Analyses I have done indicate that Medicare and other payers could see tremendous savings if we could enable physicians to overcome these barriers.

By far, the most common barrier that physicians cite is the current Medicare payment system. There are two fundamental ways in which current payment systems prevent the delivery of higher-quality, lower-cost care:

- **Medicare does not pay at all for many kinds of services that would be better for the patient and save money for payers.** For example, for many patients experiencing an acute problem, a phone call or email to their primary care physician is the best first step to determine how serious the problem is and how to address it. But primary care physicians don't get paid by Medicare to answer phone calls or emails from patients, and

if they spend a lot of time answering calls or emails, they won't be able to see as many patients in the office and as a result, they will not have enough revenue to cover their practice costs. However, if the patient goes to an emergency room instead, Medicare will pay for that and spend a lot more money.

- **Under Medicare payment systems, a physician loses revenue by doing fewer tests or procedures, even though most of the savings to Medicare is not coming from the physician's fee.** Physician payments only represent 16% of total Medicare spending, and for many types of physicians, their payments represent 10% or less of the total costs associated with the tests they order or procedures they perform. Yet if the physician finds a less costly way of treating a patient, the physician is financially penalized by losing all or part of their small share of the total Medicare payment.

These two characteristics of fee for service payment are serious barriers to improving care for patients and reducing spending for Medicare and other payers. Physicians are often reluctant to talk about the kinds of savings opportunities I described above and in the attached table because they then get pressure from payers and patients to make the changes, even though doing so could bankrupt the physicians financially.

Unfortunately, most of the "payment reforms" that Medicare and other payers are pursuing, such as pay-for-performance, value-based payment, and shared savings do not solve these problems. In my testimony to the Subcommittee, I described in detail how different approaches called Accountable Payment Models can benefit patients and save money for Medicare by directly solving the barriers described above. Even more detail on the barriers preventing higher-value care and the ways that the right kinds of payment reforms can overcome them is available in two free publications from the Center for Healthcare Quality and Payment Reform (www.chqpr.org/reports.html):

- *Ten Barriers to Healthcare Payment Reform and How to Overcome Them*
- *Transitioning to Accountable Care: Incremental Payment Reforms to Support Higher Quality, More Affordable Health Care*

Sincerely,

Harold D. Miller
President and CEO
Center for Healthcare Quality and Payment Reform

EXAMPLES OF SAVINGS OPPORTUNITIES AND BARRIERS IN CURRENT HEALTHCARE PAYMENT AND DELIVERY SYSTEMS

SPECIALTY	SAVINGS OPPORTUNITY	BARRIERS
Cardiology	Follow-up visits could be curtailed or eliminated and replaced with telephone or email contact Reduce duplicative testing	No reimbursement for contacts outside of face-to-face office visits Lack of communication among electronic medical records
Dermatology	Improve skin cancer screenings and reduce the number of biopsies used to diagnose a melanoma or skin cancer	No payment to spend adequate time on patient examination to identify suspicious lesions; it's safer to do a biopsy than to use clinical judgment about the nature of a lesion
Family Medicine	Increase access to primary care by handling many patient visits over the phone and freeing office visits for those who need them	PCPs are not paid for telephone consultations with patients
Gastroenterology	Spending on treatment of colon cancer could be reduced through more effective colon cancer screening	There is no payment for extra time needed for outreach to high-risk patients; the same payment is made for colonoscopies regardless of the risk to the patient or the appropriateness of the procedure
Infectious Disease	More aggressive outreach to patients who miss follow-up appointments to prevent complications Reduce hospital-acquired infections through pre-admission screening for MRSA, etc. Prevent admissions and readmissions with accurate antibiotics Use oral antibiotics instead of administering IV antibiotics in ER	No payment for telephone follow-up with patients Cultures are not paid for if done within 5 days of admission Poor laboratory support for rapid turnaround cultures Significant nursing time needed to get authorization for use of oral antibiotics
Orthopaedics	Order fewer MRIs and rely more on history and physical examination for diagnosis Better orthopaedic care by primary care physicians	Health system would receive less revenue if fewer MRIs are ordered; patients expect an MRI Lower revenues for orthopaedic surgeons from

SPECIALTY	SAVINGS OPPORTUNITY	BARRIERS
		fewer referrals
Pediatrics	Reduce emergency room visits and unnecessary office visits Reduce the number of CT scans to diagnose appendicitis	No payment for telephone consultations Malpractice liability from not doing tests
Pulmonology/Critical Care	Limit futile end-of-life care Discourage use of emergency room for non-critical care	Family usually incurs no financial cost by prolonging treatment Many individuals use the emergency room as their first resort for medical care, and many hospitals encourage this
Radiology	Reduce inappropriate imaging through integration of appropriateness criteria into CPOE systems	There is no payment for the extra time spent with a patient to make a determination that a test is not needed

FRED UPTON, MICHIGAN
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HENRY A. WAXMAN, CALIFORNIA
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March 13, 2013

Mr. Robert Berenson, M.D.
Institute Fellow
The Urban Institute
2100 M Street, N.W.
Washington, D.C. 20037

Dear Dr. Berenson:

Thank you for appearing at the Subcommittee on Health hearing entitled "SGR: Data, Measures, and Models; Building a Future Medicare Physician Payment System."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for 10 business days to permit Members to submit additional questions to witnesses, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

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Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Joseph R. Pitts
Chairman
Subcommittee on Health

cc: Frank Pallone, Jr., Ranking Member, Subcommittee on Health

Attachment

THE URBAN INSTITUTE 2100 M STREET, N.W. / WASHINGTON D.C. 20037

Robert A. Berenson, M.D.
Institute Fellow

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Responses to questions posed by the Honorable Renee Ellmers

Robert A. Berenson, M.D.

28 March 2013

1a. What specific [overvalued] services are you referencing?

1b. What specific data can you provide to justify this statement?

There is growing recognition by policy makers that many services in the Medicare Physician Fee Schedule are misvalued -- mostly overvalued -- because of inflated time estimates which are essential data elements in determining the calculation of work and allocation of indirect practice expenses at a CPT code level. The Medicare Payment Advisory Commission (MedPAC) in their March, 2007 Report to the Congress described the problem, made a number of policy recommendations then and has reiterated its concern about overvalued codes every year since. The Congress in the Affordable Care Act instructed CMS to take a more active role in identifying and correcting misvalued service codes.

MedPAC's policy judgment apparently was influenced by studies that identified numerous specific over-valued codes in some clinical areas. These include:

McCall, Cromwell, and Braun. Validation of Physician Survey Estimates of Surgical Times Using Operating Room Logs, *Medical Care Research and Review*, 63:1-14, 2006.

Cromwell, et al., Missing Productivity Gains in the Medicare Physician Fee Schedule: Where Are They?, *Medical Care Research and Review*, 67:676-693, 2010.

Cromwell at al., Validating CPT Typical Times for Medicare Office Evaluation and Management (E/M) Services. *Medical Care Research and Review*, 63:236-55, 2006

In addition to these important but admittedly limited formal studies, there are numerous overvalued services for which the current times assumed in the CMS data base as the basis for establishing work and practice expense relative value units simply lack face validity. If the time estimates for these common services, which virtually all health professionals and many patients have personally experienced, are substantially overvalued, it is likely that less well-known services are as well. As examples, I refer to the established time estimates for interpreting electrocardiograms, destruction of skin lesions by freezing with liquid nitrogen, ear wax

removal, and colonoscopies. I draw on my own experience as a primary care physician and a patient who has personally experienced these services.

Electrocardiograms – with automated EKG interpretations, the physician work of interpreting and reporting the EKG now takes a matter of the few seconds it takes to confirm, or occasionally, alter the automated interpretation. Yet, the time estimate used by CMS is that the physician takes either four or five minutes to interpret and report a typical EKG (there are two different codes for EKGs).

The CPT code for *destruction of a benign skin lesion* is a bit complicated because it includes a range of treatment modalities, including laser surgery, electrosurgery, and cryosurgery and treatment of benign or pre-malignant skin lesions. But the code is commonly used by physicians for freezing actinic keratoses and other small benign lesions with liquid nitrogen. The time estimate that is the basis for the payment is that it takes 3 minutes for the first and 2 minutes for each additional lesion one up to 15 total. As a physician, I applied liquid nitrogen to many skin lesions and have had some of mine frozen. The application again takes seconds, not minutes, including the pre- and post-application time to inform the patient of what the freezing will consist of and what to look for after in subsequent days.

Ear wax removal using a bulb syringe and water or solvent typically takes much less than the 19 minutes assigned to it in the CMS data base. In my experience, it takes about five to seven minutes from beginning to end for the typical patient. It would be desirable to know more systematically whether my experience is consistent with those from others – perhaps ENT physicians see different patients than primary care physicians with more tenacious ear wax? Systematically obtaining empirical data could settle the issue or at least provide a more objective basis for discussing time variations. Regardless, the 19 minutes that is the basis for the current payment level lacks face validity.

There are numerous *colonoscopy* codes and some confusion exists because some assert there is a major difference in time between screening colonoscopy and diagnostic colonoscopy. The intra-service time estimates for common diagnostic and screening colonoscopies in the CMS data base range from 30 minutes to 51.5 minutes, and total times (the physician time spent outside of the actual scoping) range from 73 to 118.5 minutes for a colonoscopy with a biopsy. A study looking at the association between time and finding polyps in screening colonoscopies published in the *New England Journal of Medicine* found that the actual intraservice times for over 2000 screening colonoscopies was 13.5 minutes when no polyps were found and about 18 minutes when polyps were removed, not 30 or 43 minutes, respectively.[1] In fact, the working CMS assumption is that a physician spends nearly 2 hours for the activities associated with a colonoscopy with a biopsy of one or more biopsies but 41 minutes less when a polyp is removed. Whatever the nuances of marginally more or less time associated with screening vs. diagnostic

[1] Barclay et al. Colonoscopy Withdrawal Times and Adenoma Detection During Screening Colonoscopy. N Engl. J Med 355:2533-41, 2006

colonoscopies and doing a biopsy vs. a polyp removal, it is common for colonoscopies of most varieties to be scheduled every 30 minutes, as in the study cited. Simply, the times used by CMS to value the range of different colonoscopies are exaggerated.

1c. What practicing physicians were consulted when formulating these policies?

The current process for establishing time estimates is based on consulting practicing physicians. The AMA-supported Resource-Based Relative Value Scale Update Committee (RUC) uses a process in which specialty societies survey at least 30 practicing physicians who are familiar with the service under consideration. Those surveys produce time and work intensity estimates on which the specialty society committee bases a time recommendation to the RUC, who mostly also are practicing physicians, but from specialties that do not necessarily have any familiarity with the service under consideration. The RUC reviews the survey results and makes a recommendation to CMS about the time and associated work for the service. Physicians may also comment directly to CMS through public rule-making. In short, there is plenty of consultation with practicing physicians.

The primary concern with this process is that those who best know how long it takes to perform a CPT defined activity also may have a bias to possibly exaggerate the time -- longer time estimates produce higher fees. The process and concerns is described in a recent report for MedPAC and available on the MedPAC web site: Braun and McCall, Methodological Concerns with the Medicare RBRVS Payment System and Recommendations for Additional Study, Dec. 2011, a report by staff from RTI International for the Medicare Payment Advisory Commission. It is my view that rather than relying on imperfect, and possibly biased, estimates from practicing physicians, the time component of the relative value units should be based on empirical data about how long it actually takes practicing physicians to perform services.

2. Given the increased authority under the PPACA to set Medicare payment rates for physicians, what further authority does the Secretary need?

The Secretary's authority is to create a fee schedule that reflects the relative resource costs of the thousands of services that are paid under the Medicare Fee Schedule. That authority does not give the Secretary the ability to be value-based purchaser, that is, modifying fees to accomplish policy objectives, such as providing a better mix of services for Medicare beneficiaries, reduced spending for taxpayers, and a more appropriate specialty distribution of physicians. Many policy experts and at least some physicians agree that Medicare beneficiaries receive enough – maybe too many – technologically oriented services, such as imaging and tests, but not enough time with their primary care and principal care clinicians and their care teams. So in addition to working aggressively to correct current mis-valuations, the Secretary should be given limited authority to modify fees up or down to support an expedited redistribution of services that are provided to Medicare beneficiaries.

This is not a new idea. A colleague and I proposed this model over 25 years ago in Hadley and Berenson, Seeking the Just Price: Constructing Relative Value Scales and Fee Schedules, *Annals of Internal Medicine*, 106:461-466, 1987.

3. Would advocating for payment reduction instead of removing the abused services from [the in-office ancillary services] exception to the self-referral law unfairly penalize the rendering physician? Wouldn't simply advocating for removing the abused service from the IOAS exception be the most effective way to prevent overutilization of the affect procedures?

I agree that for some abused, self-referral services, reducing payments might not be appropriate. My point was that a high and growing volume of particular self-referred services can be a signal that the fees are too high and should be reduced to better reflect relative resource costs. That apparently was the situation with overpriced advanced imaging services, which was addressed in the Deficit Reduction Act of 2005. For other self-referral services, it might be that the unit price in the fee schedule correctly reflects the relative resource cost, but that the marginal cost of generating more units for payment is so low that physicians are inducing demand for unneeded services. In this case, as the question posits, reducing the unit price would unfairly penalize the rendering physician who is not abusing the privilege of self-referral. Another approach, as recommended by MedPAC, would be selective application of prior authorization for services subject to inappropriate self-referral.

In short, I don't disagree that removing the abused services from the IOAS exception should apply in some cases. However, in others, price changes or other policy initiatives might make more sense. The IOAS exception exists because patients may benefit to some extent in terms of continuity of care from having their own physicians oversee provision of self-referral services. A decision to take away the exception is not an easy one. That is why I suggest that the first step be to review to make sure the fee is not much too high, therefore producing the abusive physician ordering.

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