

**ADVANCING REFORM:
MEDICARE PHYSICIANS PAYMENTS**

HEARING
BEFORE THE
COMMITTEE ON FINANCE
UNITED STATES SENATE
ONE HUNDRED THIRTEENTH CONGRESS
FIRST SESSION

MAY 14, 2013



Printed for the use of the Committee on Finance

U.S. GOVERNMENT PRINTING OFFICE

87-885—PDF

WASHINGTON : 2013

For sale by the Superintendent of Documents, U.S. Government Printing Office
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ADVANCING REFORM: MEDICARE PHYSICIANS PAYMENTS

TUESDAY, MAY 14, 2013

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10 a.m., in room SD-215, Dirksen Senate Office Building, Hon. Max Baucus (chairman of the committee) presiding.

Present: Senators Cantwell, Cardin, Hatch, Crapo, and Isakson.

Also present: Democratic Staff: Mac Campbell, General Counsel; David Schwartz, Chief Health Counsel; Karen Fisher, Professional Staff Member; and Peter Sokolove, Robert Wood Johnson Fellow. Republican Staff: Chris Campbell, Staff Director; Jay Khosla, Chief Health Counsel Policy Director; and Dan Todd, Health Policy Advisor.

OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The committee will come to order.

The best-selling business author Tom Peters once said, "If a window of opportunity appears, do not pull down the shade." We should keep those words in mind today as we examine the method Medicare uses to determine physician payments, the Sustainable Growth Rate, otherwise known as the SGR.

For the past 10 years, this flawed formula has dictated drastic reductions in Medicare payment rates. Next year, physicians will face a 25-percent cut under the SGR. This deep cut would mean many seniors would lose access to their doctor.

Each year, Congress has intervened to prevent these cuts. But we need to get beyond this annual "doc fix" ritual. The year-in, year-out uncertainty is not fair to physicians. It is not fair to seniors.

Since 2003, Congress has made 15 short-term fixes to the SGR at a cost of nearly \$150 billion. In 2010 alone, we passed 6 short-term fixes. It is time to break this cycle.

Ninety-seven percent of Medicare beneficiaries see a physician at least once a year, and most beneficiaries with chronic conditions see their doctor at least monthly. We need to ensure that seniors can continue to see their doctors. We must permanently repeal this broken formula, and we need to do it this year.

The most recent 10-year score for repealing the SGR is \$138 billion. While this is a large amount, it is more than \$100 billion less

than the last year's score. This is a window of opportunity. We need to seize it.

But we should not simply repeal the SGR. We must also change the underlying fee-for-service system that Medicare uses to pay physicians. Fee-for-service promotes volume over value. Physicians are rewarded for doing more tests and more procedures, even when unnecessary. It does not encourage physicians to coordinate patient care to save money and improve health outcomes.

Last year this committee held three roundtable sessions on improving the system to reward physicians for providing high-quality, high-value care. We heard from former CMS Administrators, private plans, and physician groups.

This year we held two hearings in which we heard from CMS leaders about their efforts to develop new payment models. We heard that there is a better way of doing business. The Innovation Center told us there are promising payment systems that would hold physicians accountable for providing high-quality, efficient care.

These models include Accountable Care Organizations, payment bundles, medical homes, and there are certainly others. They incentivize physicians to coordinate patients' care. They focus on reducing emergency visits and hospitalizations. They have the potential to control spending for Medicare and beneficiaries alike. More important, they mean better care for patients.

Physicians are eager to move to better systems. Jean Branscum from the Montana Medical Association recently wrote me about the uncertainty created by the current SGR policy. She said that "Montana physicians want new payment models that improve health care and lower costs." She added, "There's no time to waste." The continual uncertainty is driving physicians to limit the number of Medicare patients they see.

Unfortunately, the new models the Innovation Center is developing are not ready to replace the fee-for-service system. CMS and the Innovation Center need to quickly finish new models so that Medicare rewards value instead of volume. In the meantime, we must improve the current system.

We want to hear from doctors and other providers who see patients every day. They can help us identify ways to improve care and reduce unnecessary costs. We need the doctors on the front lines to step up with ideas.

Last Friday, Senator Hatch and I sent a letter to health care providers. We asked for their advice on improving the current fee-for-service system. First, we need to make sure each service is valued appropriately. Second, we want ways to reduce unnecessary services, because Congress originally enacted the SGR to control spending, but it has not worked. The replacement clearly must do a better job of controlling costs. And finally, we need advice on how to help physicians transition to alternative payment models.

Our letter asks for specific suggestions. I emphasize the word "specific." Not abstractions, but "specifics." We need concrete policies that can be implemented now to replace the SGR.

I look to our panelists to help us identify them. We have an opportunity to repeal the SGR once and for all this year. Believe me, this committee would very much like to do that. We have been

going around this merry-go-round too many times. I encourage us not to draw a shade on this window of opportunity.

[The prepared statement of Chairman Baucus appears in the appendix.]

The CHAIRMAN. Senator Hatch?

**OPENING STATEMENT OF HON. ORRIN G. HATCH,
A U.S. SENATOR FROM UTAH**

Senator HATCH. Well, thank you, Mr. Chairman. I appreciate you holding today's hearing on this important issue, Medicare physician payments.

Last year this committee held a productive series of roundtable discussions with key stakeholders on this very topic, which helped to set the stage for us to move forward with reform. The chairman and I agree that we must find a better way to pay physicians in Medicare. The SGR system—as we all know—is fundamentally flawed and must be repealed. We are committed to working together to try to do just that.

As it stands, unless Congress intervenes, Medicare physician payments will be reduced by 25 percent in 2014 due to the SGR formula. And, with such large cuts, physicians will quickly be unable to offer care to millions of seniors on Medicare. Our seniors deserve better than to have government inaction threaten the availability of their care.

Due to the recent slowdown in overall health expenditures, the current cost of permanently repealing the SGR is down sharply from a previous Congressional Budget Office estimate of \$245 billion to now less than \$150 billion. However, we know from previous years that the CBO score has a tendency to fluctuate.

I believe we currently have a good window of opportunity before us. But we need to act very soon. We must provide a stable foundation for paying our physicians, now and in the future. If we fail to act, we will run the risk of causing a physician shortage in the Medicare program that will have a broad impact for beneficiaries.

This past Friday, the chairman and I sent a letter to members of the health care provider community appealing to them for their input on how to improve the current system and how we can help physicians transition to new payment models. This builds on the discussions we started last year.

As we await responses from the provider community, we have the privilege today to hear from our panel of expert witnesses and get their thoughts on the matter. This issue is well-covered terrain. We know this is not an easy task, but physicians and patients deserve better.

We must find a more stable foundation to pay physicians treating Medicare patients. I believe if we identify the appropriate policy solutions, we can finally find a path to repeal the SGR, and that is my goal. I think it is the goal of the chairman as well. We work together on these matters. I want to personally compliment the chairman for his concerns in this area and for the work that he has done.

Thank you for convening today's hearing, and I look forward to what the witnesses have to say. Now, I have to apologize because I am in the middle of that immigration markup, and there is not

much I can do but be there, since a number of the amendments are mine. You will have to forgive me. But I am very interested in your testimony, very interested in what you have to say.

I hope we can come up with the solutions to this problem, and I will do everything in my power to support the chairman in his desire to do so. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator. I know you are very concerned about the SGR and very much want to find a replacement just as much as the rest of us. Thank you very much for your help. I appreciate it very much.

[The prepared statement of Senator Hatch appears in the appendix.]

The CHAIRMAN. Now I would like to welcome our panel. Our first witness is Mark Miller, Executive Director of the Medicare Payment Advisory Commission, otherwise known as MedPAC. Thank you, Dr. Miller, for being here. This committee relies on MedPAC very frequently and appreciates your work.

In addition, we have Bruce Steinwald, president of Bruce Steinwald Consulting and a former Director of Health Care of the Government Accountability Office. GAO is also very important to this committee.

And finally, Dr. Kavita Patel is a fellow and managing director at the Engelberg Center for Health Care Reform at the Brookings Institution.

Did I pronounce your name correctly?

Dr. PATEL. Yes.

The CHAIRMAN. Good. Thank you, everyone. Your statements will be included automatically. You will have 5 minutes each, so let her rip.

We will start with you, Dr. Miller.

STATEMENT OF MARK E. MILLER, Ph.D., EXECUTIVE DIRECTOR, MEDICARE PAYMENT ADVISORY COMMISSION (MedPAC), WASHINGTON, DC

Dr. MILLER. Chairman Baucus, Ranking Member Hatch, and distinguished committee members, I am Mark Miller, the Executive Director of the Medicare Payment Advisory Commission. I would like to thank you for inviting us to testify.

Before I get to the SGR, I think it is important to say that the Commission believes that Medicare's payment and delivery systems need to change. They need to move away from volume-driven systems to systems that focus on quality, coordination, and accountability.

The goal of any SGR reform should not be to protect a fragmented fee-for-service payment system. Regarding the SGR and looking back at history, physicians controlled both the price paid by Medicare through their charges as well as the services that were provided to beneficiaries. This naturally led to escalating physician payments, and it also led to large payment inequities between services and, ultimately, between specialties.

In the early 1990s, a fee schedule was put in place in part to correct those payment inequities, and also policies like the SGR were put in place to control volume. The Commission has recommended in the past and again more recently to repeal the SGR. The Com-

mission believes the policy is flawed. It does not create incentives for physicians to cooperate and to avoid unnecessary volume.

It is unfair to any physician who practices judiciously. It rewards physicians who are able to generate volume. Additionally, it has perpetuated the inequity between payments for procedural services on the one hand and cognitive and primary care services on the other.

The Congress has chosen to override the legislative reductions for years. That, coupled with continued service volume growth, has led to an annual process of trying to avoid large fee reductions at the end of the year. This problem creates barriers to move forward in a more thoughtful way. It creates anxiety in the provider community, and it creates administrative anomalies for CMS and the providers of care.

Furthermore, while the Commission's annual beneficiary survey continues to show strong access for Medicare beneficiaries, the Commission is concerned that that picture could change—particularly for primary care—if steps are not taken to repeal the SGR. And the time to repeal it is now.

As you have noted yourself, the cost of the repeal has been revised downward from \$300 billion to about \$140 billion. But history is cautionary here. This is because service volume has slowed down, but trends in service volume are volatile, and, if they re-accelerate, the cost of repealing the SGR would go up again.

With respect to the SGR, MedPAC has recommended the following. First, repeal the SGR and replace it with a set of legislative updates for the next 10 years. Now let me add quickly here, that MedPAC would continue to do its job and report annually to the Congress on the impact of those changes and would recommend changes if access were to be threatened under those new updates.

Second, rebalance the fee schedule, again, to bring more equity between primary care services and procedural services. The Commission believes that to move towards a reformed delivery system, we need primary care physicians and other professionals to provide primary care. The fee schedule sends clear signals dissuading medical students from pursuing primary care as a career.

Rebalancing the fee schedule has two steps. The first is a new approach to collecting data in order to reevaluate the relative values under the fee schedule and to specifically identify overpriced services. The second step, bluntly, is to reduce the payment rates for procedural services relative to primary care.

You should note that this last point also reduces the overall cost of repeal. I should also note with both of those, the legislated updates and even with the reduction for procedural services, there would be a 72-percent increase in physician spending over the next 10 years. So this is not a reduction in spending.

The Commission also recommends that there be incentives, and includes incentives for physicians to move away from fee-for-service and to either organize or join risk-based Accountable Care Organizations. As I have noted, fee-for-service focuses on generating volume. But, perhaps even more importantly, fee-for-service contributes to a lack of coordination and to a lack of accountability. It is the hope of the Commission that risk-based Accountable Care Or-

ganizations could be a platform for accountability and also a better platform for measuring quality.

In closing, I would also like to remind the committee that, through our ongoing work, the Commission has provided the Congress with a list of Medicare savings that could be used to offset the cost of the SGR if the Congress were to choose to do that. With that, I will stop and look forward to your questions. Thank you.

[The prepared statement of Dr. Miller appears in the appendix.]

The CHAIRMAN. Thank you, Doctor.

Mr. Steinwald?

**STATEMENT OF A. BRUCE STEINWALD, MBA, PRESIDENT,
BRUCE STEINWALD CONSULTING, WASHINGTON, DC**

Mr. STEINWALD. Mr. Chairman, members of the committee, thank you for having me here today. As you pointed out, Mr. Chairman, it has been a tough 11 years of dealing with the SGR and the Medicare fee schedule. But, the circumstances might be right to do away with the SGR and to reform the fee schedule. I say this in part because of the widespread acceptance of the need to replace volume incentives with value incentives in the fee schedule.

For decades, there has been a reluctance to accept cost as a legitimate concern in coverage and payment policy. And now the policy world seems to recognize that open-ended fee-for-service reimbursement is a major impediment to achieving value objectives. I also perceive—I could be wrong about this—a shift in the nature of the involvement of the medical profession in reforming Medicare physician payment. For years, the stance of the profession seemed to be, repeal SGR and then we will talk about reform. Now it seems to me that the medical profession recognizes that reform needs to be a part of the same conversation.

Third, we have a growing capability in this country to make data-driven decisions on coverage and payment in Medicare. As a society, we have made a huge investment in improving the empirical base of the decisions we make in health care delivery. Medicare coverage and payment policy may need to be adjusted to take full advantage of this growing capability.

Fourth, activity on the reform front: there has never been a shortage of reform proposals, but this appears to be an especially fertile period of experimentation in the health care delivery system, with much of it, but not all, financed through Federal research dollars. The SGR “doc fix” problem has become so prominent that it is included in Simpson-Bowles and all major budget reform proposals. So, if the Congress is able to achieve a grand bargain, it would certainly include the SGR fix.

And finally, as you mentioned, there is the lower CBO score. The cost of repealing SGR appears to be on sale at least for a period of time. It is hard to say how long it will be, as Mark pointed out. But the lower score makes repeal more attractive, or at least less unattractive, from a Federal budget perspective.

So what would a post-SGR world look like? Let me say three things about that. The movement toward a growing global payment system should be encouraged, but needs to be developed naturally for both beneficiaries and physicians. We have several integrated

delivery systems that exist in all parts of the U.S., serving urban, suburban, and rural populations. At the same time, we have Accountable Care Organizations and other hybrid forms of healthcare delivery and financing growing.

A reformed delivery and financing system that focuses on population, health, and value in service delivery should be attractive to both beneficiaries and providers alike. Second, the Medicare fee schedule, along with Medicare coverage policy, should be fine-tuned to reward value and discourage unnecessary utilization.

With the blunt instrument of SGR out of the way, Medicare could have greater opportunity to use its extensive data to make distinctions between high-value and low-value care. Some of these opportunities can be accomplished under current law, and some will require new legislation.

And finally, policymakers should never underestimate the power of fee-for-service incentives to generate more volume and more spending. Because spending increases in health care have been at low levels for the past few years, it is tempting to conclude that the pressure is off to limit spending. But I remind you that this was the situation that occurred during the 1990s when the SGR was created, and it would be unfortunate if SGR were eliminated during a similar low-spending period only to have physician spending ramp up again in the absence of effective controls.

So, in conclusion, I believe that the post-SGR world should be one of decreasing reliance on fee-for-service payment, but with effective controls in place that reward value and not volume in the Medicare fee schedule. The fee schedule is likely to be with us for some time. It can and should be improved. Those improvements in the fee schedule and the controls that I mentioned may encourage some physicians to seek alternative delivery settings, thereby providing a boost to the reform movement.

That concludes my statement. I look forward to your questions. [The prepared statement of Mr. Steinwald appears in the appendix.]

The CHAIRMAN. Thank you, Mr. Steinwald.
Dr. Patel, you are next.

**STATEMENT OF DR. KAVITA K. PATEL, M.D., M.S., FELLOW AND
MANAGING DIRECTOR, THE ENGELBERG CENTER FOR
HEALTH CARE REFORM, THE BROOKINGS INSTITUTION,
WASHINGTON, DC**

Dr. PATEL. Chairman Baucus and members of the committee, thank you for this opportunity to highlight ways to advance physician payment reform in Medicare. My name is Kavita Patel, and I am honored to present some solutions from our work at the Engelberg Center for Health Care Reform at the Brookings Institution and our related Merkin Initiative on Clinical Leadership, as well as work that has been done on the National Commission on Physician Payment Reform, and, perhaps most importantly, from my experience as a practicing primary care physician.

Eliminating the SGR has been widely discussed, as you mentioned, sir. I applaud the committee's leadership and their recent call for proposals from the physician community. The SGR must be eliminated, but we need a transition pathway, since, as many oth-

ers have mentioned, our current fee-for-service system is the one we must transition from to some of these novel methods of payment that we have been discussing for a long time. Short-term strategies that will result in better care-coordination between primary care physicians and specialists are the ultimate answer. But the question remains, how to get there.

In our work at Brookings as well as a number of other places, we have conducted surveys, spent a lot of time with physicians in practice, and also looked at the economic incentives as well as the underpinnings of finance. One thing that has been clear in my work as a physician, as well as with numbers of health professionals whom we have spoken with, is that there are currently many initiatives that physicians participate in to promote higher value and quality.

Just to name a few, there are meaningful use measures, the use of electronic health records, the Physician Quality Reporting System, value-based modifiers, and electronic prescribing, a number of which came from the work in this committee. All of these efforts combined, however, are simply not enough when you look at the aggregate amount of either bonuses or financial penalties that might be assigned to this.

One straightforward mechanism in the short term to help physicians transition in the fee-for-service setting, would be to think about how to harmonize all of these programs, understand when the data is being submitted, and how physicians can use a larger payment from these pieces together to benefit in more of a care coordination payment manner in which they could work together and fulfill the requirements for each of the individual programs, but together form a better way of working between different silos which we currently do not have.

Let me offer an illustrative example based on our work at Brookings as well as my own experience. In the case of meaningful use as well as PQRS, there are a number of ways physicians can submit measures, electronically as well as through participation in a registry. The payments for PQRS average about \$1,000 for each provider per year. Imagine if that \$1,000 combined with the upwards of \$44,000 in incentives for electronic health records, could be used by a cardiologist in conjunction with a primary care physician to take better care of a population of patients like mine who have diabetes, heart failure, irregular heart rhythms, and a number of other problems for which the individual measures may not actually accurately capture the care provided to that patient.

This is one manner in which current programs in our fee-for-service system can be harmonized and actually benefit us to help physicians see a way to take on the clinical risks and the financial risks to move to longer-term payment models. Another step that would help in the short-term setting would also be to do what CMS has been doing in terms of looking through the evaluation and management coding to better understand the value of these services. Another example has been the recent work by Medicare to actually evaluate, at a higher payment rate, care coordination when patients are discharged from a hospital. These are important steps that certainly can be accelerated and highlighted by the important work of this committee.

And then, in summary, some of the tools that are necessary to take current programs into a longer-term setting must be observed. We have already heard a little bit about analytic methods to help physicians understand how they are using and utilizing care, but what is missing right now is timely data.

We hear that over and over again in our work with physicians, that they are hungry for actionable data that can change the point-of-service care. When I submit my measures for meaningful use or for my value-based modifier payments, those measures are not acted upon financially for another 2 years. Often this data lag really causes us to miss a window of opportunity to have meaningful action in the patient setting.

Additional tools that CMS, as well as others, and particularly the professional societies, are well-capable of providing can be offered to help physicians understand how to move from current payment to future payment. This includes taking more financial risk—this is not something I was taught in medical school, but I am eager to learn—as well as taking on more clinical risk, which I think we have heard a lot about in the forms of Accountable Care Organizations.

So, in summary, I do hope that this committee will consider that there is a pathway, starting now, from the repeal of the SGR to longer-term payment reforms. I thank you for this time and look forward to your questions.

[The prepared statement of Dr. Patel appears in the appendix.]

The CHAIRMAN. Thank you, everybody. Dr. Miller, you said something interesting: that even with these recommended changes, physician reimbursement will be about 72 percent higher than it is today. That is, I think, over 10 years, or maybe that is in the 10th year. Could you expand on that, please?

Dr. MILLER. Yes. What I was referring to is that the Commission's proposal is to set the physician fee schedules, fee schedule payments, through the 10-year window and eliminate the SGR as a mechanism for setting those. At the same time, in order to get some greater equity in the fee schedule, we would actually pull down the conversion factor or the payment rate for procedural services relative to primary care services.

As you might imagine, the specialty societies would be upset with that kind of proposal. But what I was trying to point out is, because more patients will be coming into the system and because service volume continues to increase, aggregate payments to physicians would continue to increase over that 10-year period.

So, when you look at even reducing the fee that you pay for procedural service, you should not assume that net payments go down, because still more services are being provided.

The CHAIRMAN. Right, and I do not quite understand that, because you said that services are down a bit now and that explains a different estimate for—

Dr. MILLER. The score.

The CHAIRMAN. The score is down. That is right.

Dr. MILLER. I did say that. The service volume has slowed down, but there is not zero growth in service volume.

The CHAIRMAN. All right. Why will service volume increase, do you think, under this new regime?

Dr. MILLER. The trends in volume have always gone up. They have slowed down, but the baseline assumptions in all of our experiences are that service volume will continue to grow over time. Some of it will be driven by technology. Some of it will be driven by the clinical needs of the patients. But under a fee-for-service system, some of it will be driven by the incentives of the fee-for-service system.

The CHAIRMAN. How do you address the concern that the specialists have, that their income, relative to primary care, might not be what they expect or hope it to be? Dr. Patel mentioned something interesting about learning to accept or deal with financial risks. It seems to me that there might be an opening there somehow for specialty physicians to realize that, hey, they have to be a part of the solution here, but in a way too that eases their concern over their income.

Dr. MILLER. I will try to do that, but you know I generally do not come to you with really popular ideas, Senator.

The CHAIRMAN. No, but you are very perceptive.

Dr. MILLER. Well, thanks for that. There are two things that I would say. The first thing to focus on—and I tried to make this clear in my 5 minutes, but it is a lot to try to get in in 5 minutes—is that compensation is very distorted in the payment system now. So for example, you have certain specialties. Given the services that they provide, they are reimbursed 2 and 3 times, both in aggregate and at an hourly basis, what a primary care physician gets reimbursed.

So, I think the first point, in the Commission's view, is that there is an equity issue and that the specialists need to recognize that, given the greater circumstances that we are in, one being the desire to eliminate the SGR, because specialists do not like that either. Now, to your point of, could there be something to offer them? I think the Commission's view is, if you put pressure on fee-for-service, restraining fees, adjusting fees to get this greater equity, that is going to be an environment that specialists might want to move away from and, perhaps, to an Accountable Care Organization where they have the opportunity, if volume is controlled, to share in some of those savings.

The CHAIRMAN. To anyone who wants to respond to this, the question is, how quickly and thoroughly can we move to this new regime, whatever it is? I am reminded of two rules I think are pretty important. The first is: do it now. And the second is: do it right the first time. But make sure we do it right. And do it right tends to mean you have to think it through and not be hasty. So how do we move as quickly as possible, yet lower the probability of significant mistakes either by pushing CMS or through legislative changes to move to this new regime?

Dr. Patel mentioned some interim transition measures like coordinating all of the current measures to be undertaken, which makes some sense. Just generally, I know it is a broad question, but how do we move—what is the general approach we need to take here, whether it is accountable care, bundling, whatever it is that we move to?

Mr. STEINWALD. Well, I think the good news is that it is already happening. Partially with Federal support, but not entirely. When

people say there are parts of the population that could never be served by these alternative delivery systems, I look around the country, and I see that there is no part of the country that is not served, at least, by some of these integrated delivery systems. Whether they are rural areas served by Intermountain Healthcare or intensely urban areas like Denver Health serves, these organizations exist and can serve all kinds of populations.

The CHAIRMAN. But what do we do to speed it up in those other parts of the country?

Mr. STEINWALD. Well, I think one of the things Mark eluded to is, you want both beneficiaries and providers to be attracted to these changes. But part of the attraction is to not feel wedded to the system that they currently are familiar with. Therefore, that system needs to be modified so that in leaving that system, there has to be something to go to. And I agree that it has to be done organically, because we do not want to repeat the errors of the 1980s in the managed care movement. Attractive to go to, attractive to leave, I think is the combination.

The CHAIRMAN. Thank you very much.

Senator Cardin?

Senator CARDIN. Thank you, Mr. Chairman. Let me thank all of our witnesses. Dr. Miller, I want to go back to the 72-percent projected increase if you were to do the updates over the next 10 years. How much of that is related to volume?

Dr. MILLER. I am going to say a third or a fourth of it.

Senator CARDIN. So you are projecting a slower growth rate in volume over the next decade than in the past decade?

Dr. MILLER. Just to be clear, I am not. But in the CBO base, yes.

Senator CARDIN. Because I am looking at the volume growth on physician services. It looks like it was around 35 percent over the last decade, at least for major procedures, evaluation and management, if I am looking at the chart from MedPAC correctly.

Dr. MILLER. From our testimony?

Senator CARDIN. Yes, Figure 2 is what I am looking at.

Dr. MILLER. I think I know the chart. Keep going.

Senator CARDIN. Procedures such as testing and imaging are going up at a much higher growth rate on volume comparatively.

Dr. MILLER. Right.

Senator CARDIN. I guess my question to you is, are you suggesting that you are going to lock in the adjustments over the next 10 years, trying to give a fairer reimbursement to primary care, versus the higher-cost specialties? Will you still be relying on the RUC? * Are you still going to be using the process in which you accept a significant amount of the information from the RUC, or not?

Dr. MILLER. All right. There are a couple pieces to this. The RUC would still be in place, and we would envision that CMS would continue to accept information from the RUC. But also, MedPAC made a set of recommendations on the HHS and the Secretary side of that calculus in order to bring more information and parity between CMS and the RUC—and the Secretary could use that information—and an advisory board that we suggested get constructed

*The Relative Value Scale Update Committee.

there, to drive the RUC's process in a more organized way so that they are not completely taking all advice that the RUC provides.

Senator CARDIN. It seems to me that what you are doing is dividing accountability and responsibility here with, perhaps, no one being ultimately held accountable. Would it not be better just to bring it all within CMS?

Dr. MILLER. The only thing I would say about that is that I do think you want input from the medical community. I just do not—

Senator CARDIN. Absolutely. I do not disagree with that, but who is responsible for the final rate setting?

Dr. MILLER. CMS.

Senator CARDIN. So, if they take a certain amount of information from the outside, they are basically using that to justify their decisions? And then that is not a very open process as to how those numbers are worked out. Then you are suggesting you are not satisfied with balance between primary and higher-cost specialties.

I am not sure that what you are suggesting gives us an accountable system. Whom do we hold accountable?

Dr. MILLER. Well, I think what I am trying to do is get greater parity between CMS and the RUC so that CMS is not completely dependent on the advice that comes from the RUC and drives the RUC's activities.

We believe these services are overpriced. As part of our proposal, we have a data collection process where the Secretary would say, I believe these are overpriced and I direct you, the RUC, to go back and give me different values. And, if you do not, then I am going to use this information to reset.

So the two things are to get greater parity between CMS and the RUC, and then, through that process, we believe there will be greater parity in the payment system between the proceduralist and primary care.

Senator CARDIN. I understand that. Let me get to one more question for the panel.

Dr. MILLER. I am sorry.

Senator CARDIN. No. That was a good answer.

One more question for the panel, and that is, we all agree we have to get rid of the SGR system, and, absolutely, the dollar offset today is much more friendly than it was 2 years ago. So the opportunity is now, as the chairman has said. And we should do it.

We do not agree as to what we should replace it with. We have been looking at this now for a decade, and yet it is somewhat disappointing we are not further along as to how we can replace it with a payment system that rewards quality rather than quantity, that really manages the individual rather than rewards multiple visits from different specialists.

Why are we not further along on this? How much longer is this going to take? Any one of you?

Dr. PATEL. It has taken a long time because I do think it has been difficult to actually say, let us change the system. And then, to assign some sort of responsibility is ultimately difficult, I think. As we all have responsibility to our patients, we have had a challenge in trying to say, well, change payment and then hold providers accountable in a certain way. I actually think some of the

shorter-term steps that I discussed have been a huge milestone in helping us get there. I do believe that, with a decade of discussion, we are ready to do it now over a short time period.

Senator CARDIN. I would just make one last point, Mr. Chairman, if I might. It seems to me that if we fix SGR—which I am for—and we do not substitute a proposal that deals with the underlying problem, we are going to have a hard time later substituting in the payment structure, it seems to me, politically, if we put off doing it all at one time.

Dr. MILLER. The thing I would say is, I think two major stumbling blocks—not the only two, and I think Dr. Patel's points stand here—are (1), the price was huge before. And the Congress just had to grapple with that, and it was difficult. The second is, there is not the organizational structure out there that you can point to and say, if this organizational structure existed, you could take accountability for it.

Our hope in pushing the providers towards risk-based Accountable Care Organizations is that that structure begins to exist, and—I know I am out of time—it is starting to. There are 250 of them now. Four percent of the population is in them. They are starting to arise. I am not saying they are the answer, but something is starting to rise out there.

Senator CARDIN. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

I might say, I do not totally agree with you, Dr. Miller. That is because it is just too big a slug of money. And the second thing is, there is no organization. But I do feel we are starting to make some headway here, and I really appreciate that. Because for years and years and years, I have told physician groups, come up with a solution. Come up with a solution. You do not like it, well, come up with an alternative. They never have.

But now we are getting to the point where various groups are starting to realize that maybe we have to, and now is the time. And second, I might say, as far as I am concerned, I am going to encourage this movement while we have the opportunity, very strongly. Maybe with some carrots, and maybe with some sticks.

Now is the time. I appreciate the movement that groups are undertaking, addressing your point. But I think now we have the responsibility to keep pushing even further. Addressing your other point, if we do not do it now, we are never going to do it. Thank you very much.

Senator Crapo? I apologize that I have to leave, but Senator Cantwell will take over the hearing.

Senator CRAPO. Thank you, Mr. Chairman.

Dr. Patel, in your testimony, one of the recommendations that you make is that higher payment for facility-based services that can be performed in a lower cost setting should be eliminated. Could you elaborate on that a little bit?

Dr. PATEL. Yes. Thank you, Senator, for pointing out one of our recommendations on physician payment overhaul. In truth, right now there has been, because of the formulas assigned for calculation of facility-based payments, a differential such that, for example, if a physician had performed an ultrasound of the heart in an outpatient stand-alone community-based office, they would receive

a certain dollar amount, approximately \$159 for that. In a hospital-based facility, for the exact same physician, the exact same service, no additional personnel, no trainees, residents, students, or fellows involved, same exact service, same patient, they can receive about 3 times that amount as a payment. That is just one example of some of the site service differential payments which we think are an opportunity for savings in the Medicare system.

Senator CRAPO. Do you think that this differential in payment that you have described is one of the driving factors behind what we are seeing now with so many hospitals purchasing physician practices?

Dr. PATEL. It is one of the main driving factors. And it is an area of concern that we have as, not just physicians, but in looking at financing of the Medicare system. We think it is sending the wrong message for the care for our patients. Now, that does not hold for training institutions and places that have additional factors, but that is not the case that we are discussing.

Senator CRAPO. Thank you. Mr. Steinwald, in your testimony, you indicate—as I think almost everyone has indicated—that policies need to be developed to encourage providers to elevate value as the chief objective in determining what services are performed. Could you just tell me what two or three of those policies you think are the most promising that we should be focusing on?

Mr. STEINWALD. Right. I will start by repeating what I said a moment ago, which is, never underestimate the power of fee-for-service incentives to generate volumes. So, you are dealing with that underlying incentive. And while we are still using the fee schedule and still paying fee-for-service, we need to find counter-measures—if you want to call them that—to make sure that we are rewarding value instead of volume.

So, such things as have been done in the private sector, like prior authorization for payment for expensive imaging technologies, using physician profiling, which Medicare has done, just to provide feedback, but perhaps you can put some teeth in them to make sure that the physicians who are overusing services are not rewarded for doing that. As long as we are going to rely somewhat on fee-for-service to pay for services to Medicare beneficiaries, we are going to have to deal with the volume incentive.

I also think that we ought to coordinate payment policy with a coverage policy. There are two ways of dealing with a low-value service. One is to pay less for it. Another is to not cover it if there is a more high-value service that is a substitute. So that is another thing I think that needs to be considered: coverage policy in addition to payment.

Senator CRAPO. Thank you very much.

And, Dr. Miller, you just mentioned the fact that you think one of the concerns or causes of our inability to get there in terms of finding the right alternatives has been the lack of the organizational structure that is necessary to help us transition to a new and more successful payment system. Could you describe the organizational structure that you are talking about there a little more specifically?

Dr. MILLER. Well, I think what the Commission is mostly focused on at the moment is the Accountable Care Organizations that were

created by law, and also being run out of the Innovation Center, the Pioneer Accountable Care Organizations. I think the line of thinking is that—related to what Dr. Patel said—you can sort of lay out lots of different incentives for physicians to try to follow and rationalize, and I think she is right: currently there is an array of them.

They probably have some effect, but they are also relatively confusing. Or, alternatively, say doctors could organize as a set of providers, accept some degree of risk, and then, as a group of physicians, decide what clinical evidence and pathways they are going to pursue. But the key thing is to come together as a group of providers, organize, and then accept, on a population basis, a risk-based payment, and then the Federal Government should, obviously, have some kind of quality measures to be sure that care is being provided. But those can be much more aggregated and population-based. So I think that is the line of thinking, and there is at least something of a structure there that is starting to emerge.

I also want to say one thing quickly on the site-neutral point that you asked Dr. Patel. We also have a recommendation on that from a year or so ago, and we have some upcoming research on some other ideas along those lines that will come out in June, if you are interested in that.

Senator CRAPO. Thank you. I am interested. I look forward to that.

Dr. MILLER. Yes. Sorry to change topics there.

Senator CRAPO. No trouble.

Senator CANTWELL [presiding]. Thank you. Dr. Miller—well, actually for any of the panelists. I appreciate everyone's testimony this morning and certainly the focus on the ACO model, which is something big in the Pacific Northwest and has yielded some great efficiencies as they have tried to move towards that. And certainly we would like to leapfrog towards that as soon as possible.

But we did write into the Affordable Care Act a value-based payment modifier that CMS is putting out preliminary rules on now that would be implemented fully by 2017 as a process for getting off of fee-for-service and focusing on outcome-based results. I did not see much of that in anybody's testimony.

So I am just wondering what people are thinking about that, or, as I said, we would certainly like to leapfrog into ACOs, but getting off of fee-for-service and focusing on better outcomes and rewarding people for better outcomes at lower, oftentimes, at lower rates, we think is where we need to be going in the short term.

Dr. MILLER. Right. And I think what I would say is that we understand—I think the Commission's view is that they understand the concept, the notion of trying to reward a provider for efficiency, for high-quality, low-resource use. I think some of the concern about that particular modifier is how accurately it can be put together for an individual provider.

I am not really deep on this, but my sense is that in the first wave of implementation that went out on it, CMS was saying, for groups of physicians, that there was some concern about the stability of measurement. And one of the things about an organizational structure of some size is, you get a lot more stability when

you look at quality and efficiency that way. So, one of the concerns with the modifiers is how stable it can be for any given provider.

Dr. PATEL. And I will just add that, for the beginning of the program, you have to have at least 100 eligible health professionals. So, to Dr. Miller's point, you need not only the size but, in terms of the measurement for 2015, they will be using performance year 2013. So we are still seeing this lag in getting physicians' information about what they could be doing at any real point in time. But we think it is an important step in the right direction to get you closer to taking on more of the risks.

Senator CANTWELL. Well, this was a part of the debate. I know because, obviously, it was my language, and this is a philosophy from the Northwest. I mean, sure we would like to get paid more. Sure they would, but we gave up on that a long time ago because we are more efficient and we have better outcomes.

So now all we want is the rest of the Nation to move towards that same level of efficiency so we are not penalized, so that physicians do not go practice medicine somewhere else just so they can get paid more when we actually have better outcomes. So we knew that the individual physician—I mean, that was part of the debate among committee members too. They knew if you isolated it down to that level, it would be somewhat problematic.

And we get that there may be regions or parts of the country that may be, you know, more uniquely challenged to face this. But we are talking about billions of dollars of savings here if you move off of fee-for-service. And, as I said, we would leapfrog right to ACOs because we are ready to go there, but I do not know that everybody else is. So we definitely believe that the index should be put in place. So, we will certainly be working with everyone to be more vocal about it, because we do think it is an important interim step.

Dr. Miller, on the kind of efficiencies that you think we can get out of ACOs, do you think there is enough savings there to then take those savings and focus on graduate medical education so that we can prioritize the volume that we need for primary care physicians?

Dr. MILLER. I have not thought about the issue in that way, and I would be very hard-pressed to tell you what kinds of savings to expect out of it. What I can say is that the Commission put together a proposal. It is a few years back now. I am forgetting exactly when we put it out, but the notion on graduate medical education was to stop having this kind of blind focus on slots which are producing more of the same when all of us at the same time are saying, don't we need a differently organized delivery system?

We had a set of recommendations that would use those resources differently and direct them to graduate programs that are more focused on systems, focused on primary care, focused on rural types of care, so that we would get better accountability out of the graduate medical education dollars that we are spending. Like I said, it has been a few years now. I am not quite on top of that. But I had not thought about it in the context of the ACO.

Senator CANTWELL. Given the demand that we are going to face, do we need to dramatically increase the number of GME slots for primary care?

Dr. MILLER. Our point has been 2-fold. One, be sure that the graduate medical education dollars that are being spent now are directed towards accountability and producing more of the types of professionals who operate in a system-based care. If you are going to add slots at that point, then think about which way you want those slots to go and what you want them to be devoted to.

Our basic concern is that just adding slots gets you more of the same in the current system.

Senator CANTWELL. Thank you.

Senator Isakson?

Senator ISAKSON. Thank you, Madam Chairman. Dr. Patel, when you were answering Senator Crapo's question, it prompted me to follow up with a question to you. I represent a State that has 10.5 million people. Five and a half million live in the metropolitan Atlanta area. The other 5 million live in the largest geographic expanse east of the Mississippi River in one State. So they are a long way from medical facilities.

In fact, we have lost two rural hospitals in the last year in Georgia. It seems like many of the directives and regulations and rules drive people to more expensive care, like the imaging example on the heart that you gave as an example.

As we try to clean up the SGR and make some reforms, should we look at Stark laws, antitrust laws, the Affordable Care Act, in many cases, which directs people to a more expensive reimbursement for a service than they might otherwise get?

Dr. PATEL. Thank you, Senator. I do think the issue of how we can make sure that patients who do not have access to or do not live within urban areas have ready access to high-value providers is a huge one. I think that—not being an attorney, in full disclosure, I will tell you—not looking at Stark laws or antitrust laws would be a mistake if what we are trying to do is also help providers, as I mentioned, take on more of that risk that we did not really go to medical school to do. But we understand we need to, to get away from our fee-for-service system.

So I do think that there are aspects of the Affordable Care Act that actually strengthen the ability to go to high-value providers. What I think all three of us have tried to reiterate is that what we need to do now is deal with the underlying formulas and mechanisms for which we still pay in Medicare to really drive that forward.

Senator ISAKSON. When you were commenting on reimbursement based on quality of care, in that discussion, you made reference to a care coordinator between primary care and specialties. Was that begging a reimbursement for that coordination, when you made that statement?

Dr. PATEL. Yes, Senator. Thank you for picking up on that. It is not asking for an additional reimbursement. I am arguing that we can take proportions of what we are already paying for now and move that to reimbursement that actually allows primary care doctors and specialists to talk to each other more effectively.

Senator ISAKSON. And get a better outcome because of it.

Dr. PATEL. Correct. Thank you. Yes.

Senator ISAKSON. Dr. Miller—this really is probably for any of you who want to answer, but I would particularly like to hear Dr. Miller's answer. We talk about a better-educated—I think I am a better patient and have better health when I am educated as to what is wrong with me and what I need to do to correct it, or how I need to interact as a patient with the medical system.

As we have studied Medicare for years, and I have looked at it, I have been a big advocate of raising the visibility of durable power of attorneys, living wills, end-of-life directives, advance directives, things of that nature, both for the quality of care for the patient as well as the common sense it makes for a patient, when of sound mind and body, to say what their wishes would be if they were not of sound mind or body or if they were in an irreversible cessation of brain waves or something like that. Is there a way we could reimburse for counseling sought by the Medicare beneficiary on that? Is there some way we could improve that education in America today for the benefit of both the patient as well as the system?

Dr. MILLER. The only thing I can offer you on that is that we have a line of research going now on something called shared decision-making, where information is brought to bear for the patient when they are facing particular decisions, and then that helps them go into the room with a physician, or whatever other health professional, and be more educated about their choices and what are the consequences of their choices. We are just now coming up to looking at it in the end-of-life environment. So I do not have much to offer you here, but that is kind of a path that we are looking at this year, a decision-making path.

Senator ISAKSON. Is there any other comment from the panel?

Dr. PATEL. I would just say, as a physician, I know that one of the areas in which all clinical providers have agreed is that we need to do a better job with understanding how to counsel and also receive information from patients about their preferences. There have been a number of attempts to do this in the Medicare program, and they have often been vilified and made out to be or misconstrued as something other than just sharing information.

So, Senator, I think it would be a welcome attribute to clinical service if we provided for a very direct way to engage with patients on these issues.

Senator ISAKSON. Yes, and if it is beneficiary- or patient-directed, I think that makes an awful lot of difference in the politics. Mr. Steinwald?

Mr. STEINWALD. I agree with what she said. The evidence, I believe, shows especially when people have multiple chronic illnesses and are at end-of-life, once they are informed and are making the decisions themselves or their family's directed decision-makers are making them, they tend to choose less care and fewer resources and are more likely to sign up for hospice care as well.

Senator ISAKSON. Thank you, Madam Chairman.

Senator CANTWELL. Thank you very much, and I am sure that my colleagues would love to see any recommendations that you are making in this area, moving forward or as soon as possible. Not seeing any of my other colleagues here, I am going to adjourn the hearing, but thank you so much for your testimony this morning. This is a critically important part of our delivery system reform,

and becoming more efficient and using those dollars to drive better quality at lower costs is going to be critical to the entire country. So we look forward to receiving more input from all of you. We are adjourned.

[Whereupon, at 11 a.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

Hearing Statement of Senator Max Baucus (D-Mont.) On Improving the Medicare Physician Payment System *As prepared for delivery*

The best-selling business author Tom Peters once said, "If a window of opportunity appears, don't pull down the shade."

We should keep those words in mind today as we examine the method Medicare uses to determine physician payments, the sustainable growth rate, otherwise known as the SGR. For the past ten years, this flawed formula has dictated drastic reductions in Medicare physician payments.

Next year, physicians will face a 25 percent cut under the SGR. This deep cut would mean many seniors could lose access to their doctor.

Each year, Congress has intervened to prevent these cuts. But we need to get beyond this annual "doc fix" ritual. The year-in, year-out uncertainty is not fair to physicians or seniors.

Since 2003, Congress has made 15 short-term fixes to the SGR at a cost of nearly \$150 billion. In 2010 alone, we passed six short-term fixes. It is time to break this cycle.

Ninety-seven percent of Medicare beneficiaries see a physician at least once a year, and most beneficiaries with chronic conditions see their doctor at least monthly.

We need to ensure that seniors can continue to see their doctors. We must permanently repeal this broken formula and we need to do it this year.

The most recent 10-year score for repealing the SGR is \$138 billion. While this is a large amount, it is more than \$100 billion less than last year's score. This is a window of opportunity. We need to seize it.

But we should not simply repeal the SGR. We also must change the underlying fee-for-service system that Medicare uses to pay physicians. Fee-for-service promotes volume over value. Physicians are rewarded for doing more tests and more procedures, even when unnecessary.

It does not encourage physicians to coordinate patient care to save money and improve health outcomes.

Last year this Committee held three roundtable sessions on improving the system to reward physicians for providing high-quality, high value care. We heard from former CMS Administrators, private plans and physician groups.

This year, we held two hearings in which we heard from CMS leaders about their efforts to develop new payment models.

We heard that there is a better way of doing business. The Innovation Center told us there are promising payment systems that would hold physicians accountable for providing high quality, efficient care.

These models include accountable care organizations, payment bundles, and medical homes. They incentivize physicians to coordinate patients' care. They focus on reducing emergency visits and hospitalizations.

They have the potential to control spending for Medicare and beneficiaries alike. More important, they mean better care for patients.

Physicians are eager to move to better systems. Jean Branscum from the Montana Medical Association recently wrote to me about the uncertainty created by the current SGR policy.

She said that Montana physicians want new payment models that improve health care and lower costs. She added that there's no time to waste. The continual uncertainty is driving physicians to limit the number of Medicare patients they see.

Unfortunately, the new models the Innovation Center is developing are not ready to replace the fee-for-service system. CMS and the Innovation Center need to quickly finish the new models so Medicare rewards value instead of volume. In the meantime, we must improve the current system.

We want to hear from doctors and other providers who see patients every day. They can help us identify ways to improve care and reduce unnecessary costs. We need the doctors on the front lines to step up with ideas.

Last Friday, Senator Hatch and I sent a letter to health care providers. We asked for their advice on improving the current fee-for service system.

First, we need to make sure each service is valued appropriately. Second, we want ways to reduce unnecessary services. Congress originally enacted the SGR to control spending, but it hasn't worked. The replacement clearly must do a better job of controlling costs. Finally, we need advice on how to help physicians transition to alternative payment models.

Our letter asks for specific suggestions. I emphasize "specific." We need concrete policies that can be implemented now to replace the SGR.

I look to our panelists to help us identify short-term, ready-to-go solutions. We have an opportunity to repeal the SGR once and for all this year. I encourage us to not draw the shade on this window of opportunity.

**STATEMENT OF HON. ORRIN G. HATCH, RANKING MEMBER
U.S. SENATE COMMITTEE ON FINANCE HEARING OF MAY 14, 2013
ADVANCING REFORM: MEDICARE PHYSICIANS PAYMENTS**

WASHINGTON – U.S. Senator Orrin Hatch (R-Utah), Ranking Member of the Senate Finance Committee, today delivered the following opening statement at a committee hearing examining Medicare physician payments:

Last year, this committee held a productive series of roundtable discussions with key stakeholders on this very topic, which helped to set the stage for us to move forward with reform.

The Chairman and I agree that we must find a better way to pay physicians in Medicare. The SGR system is fundamentally flawed and must be repealed – we are committed to working together to do just that.

As it stands, unless Congress intervenes, Medicare physician payments will be reduced by 25 percent in 2014 due to the SGR formula. With such large cuts, physicians will quickly be unable to offer care to millions of seniors on Medicare.

Our seniors deserve better than to have government inaction threaten the availability of their care.

Due to the recent slowdown in overall health expenditures, the current cost of permanently repealing the SGR is down sharply from a previous Congressional Budget Office estimate of \$245 billion to less than \$150 billion.

However, we know from previous years that the CBO score has a tendency to fluctuate.

I believe we currently have a good window of opportunity before us. But, we must act soon.

We must provide a stable foundation for paying our physicians, now and in the future. If we fail to act, we run the risk of causing a physician shortage in the Medicare program that has broad impact for beneficiaries.

This past Friday, the Chairman and I sent a letter to members of the health care provider community appealing to them for their input on how to improve the current system and help physicians transition to new payment models. This builds on the discussions we started last year.

As we await responses from the provider community, we have the privilege today to hear from our panel of expert witnesses and get their thoughts on the matter.

This issue is well-covered terrain.

We know this is not an easy task, but physicians and patients deserve better. We must find a more stable foundation to pay physicians treating Medicare patients. I believe if we identify the appropriate policy solutions, we can finally find a path to repeal the SGR.

Once again, I thank you, Chairman Baucus, for convening today's hearing and I look forward to hearing from our witnesses.

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**Moving Forward From
the Sustainable Growth Rate
(SGR) System**

May 14, 2013

Statement of

Mark E. Miller, Ph.D.

Executive Director

Medicare Payment Advisory Commission

Before the

Committee on Finance

U.S. Senate

Chairman Baucus, Ranking Member Hatch, distinguished Committee members. I am Mark Miller, executive director of the Medicare Payment Advisory Commission (MedPAC). I appreciate the opportunity to be here with you this morning to discuss 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 (such as nurse practitioners or therapists) 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, comprising 12 percent of total Medicare spending.

Medicare pays physicians and other health professionals 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 better able to raise charges than others.² The Medicare physician fee schedule (PFS) was developed by a research team at Harvard 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 As noted above, physicians are able to order more or fewer services, and Medicare has gone through periods of high volume growth.⁵ This led to concerns upon implementation of the PFS that physicians would respond to fee adjustments by generating more service volume. As a response, the Congress created volume-control policies, such as the SGR, 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. Further, the SGR formula also allows for volume growth equal to the rate of growth in per capita gross domestic product (GDP). As a

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.

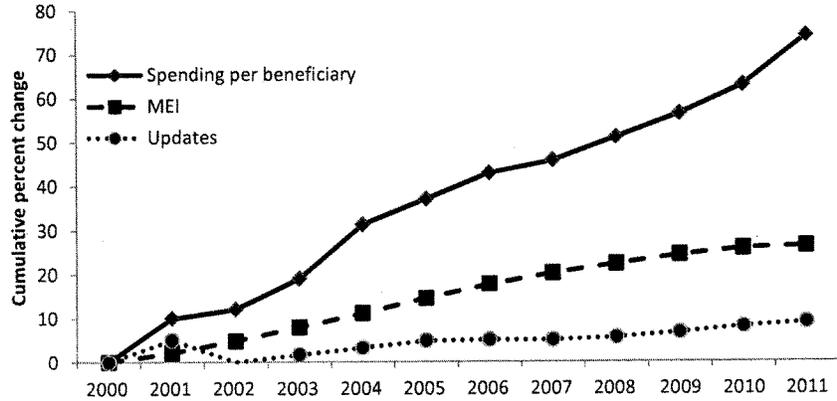
⁵ Government Accountability Office. 2006. *Trends in service utilization, spending, and fees prompt consideration of alternative payment approaches*. GAO-06-1008T. <http://www.gao.gov/assets/120/114491.pdf>.

result, the 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.

Beginning in 2002, the formula produced negative updates 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 believes that 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. However, volume growth remains high since the SGR does not differentiate between physicians who restrain volume and physicians who do not restrain volume (Figure 2).

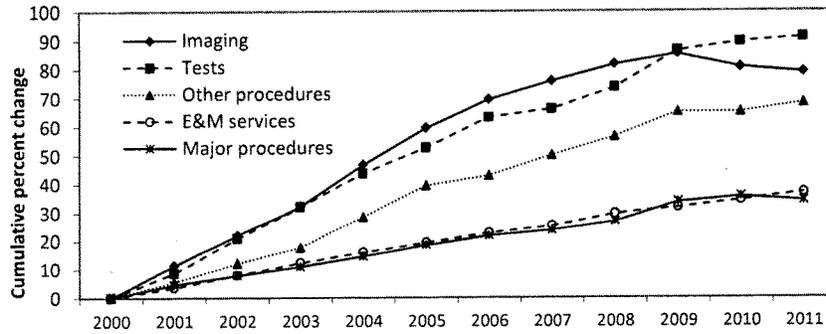
Figure 1. Volume growth has caused spending to increase faster than input prices and updates, 2000-2011



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.

The Commission's position on the SGR system

The Commission believes that the SGR is fundamentally flawed and is creating instability in the Medicare program for providers and beneficiaries, and that the time to repeal the SGR is now. In October 2011, CBO's estimate of a 10-year freeze was about \$300 billion over 10 years. Their current estimate of a 10-year freeze is \$138 billion. We urge the Congress to act now to take advantage of this lower estimate; if history is any guide, the cost of repeal could increase again. In addition, further delay would expose beneficiaries to an increasing risk of impaired access, especially access to primary care.

The Commission's principles for repealing the SGR are expressed in two letters to the Congress—a letter to the Congress in October 2011, followed by a letter to the Congress in April 2013. Both are attached to this testimony and summarized in brief below. The October 2011 letter lays out the Commission's principles and a set of four recommendations for moving forward from the SGR system and the April 2013 letter reiterates these points as well as providing context for the increased urgency to repeal the SGR now, given the lower cost of repeal.

Several principles inform 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.

Working from these principles, MedPAC made four distinct recommendations in October 2011. 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. Second, CMS should collect data to improve payment equity within the fee schedule. Third, CMS should identify overpriced services and adjust the relative value units of those services. And fourth, the Medicare program should encourage physician movement from fee-for-service into risk-bearing accountable care organizations (ACOs) by creating greater opportunities for shared savings. With these recommendations, we offered a list of possible offsets if the Congress were to decide to offset the cost of repeal from within the Medicare program.

Repeal is urgent

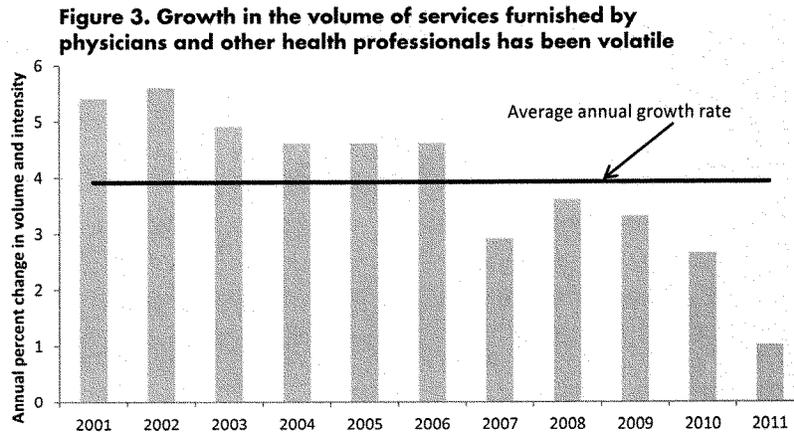
Temporary, stop-gap fixes to the SGR have had a destabilizing influence on the Medicare program by creating uncertainty for physicians, other health professionals, and beneficiaries. Moreover, the short-term overrides to the SGR have led to an administrative burden for providers and CMS due to holding of claims, delays in submission of claims, and reprocessing of claims.

Two reasons have often been given for delaying repeal: the large budgetary cost of repeal and concerns 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 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).



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.

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

It is unclear why volume growth has had such volatility. Reasons offered for the slowdown 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. Five months ago, before CBO incorporated the most recent experience with volume growth in their budget 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. For this reason, it is a particularly opportune time to repeal the SGR.

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. Although we do not yet see evidence of a nationwide problem in access to care for Medicare beneficiaries, access is strained in some markets—particularly for primary care. These problems could spread to more markets due to increases in the Medicare population, a large cohort of physicians reaching retirement age, and newly insured patients seeking care in 2014. Growing “SGR fatigue” among physicians, resulting from annual crises prompted by pending Medicare payment cuts, can only exacerbate any access problems that might develop.

Even with the new, lower score for SGR repeal, it may still be necessary to replace the SGR with a 10-year schedule of low, or even negative, legislated fee-schedule updates. That new schedule

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>.

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

of updates would establish a new budgetary baseline, but 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. Given the Commission's strong interest in delivery system reform and the important role primary care will play in such reform, the Commission is concerned that there is an imbalance between supply and demand in primary care. 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. Two of our recommendations in October 2011 would improve the valuation of services under the 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.

Consistent with repealing the SGR in a fiscally responsible way, the Commission included potential options for the Congress to consider in constraining the cost of repeal, including an update path for physicians and other health professionals that is higher for primary care services than the update path for other services. In addition to constraining the cost of repeal this would also counter inequities in the fee schedule between primary care and other services. These

October 2011 updates would have resulted in physicians and other health professionals bearing about one-third of the fiscal burden of repeal.

Given that the cost of repeal has decreased, the 10-year path of legislated updates described in our October 2011 letter could be revised. To be clear, we still believe it is necessary to have a differential between primary care services and other services in order to redress the imbalance between fees for primary care and other services. However, while our 2011 recommendations included reductions for services other than primary care of 5.9 percent each year for three years, our preliminary estimate is that each of those reductions could now be 3 percent or less. This estimate assumes that primary care fees are held constant throughout the 10-year period and that one-third of the fiscal burden of repeal is borne by physicians and other health professionals paid under the fee schedule.

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. Specifically, as described above, physicians and other health professionals paid under the fee schedule would bear one-third of the cost of repeal and the remaining two-thirds would have been spread across all of the other participants in Medicare (other providers and suppliers, health plans, and beneficiaries).

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's recent estimate that the cost of repealing the SGR is lower by \$100 billion 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 reduce the deficit.

Attachments: April 2013 letter to the Congress, October 2011 letter to the Congress

Attachment
April 2013 letter to the Congress



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Glenn M. Hackbarth, J.D., Chairman
 Michael Chernew, Ph.D., Vice Chairman
 Mark E. Miller, Ph.D., Executive Director

April 10, 2013

The Honorable Max Baucus
 Chairman, Committee on Finance
 U.S. Senate
 219 Dirksen Senate Office Building
 Washington, DC 20510

The Honorable Dave Camp
 Chairman, Committee on Ways and Means
 U.S. House of Representatives
 1102 Longworth House Office Building
 Washington, DC 20515

The Honorable Fred Upton
 Chairman, Committee on Energy and Commerce
 U.S. House of Representatives
 2125 Rayburn House Office Building
 Washington, DC 20515

The Honorable Orrin G. Hatch
 Ranking Member, Committee on Finance
 U.S. Senate
 203 Hart Senate Office Building
 Washington, DC 20510

The Honorable Sander M. Levin
 Ranking Member, Committee on Ways and Means
 U.S. House of Representatives
 1106 Longworth House Office Building
 Washington, DC 20515

The Honorable Henry A. Waxman
 Ranking Member, Committee on Energy and
 Commerce
 U.S. House of Representatives
 2322A Rayburn House Office Building
 Washington, DC 20515

RE: Moving forward from the sustainable growth rate system

Dear Chairmen and Ranking Members:

Having been asked at recent hearings about MedPAC's view on the sustainable growth rate (SGR) formula, I am writing to provide some updated information.

The time to repeal SGR is now. Further delay would expose beneficiaries to an increasing risk of impaired access, especially access to primary care. Although we do not yet see evidence of a nationwide problem in access to care for Medicare beneficiaries, access is strained in some markets. Those problems could spread to more markets due to increases in the Medicare population, a large cohort of physicians reaching retirement age, and newly insured patients seeking care in 2014. Growing "SGR fatigue" among physicians, resulting from annual crises prompted by pending Medicare payment cuts, can only aggravate any access problems that might develop.

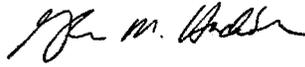
In October 2011, MedPAC made four distinct recommendations. First, the link between cumulative fee-schedule expenditures and annual conversion factor updates is unworkable and should be eliminated. In place of the SGR, the Commission outlined a 10-year path of legislated updates, including updates for primary care services that are different from those for other services. Second, CMS should collect data to improve payment equity within the fee schedule. Third, CMS should identify overpriced services and adjust the RVUs of those services. And fourth, the Medicare program should encourage physician movement from fee-for-service into risk-bearing accountable care organizations (ACOs) by creating greater opportunities for shared savings. With these recommendations, we offered a list of possible offsets if the Congress were to decide to offset the cost of repeal from within the Medicare program.

Our basic position has not changed, but the Congressional Budget Office's (CBO's) estimate of the cost of repeal has changed. In October 2011, CBO's estimate of a 10-year freeze was about \$300 billion over 10 years. Their current estimate of a 10-year freeze is \$138 billion. We urge the Congress to act now to take advantage of this lower estimate; if history is any guide, the cost of repeal could increase again.

Providing higher payment updates for primary care compared with other fee schedule services would counter inequities in the physician and other health professionals fee schedule and contain the cost of the repeal. Further, given that the cost of repeal has decreased, the 10-year path of legislated updates described in our October 2011 letter could be revised. The October 2011 updates would have resulted in physicians and other health professionals bearing about one-third of the fiscal burden of repeal while the remaining two-thirds would have been spread across all of the other participants in Medicare (other providers and suppliers, health plans, and beneficiaries). If those same proportions were maintained, the fee schedule conversion factors could be higher as a result of the new CBO score. To be clear, we still believe it is necessary to have a differential between primary care services and other services. However, while our 2011 recommendations included reductions for services other than primary care of 5.9 percent each year for three years, our preliminary estimate is that each of those reductions could now be 3 percent or less. This estimate assumes that primary care fees are held constant throughout the 10-year period and that one-third of the fiscal burden of repeal is borne by physicians and other health professionals paid under the fee schedule.

While a specific sequence of legislated updates would establish a new budgetary baseline, they 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.

Sincerely,

A handwritten signature in black ink, appearing to read "Glenn M. Hackbarth". The signature is fluid and cursive, with the first name being the most prominent.

Glenn M. Hackbarth, J.D.
Chairman

Attachment
October 2011 letter to the Congress



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Glenn M. Hackbart, J.D., Chairman
 Robert A. Berenson, M.D., F.A.C.P., Vice Chairman
 Mark E. Miller, Ph.D., Executive Director

October 14, 2011

The Honorable Max Baucus
 Chairman, Committee on Finance
 U.S. Senate
 219 Dirksen Senate Office Building
 Washington, DC 20510

The Honorable Dave Camp
 Chairman, Committee on Ways and Means
 U.S. House of Representatives
 1102 Longworth House Office Building
 Washington, DC 20515

The Honorable Fred Upton
 Chairman, Committee on Energy and Commerce
 U.S. House of Representatives
 2125 Rayburn House Office Building
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The Honorable Orrin G. Hatch
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 1139E Longworth House Office Building
 Washington, DC 20515

The Honorable Henry A. Waxman
 Ranking Member, Committee on Energy and
 Commerce
 U.S. House of Representatives
 2322A Rayburn House Office Building
 Washington, DC 20515

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.

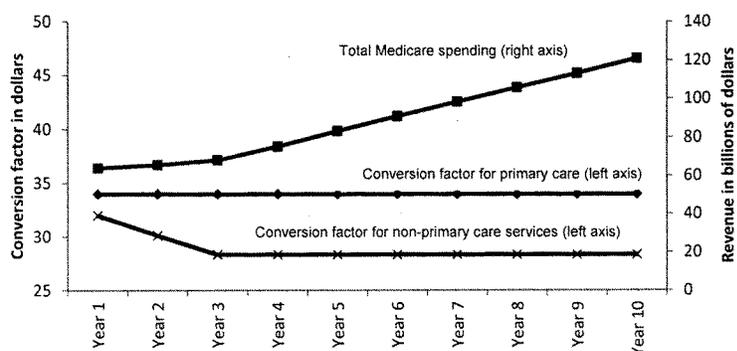
Respectfully, we submit the recommendations described below. Several of them are interrelated. Our willingness to recommend difficult measures underscores the urgency we attach to repealing the SGR. The cost of repealing the SGR, as well as the cost of any short-term reprieves, will only increase. Meanwhile, 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

¹Alternative 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.

²Medicare 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

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

³Boukus, 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

Year	Primary care		Other services		Annual payments (billion)
	Payment rate change	Conversion factor	Payment rate change	Conversion factor	
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

⁴Expanded 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.

⁵The 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

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

⁷Medicare 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—analogueous 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

⁸Centers 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.

⁹American 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.

¹⁰One 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,

A handwritten signature in black ink, appearing to read "Glenn M. Hackbarth". The signature is fluid and cursive, with the first letters of the first and last names being capitalized and prominent.

Glenn M. Hackbarth, J.D.
Chairman

Appendix

**TABLE
A-1**
Commissioners' voting on recommendations

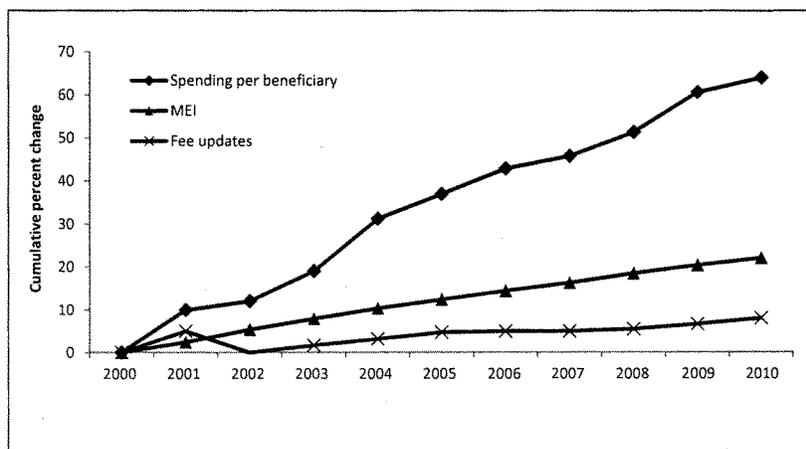
- 1** The Congress should repeal the sustainable growth rate (SGR) system and replace it with a 10-year path of statutory fee-schedule updates. This path is comprised of a freeze in current payment levels for primary care and, for all other services, annual payment reductions of 5.9 percent for three 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)				Private insurance (age 50-64)			
	2007	2008	2009	2010	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, 3,900 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.

Testimony of Kavita K. Patel MD, MS
Fellow and Managing Director
The Engelberg Center for Health Care Reform at the Brookings Institution

May 14, 2013

Chairman Baucus, Ranking Member Hatch and members of the Committee, thank you for this opportunity to highlight ways to advance physician payment reforms in Medicare. The Medicare program retains a strong commitment to provide care to approximately 50 million beneficiaries across the country; a key partner in the provision of this care are the 900,000 healthcare providers who see beneficiaries in medical offices, hospitals, skilled nursing facilities and other settings.¹ Each day, providers work hard to deliver the best care for their patients yet our current payment system falls short time and time again, with financing mechanisms that perpetuate fragmented care and volume over coordination and value. Fortunately, there are better ways to pay physicians that can enable them to improve care, enhance the patient experience and potentially achieve greater savings for the Medicare system overall. I am honored to present some solutions from my work at the Engelberg Center for Health Care Reform at the Brookings Institution and our Merkin Initiative on Clinical Leadership, as a Commissioner on the National Commission on Physician Payment Reform and perhaps most importantly, as a practicing internal medicine physician.²

¹ Report to the Congress: Medicare Payment Policy. Medicare Payment Advisory Commission. http://www.medpac.gov/documents/Mar12_EntireReport.pdf

² Frist W, Schroeder S, et al. *Report of The National Commission on Physician Payment Reform*. The National Commission on Physician Payment Reform. http://physicianpaymentcommission.org/wp-content/uploads/2013/03/physician_payment_report.pdf

Current Payment Policies in Medicare

Currently, Medicare pays physicians primarily by a fee-for-service (FFS) schedule that is informed by relative value units (RVUs). Relative value units are determined from the Resource Based Relative Value Scale (RBRVS) which defines the value of a service through a calculation of physician work, practice expense and practice liability.⁴ A relative value unit is assigned to every medical service that physicians carry out during a clinical visit.⁵ The RVU is then adjusted by geographic region (so a procedure performed in Miami, Florida is worth more than a procedure performed in Salem, Oregon). This value is then multiplied by a fixed conversion factor, which changes annually, to determine the amount of payment to the physician. As the number of billable service codes have grown over time, an extensive regulatory process was enacted to develop RVU weights and update them year over year.

Over time, the RVU updating system has placed an increasing importance, evidenced by RVU weights, on procedures, scans, and other technical services that fix certain ailments or problems. Emphasis on technologies and interventions have resulted in a marked disparity between reimbursement for specialties which emphasize procedures such as cardiology and gastroenterology and those that do not such as primary care, endocrinology or infectious diseases, thus exacerbating shortages and the hierarchical culture within medicine.

The 1997 Balanced Budget Act exacerbated the problem with the introduction of the sustainable growth rate or SGR. The SGR was intended to keep the growth in

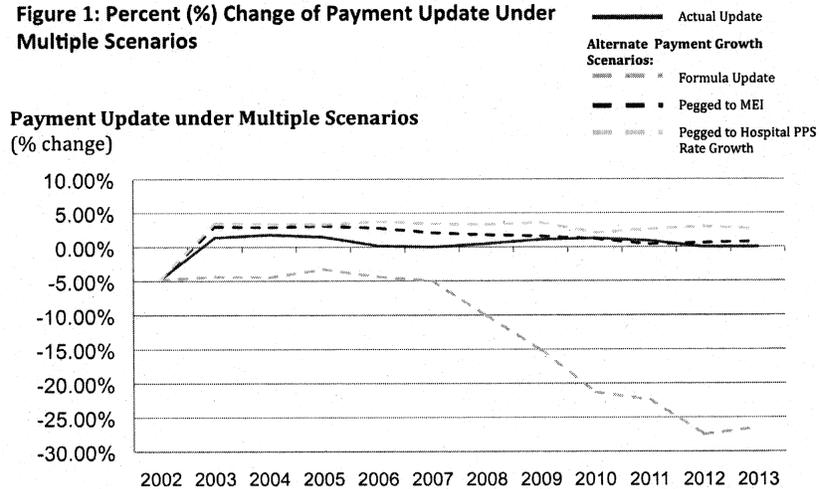
⁴ The RBRVS has three components. Physician work accounts for the time, skill, physical effort, mental judgment and stress involved in providing a service and is approximately 48 percent of the relative value unit. Practice expense refers to the direct costs incurred by the physician and includes the cost of maintaining an office, staff and supplies and accounts for 48 percent. Professional liability insurance takes into account the malpractice insurance essential for maintaining a practice and is 4 percent of the calculation. *Overview of the RBRVS*. American Medical Association. <http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/medicare/the-resource-based-relative-value-scale/overview-of-rbrvs.page>

⁵ The Centers for Medicare and Medicaid Services (CMS) uses Current Procedural Terminology (CPT) codes to determine services that it will reimburse for Medicare enrollees and each CPT code has an assigned relative value unit.

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

Every year since then, the scheduled SGR payment rate reductions have not taken full effect. Instead, because of concerns about access to care and the sufficiency of payments, Congress has headed off the full payment reductions on a short-term basis. Typically, this has involved offsetting at least some of the budgetary costs with payment reductions affecting other Medicare providers. As **Figure 1** illustrates, actual updates as well as the SGR formula update still grow at rates far below input costs (MEI) and payment rates for other providers, thus exacerbating systemic flaws. In short, our system is broken.

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



SOURCE: CMS Office of the Actuary

Payment Reforms in the Affordable Care Act

The Affordable Care Act included over 100 policy changes in Medicare provider payments, many of which are currently being phased into the current delivery system and affect physicians directly.⁶ These reforms include Medicare Accountable Care Organizations (ACOs), Value-based payment modifiers, the Bundled Payments for Care Improvement initiative as well a number of broader efforts for statewide level innovation, multipayer efforts to promote primary care and alignment of payments for Medicare-Medicaid beneficiaries (dual eligibles). These reforms are incredibly effective at encouraging providers to delivery high-quality, coordinated care at a lower cost and enable Medicare to pay for value. As Jonathan Blum, Acting Deputy Administrator and Director of the Center for Medicare recently pointed out in his testimony before this committee, “the Medicare program has been transformed from a passive payer of services into an active purchaser of high-quality, affordable care.”⁷ While these reforms will offer a great deal of insight into how we can improve Medicare physician payment through authorities granted in the Patient Protection and Affordable Care Act, they are still largely based on a fee-for-service payment system. We must acknowledge the limitations in implementing payment reforms in the face of a dominant fee-for-service system. One early large-scale Medicare pilot implemented in oncology in 2006 serves as a good example: in conjunction with reductions in Part B drug payments, oncologists received an additional payment to report on whether the chemotherapy care provided by them adhered to certain evidence-based guidelines. This promoted comparisons to the published guidelines and also supported the development of evidence on how widely published guidelines were being followed

⁶ Policy Options to Sustain Medicare for the Future. January 2013. Kaiser Family Foundation. <http://kaiserfamilyfoundation.files.wordpress.com/2013/02/8402.pdf>

⁷ Statement of Jonathan Blum on Delivery System Reform: Progress Report from CMS Before the Senate Finance Committee. 28 February 2013. Full transcript available at: [http://www.finance.senate.gov/imo/media/doc/CMS%20Delivery%20System%20Reform%20Testimony%202.28.13%20\(1.%20Blum\).pdf](http://www.finance.senate.gov/imo/media/doc/CMS%20Delivery%20System%20Reform%20Testimony%202.28.13%20(1.%20Blum).pdf)

in practice.⁸ However this pilot did not make any changes in the underlying structure of fee-for-service payments and did not explicitly tie payments to measured improvements in performance, resulting in limited feasibility and adoption. In order to move away from our current system and build on the promise of ongoing efforts we must remove the SGR as a constant impediment to true systemic change.

Recommendations of the National Commission on Physician Payment Reform

In an effort to explore new ways that to pay for care that can yield better results for both payers and patients, the Society of General Internal Medicine convened the National Commission on Physician Payment Reform in 2012. Our commission, composed of a broad range of leadership and expertise spanning the public and private sectors, adopted twelve specific recommendations for reforming physician payment:

1. The SGR adjustment should be eliminated
2. The transition to an approach based on quality and value should start with the testing of new models of care over a 5-year time period and incorporating them into increasing numbers of practices, with the goal of broad adoption by the end of the decade.
3. Cost-savings should come from within the Medicare program as a whole. Medicare should where possible, avoid cutting just physician payments to offset the cost of SGR repeal, but should also look for savings from reductions in inappropriate utilization of Medicare services.
4. The Relative Value Scale Update Committee (RUC) should continue to make changes to become more representative of the medical profession as a whole and to make its decision-making more transparent. CMS has a statutory responsibility to ensure that the relative values it adopts are accurate and

⁸ Doherty J, Tanamor M, Feigert J, et al: Oncologists' Experience in Reporting Cancer Staging and Guideline Adherence: Lessons from the 2006 Medicare Oncology Demonstration. *J Oncol Pract.* 6(2): 56-59. 2010.

appropriate, and therefore it should develop alternative open, evidence-based, and expert processes beyond the recommendations of the RUC to validate the data and methods it uses to establish and update relative values.

5. For both Medicare and private insurers, annual updates should be increased for evaluation and management codes, which are currently undervalued, and updates for procedural diagnosis codes, which are generally overvalued and thus create incentives for overuse, should be frozen for a period of three years. During this time period, efforts should continue to improve the accuracy of relative values, which may result in some increases as well as some decreases in payments for specific services.
6. Fee-for-service contracts should always include a component of quality or outcome-based performance reimbursement.
7. Higher payment for facility-based services that can be performed in a lower cost setting should be eliminated. Additionally, the payment mechanism for physicians should be transparent, and should reimburse physicians roughly equally for equivalent services.
8. In practices having fewer than five providers, changes in fee-for-service reimbursement should encourage methods for the practices to form virtual relationships and thereby share resources to achieve higher quality care.
9. Over time, payers should largely eliminate stand-alone fee-for-service payment to physicians because of its inherent inefficiencies and problematic financial incentives.
10. Because fee-for-service will remain an important mode of payment into the future even as the nation shifts to fixed-payment models, future models of physician payment should include appropriate elements of each. Thus, it will be necessary to continue recalibrating fee-for-service payments, even as the nation migrates away from that method of paying physicians.
11. As the nation moves from a fee-for-service system to one that pays physicians through fixed payments, initial payment reforms should focus on areas where significant potential exists for cost savings and higher quality.

12. Measures should be put into place to safeguard access to high quality care, assess the adequacy of risk-adjustment indicators, and promote strong physician commitment to patients.

Moving Beyond the SGR

Eliminating the SGR is a principal recommendation of many expert reports, including our Commission's Report, MEDPAC, The Brookings Institution, Simpson-Bowles and the Bipartisan Policy Center, but the question remains, repeal and replace with what? ^{9,10,11} As stated above we (and other clinical groups and societies) recommend a five year transition to newer models of payment which move away from FFS as the dominant payer. But the devil is in the details, and proposals to move towards new models over a period of time leaves policymakers and physicians wondering what their practices will look like next month, next year and beyond. In moving from principle to practice, it is also important to acknowledge that while there will be no one payment model that applies to all physicians, payment models must be relevant to primary care physicians and specialists alike. Additionally, given the growing complexity of caring for Medicare beneficiaries, payment models should encourage collaborations between specialists and primary care physicians rather than focus on a model that is suited for one clinical specialty alone.

⁹ Antos J, Baicker K, McClellan M, et al. *Bending the Curve: Person-Centered Health Care Reform*. April 2013.

Full report here: <http://www.brookings.edu/research/reports/2013/04/person-centered-health-care-reform>

¹⁰ Bowles E, Simpson A, et al. *A Bipartisan Path Forward to Securing America's Future*. Moment of Truth Project. April 2013. Full report available here:

<http://www.momentoftruthproject.org/sites/default/files/Full%20Plan%20of%20Securing%20America's%20Future.pdf>

¹¹ Daschle T, Domenici P, Frist W, Rivlin A, et al. *A Bipartisan Rx for Patient-Centered Care and System-Wide Cost Containment*. Bipartisan Policy Center. April 2013. Full report available here:

<http://bipartisanpolicy.org/sites/default/files/BPC%20Cost%20Containment%20Report.PDF>

Short-Term Steps in Advancing Payment Reforms

To facilitate providers' transition to alternatives to fee-for-service payments, CMS should harmonize current payment adjustments and quality improvement initiatives and apply those funds towards a care coordination payment which could give physicians more support for broader long-term reform pathways. Medicare has implemented quality reporting systems and payment adjustments for physicians, hospitals, and other providers. But these payments are generally administered as either a flat percentage or adjuster to all FFS payments. In contrast, shifting some existing FFS payments into a care coordination payment would give providers more support in moving toward condition-based, episodic payments, or global payments that allow for management of a population of payments that would otherwise be impossible in the current payment setting.

Table One highlights current efforts within the Medicare to increase value in care; each initiative is important but in isolation results in marginal financial gains and at times each of these initiatives is limited in scope. For example, quality measures for the Physician Quality Reporting System (PQRS) have flexible annual submission options, with qualification through registries, electronic health records etc. However, the program has suffered from criticism that measures are not as relevant to specialists. And at best, providers will gain approximately an average of \$1059 for participation per year, which some might say is not worth the effort, even in a penalty phase of the program. With the passage of the American Taxpayer Relief Act of 2013, a mechanism will be in place by 2014 for specialty specific efforts to satisfy CMS' reporting requirements for PQRS, which will encourage higher specialist participation in quality improvement efforts and help align clinician-developed quality measures with CMS' mandate to examine quality of patient care. Applying these measures to help physicians understand how registries can not only benefit their patients but lead to better predictability in a changing payment landscape will facilitate entry into pathways of reform.

Meaningful use measures are also quite detailed with important process metrics but physicians will likely also “perform to the measure” and may have difficulty going beyond unless there are linkages to payment reform. This is reflective of the sentiment that many providers express that they are constantly being asked to measure and perform, all while trying to see just as many patients in a day of work with little to no reward for doing less or changing workflows in order to reduce inappropriate utilization of resources. For example, proposed Stage 2 meaningful use measures include 17 core measures and six additional menu objectives from which a physician would choose at least three. This adds up to a total of 20 distinct actions that often involve all office staff. Rather than adding to these measures, CMS should consider how existing measure components could be applied to a payment update overall or a *care coordination payment* for the care of a patient with a chronic disease.

Table One: Current Incentive Opportunities Which Can Serve as a Foundation for Payment Reforms

	Physician Requirements	Financial Incentives	Financial Penalties	Estimated bonus/penalty
PQRS	2013: Must choose 3 individual measures (of the 139 total) and report 80% of Medicare encounters that apply or select one Measures Group (of the 22 total) and report 30 unique encounters. Report via paper-claims, registries, EHRs, or the group practice option.	Eligible professionals who participate are eligible for incentive payments. 2013: 0.5% of the total Medicare charges if no Maintenance of Certification, 1.0% if Maintenance of Certification.	Eligible professionals who do not participate in 2013 and beyond will face a penalty beginning in 2015.	In 2011, average bonuses were \$1,059/individual and \$9,863/practice.
Value-Based Modifier	Beginning 2015 (based on PY 2013), most organizations with 100+ eligible professionals must self-nominate to participate in the 2013 PQRS via the web-interface GPRO, a qualified registry, or administrative claims data.	For those that self nominate and elect quality-tiering, performance rates will affect the value-based modifier which <i>may</i> adjust it up. For those that don't elect quality-tiering, the value-based modifier is 0.0%	-1.0% value-based modifier for groups with 100+ eligible professionals who do not participate in PQRS (plus the -1.5% penalty for not participating in PQRS).	

Meaningful Use/EHR Incentive	Eligible professionals or hospitals must choose to participate in the Medicare or Medicaid EHR incentive program. Stage 1 (current): Data capture and sharing of 15 core measures, 5 of 10 menu measures, and 6 clinical quality measures.	Medicare incentive payment is 75% of Medicare allowed charges, up to a maximum cap of \$44,000 over 5 years. Must start by 2014.	Subject to adjustments in Medicare reimbursements equal to -1% per year (or -2.0% if subject to eRX penalty) between 2015 and 2019, maxing out at -5%.	Maximum bonus for participants that started Medicare program. ¹¹ Total: \$44,000
Electronic Prescribing	Eligible professionals who e-prescribe must attach the code G8553 to applicable claims for Medicare services. This code signals that a HIT system was used to send electronic order for prescriptions.	2013: 0.5% unless participations earned a Meaningful Use EHR incentive under Medicare, then 0%.	2013: -1.5% 2014 and beyond: -2.0%	In 2011, average bonuses (1% bonus) were \$1,912/individual and \$6,609/practice. ¹²

¹¹ 2011 Reporting Experience Include Trends (2008-2011): Physician Quality Reporting System and Electronic Prescribing (eRx) Incentive Program. Center for Medicare & Medicaid Services. 09 April 2013. Available at: http://cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2011_PQRSeRx_Experience_Report_04092013.zip

¹² An Introduction to the Medicare EHR Incentive Program for Eligible Professionals. Center for Medicare & Medicaid Services.

Available at: http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/beginners_guide.pdf

¹³ CMS 2011 Reporting Experience Include Trends (2008-2011): Physician Quality Reporting System and Electronic Prescribing (eRx) Incentive program

In the case of a care coordination payment, providers who opt to enter into a care coordination pathway in the first year can receive a lump sum of payment. This payment would be roughly equivalent to the potential bonus payments for all programs in table one. In return they would have to demonstrate that they are improving clinical practice and implementing outcomes-based clinical measures which are germane to their practice. In this example, a cardiologist would receive a population level care coordination payment derived from bonus payments and some FFS payments who does the following:

- Participates in a care coordination pathway for chronic cardiac disease (atrial fibrillation, congestive heart failure, etc)
- Subscribes to a cardiac specific registry (thus meeting PQRS requirements)
- Implements patient engagement tools for electronic care coordination, medication reminders, therapeutic lab monitoring for anticoagulation (meeting requirements for meaningful use, value-based modifier program, e-prescribing)

- Implements a significant practice transformation (potentially a new component which allows for a physician in a small, medium or large practice to individualize their approach to innovation)

The cardiologist would satisfy program requirements and would receive the maximum bonus payments.

Implementing this kind of approach involves potentially supporting CMS and additional entities to provide data on performance measures and quality improvement at more regular intervals along with technical assistance to understand how to translate incoming data into practice transformation. This process can begin in the year following a SGR repeal and can be supported through the assistance of existing clinical societies and quality improvement organizations. In this manner, assumption of clinical and performance risk becomes more commonplace for physicians. Simply put, physicians understand that they need to be held accountable for payment in a standard fashion, but want to feel that they can bring some degree of personalization into their practice in order to meet the needs of their populations.

Finally, I encourage CMS to continue implementing important changes through the Physician Fee Schedule including recent changes for care coordination.¹² These changes are an important acknowledgment that while we migrate from a payment system dominated by fee-for-service, we need to also enhance the existing system to be aligned with the expected outcomes of policy changes. Recent calls for evaluating the distribution of evaluation and management codes and determining the accuracy and appropriate valuation are also an important step in the short term.

¹² Bindman A, Blum J, Kronick R. Medicare's Transitional Care Payment — A Step toward the Medical Home. *N Engl J Med* 2013; 368:692-694

Movement from The Short Term to Longer Term Sustainable Payment Reforms

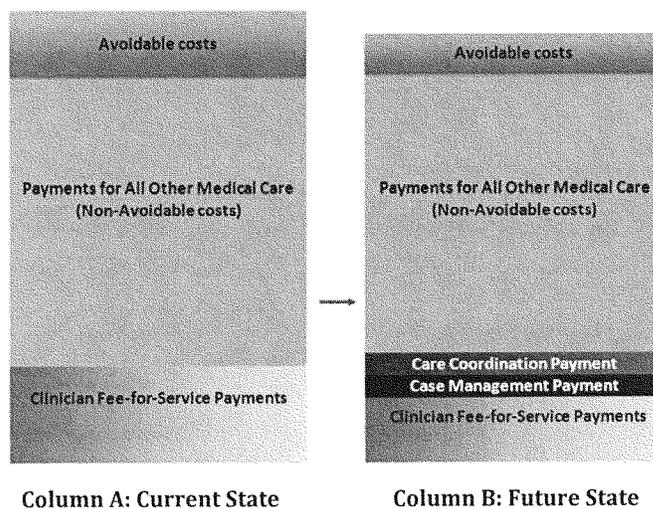
As clinicians of all specialty types realize that there is a viable pathway to care for patients and work across silos. The appetite for a more attractive option is evidenced by the overwhelming response to applications for the CMMI Challenge Grants, BPCI initiative, Medicare Shared Savings Program and other efforts. Clearly, physicians want an alternative.

Through my work at the Brookings Institution's Engelberg Center for Health Care Reform and the Richard Merkin Initiative on Clinical Leadership, we have been meeting with physicians in primary care and specialties as well as other healthcare stakeholders. With iterative feedback from clinicians in practice, we have proposed a longer term payment model that takes into account the currently uncompensated critical elements of patient care, the need for more flexibility in the way physicians are able to use their time and treatment resources in the best interest of their patients' individual circumstances, and the need to implement care reforms in a way that recognizes the intense and growing cost pressures in our health care system.

Our model, outlined in **Figure 2**, would build on the short term payment advances above with incorporation of a payment for care coordination that is derived from the programs in **Table One** and identify additional opportunities to improve care and lower costs that are not reimbursed well in traditional fee-for-service payment systems. For example, a common procedure in the outpatient cardiac practice is the echocardiogram (echo), or ultrasound of the heart. This procedure is sometimes performed in place of preventive counseling or watchful monitoring of a patient in coordination with a primary care physician, in large part because a hospital-based outpatient cardiology practice receives up to \$450 for an echo compared to \$53 for a visit without the procedure. Imagine paying both the cardiologist and primary care physician a fixed payment of \$400 that allows for longer term communication and conservative monitoring in return for reporting on clinical outcomes at a population level. The clinicians are take the financial risk involved in the clinical care of their

patient using the investments previously made by clinically driven pathways, registries and care coordination solutions.

Figure 2: Potential Pathway for Longer Term Payment Reform



Column A represents total spending on health care and reflects the current state of physician payment: exclusive reliance on the FFS model for physician payments, with waste and inefficiency in the form of redundant and unnecessary care, breakdowns in coordination, escalation of preventable complications etc. This leaves the total cost of physician care high.

Column B illustrates total spending in our alternative payment model. First, a set of services currently reimbursed for a particular episode of care or part of chronic care management are bundled together into a single payment to physicians as a case management payment. For example in clinical oncology a case management payment would include after hours phone care for breast cancer or a palliative care counselor for patients with lung cancer. This enables clinicians to focus less on volume and more on tighter coordination among providers and settings for patients. In addition, we continue the aforementioned care coordination payment paid to

physicians, which is built on concepts such as PQRs/ MU and actually *increases* the current level of physician payment relative to the fee-for-service baseline in Column A. Care coordination payments allow flexibility for physicians to invest in clinical practices and infrastructure through practice transformations that maximizes their ability to treat patients in clinically appropriate ways while not reducing their income due to reductions in billable procedures that would otherwise occur. The investments in clinical practice can include infrastructure/HIT investments or in the case of a small practice, an investment in a shared clinical social worker with other small practices with similar patient populations.

Continuous quality improvement resulting from adherence to clinician-driven process and outcomes measures and the increased flexibility in income will push physicians to decrease and ultimately eliminate the waste and inefficiencies that plague the current system. Overall physician payments increases, offset by reductions in total Medicare spending and system wide savings. Care coordination payments that enhance total physician income tied to quality measures would encourage physicians to collaborate and focus on elements of patient care that reduce cost and inefficiencies across the spectrum. In oncology, for example, we do not specify which metrics should be used in which case but comment that target metrics would change over time and as efficiency is maximized in certain areas of care (i.e. ED visit rates) bonus payments would not cease because of lack of room for improvement. Measures would have to be selected with flexibility to accommodate various provider circumstances and changes in the long term improved performance in certain areas.

Physicians who enter into broader accountable care arrangements in which there is a shared savings component will likely find that this model could lead to an increased proportion of shared savings beyond the 2% threshold; therefore our described model would not be mutually exclusive to ACO arrangements, but could enhance them given the decreased reliance on fee-for-service reimbursement.

Tools that Enable Financial, Clinical and Performance Risk

As I have mentioned earlier, physicians will need tools to better understand risk- these are not lessons we had in medical school or in clinical training. Financial metrics (such as those available to ACOs), performance metrics in the form of actionable and regular data feeds as well as peer-led initiatives should be considered essential components of a payment reform package.

Conclusion

Our nation is in a sustained period of constrained finances and while the cost to repeal the SGR has been decreased to \$138 billion, finding the offsets and mechanism to pay for such a solution will not be easy. But it is essential that this Committee seize the opportunity to finally dispel the notion that we allow for a system that rewards the balkanization of our patients through a payment mechanism which promotes volume over value. I commend Senators Baucus and Hatch in their recent call for proposals and specific suggestions from the clinical community and look forward to working with the Committee to identify a tangible path forward. Thank you for this opportunity and I look forward to your questions and comments.

Testimony
Before the Committee on Finance,
United States Senate

**SGR AND THE MEDICARE FEE SCHEDULE:
CONSIDERATIONS FOR A POST-SGR WORLD**

Statement of A. Bruce Steinwald
President, Bruce Steinwald Consulting
May 14, 2013

Mr. Chairman and Members of the Committee:

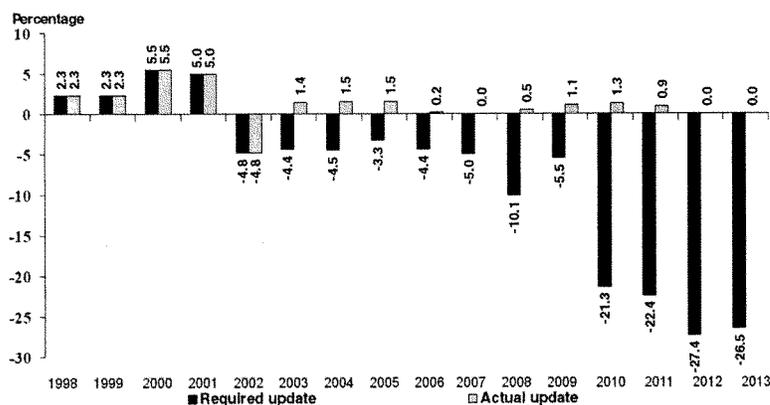
Thank you for inviting me here today to participate in your hearing on Medicare payment reform. I am Bruce Steinwald, head of a small consulting practice consisting of myself and a home office where I prepared this statement. For several years I was with the Government Accountability Office (GAO) Health Care Team where I directed many health care -related studies and testified before congressional committees on Medicare payment and health care spending issues. This work includes several studies, testimonies, and presentations on Medicare's Sustainable Growth Rate (SGR) system for controlling spending on physician services under Medicare Part B.

In my remarks today I will emphasize three points. First, while the circumstances may be favorable for finally doing away with the SGR, the problem that SGR was designed to address, excessive spending under the Medicare fee schedule, will not go away by itself. Second, this problem arises from the very powerful incentives to increase volume when services are paid for on a fee-for-service basis. Last, because the fee schedule and fee-for-service payment are likely to be with us for some time, policies need to be developed that encourage providers to elevate value as the chief criterion for determining which services are performed.

LOOKING BACKWARD

Much has been written about how the Medicare Fee Schedule (MFS) and the SGR were designed to work together.¹ Rather than review this material, I begin with a graphic representing how the SGR has not worked. Chart 1 shows the history of MFS payment updates since the late 1990s.

Chart 1: Actual Updates compared to Required Updates, 1998-2013



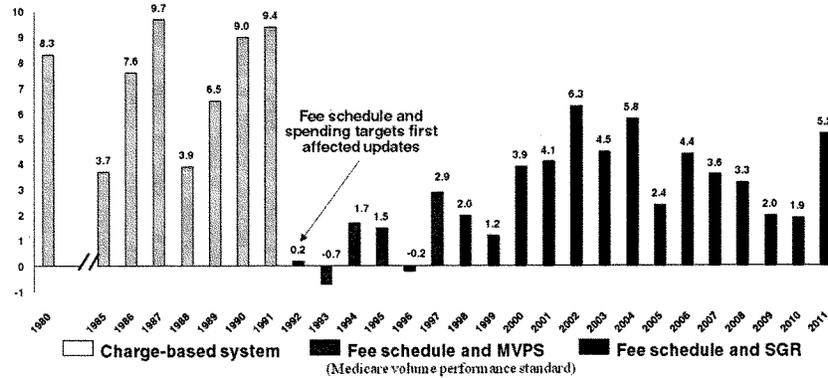
Source: Data from the Medicare Boards of Trustees and CMS Office of the Actuary (as cited in J. Farb's February 2013 presentation at the National Health Policy Forum)

Notes: Beginning with 2008, required updates are a result of both the SGR formula and legislative changes. The physician updates for 2010 and 2011 reflect the impact of the two different updates that were effective during parts of 2010. For January through May 2010, the physician update was 0 percent. For June through December 2010, the physician update was 2.2 percent.

The SGR appeared to work as intended at first but, because MFS spending exceeded the SGR target, fees were reduced by about 5 percent in 2002, and the SGR would have required further reductions in subsequent years. Since 2003, not wanting to jeopardize beneficiary access to physician services, which overall has been excellent, Congress has acted to prevent the SGR from further reducing Medicare fees in every year up to and including 2013. This annual ritual of kicking the can down the road has been a major annoyance for both the Congress and doctors who participate in the Medicare program.

While we can all agree that the SGR has not worked as intended, it is worth reviewing why this policy was adopted as a cost containment measure in the first place. Chart 2 shows the trends in spending increases attributable to increases in the volume and intensity (or complexity) of physician services furnished to Medicare beneficiaries over the 1980 to 2011 period.ⁱⁱ

Chart 2: Growth in Volume and Intensity of Medicare Physician Services Per FFS Beneficiary, 1980-2011



Source: Data from the Medicare Boards of Trustees (as cited in J. Farb's February 2013 presentation at the National Health Policy Forum)

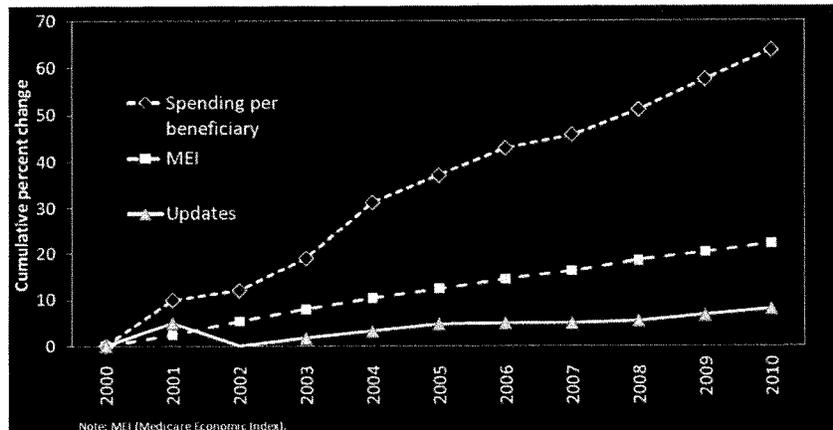
During the 1980s and early 1990s, when Medicare used a “Customary-Prevailing – Reasonable” method of setting physician fees, volume and associated spending increased rapidly. Clearly, something needed to be done, and it was. When the resource-based relative value Medicare fee schedule was installed in 1992, along with the SGR predecessor target system to control spending increases, the Medicare Volume Performance Standards (MVPS), the problem appeared to be licked – for a while. Throughout the remainder of the 1990s volume growth was moderate. Indeed, although it is hard to believe in the present, one of the reasons that SGR replaced MVPS was to provide physicians more upside in fee increases as a reward for limiting volume increases.

At the beginning of the 21st century, spending increases associated with rising volume began trending upward again – not as much as in the 1980s, but still

enough to trigger payment decreases under the SGR formula. The allowance above inflation in the cost of running a medical practice was set at real growth in Gross Domestic Product.ⁱⁱⁱ Thus, whenever volume growth generated spending increases exceeding about 2.4 percent, SGR was bound to put the squeeze on fees. As you can see, while volume growth did not exceed this threshold in every year, the average growth exceeded real GDP growth substantially during this period.

My final chart, from MedPAC, shows the relationship between Medicare fee updates, inflation in the cost of running a medical practice, and Medicare spending per fee-for-service per beneficiary during the first decade of this century. Looking at Chart 3, one can certainly sympathize with physicians whose practices provided a constant flow of services, because the very modest increase in fee levels during this period was not enough to keep up with inflation in input prices physicians paid, on average, to run their practices.

Chart 3: Increased Volume Growth has Impacted Physician Spending More than Input Prices and Payment Updates, 2000-2010



Source: MedPAC, June 2012 Databook

However, there are many other physicians who have prospered from increasing the volume and complexity of services, generating additional income even when fees were constant. In my view, the greatest defect of SGR has been its treatment of all physicians the same, regardless of their individual contributions to Medicare's spending problem.

LOOKING AHEAD

While there have been many calls for repealing SGR since 2002, and many Congressional hearings oriented to this outcome, circumstances today may be more favorable for finally doing away with SGR than they have been in the past. I leave it to others to delineate the specific characteristics of Medicare payment policy without the looming specter of SGR, but here are a few observations of current conditions that appear to favor reform in physician payment.

Widespread acceptance of the need to replace volume incentives with value incentives—For decades there has been a reluctance to accept cost as a legitimate concern in coverage and payment policy. While Medicare has a long way to go to incorporate this concern, the policy world at least seems to recognize that open-ended fee-for-service reimbursement is a major impediment to achieving value objectives.

Involvement of the medical profession in reforming physician payment—For many years the medical profession has been staunchly in favor of repeal of SGR without being willing, in my view, to offer a *quid pro quo*.^{iv} This appears to be changing as many medical organizations have shown leadership in encouraging physicians to adopt value-based criteria. I am especially impressed, for example, in the voluntary participation of specialty societies to encourage limitation of certain inappropriate and unnecessary procedures as indicated by the Choosing Wisely Campaign.

Growing capability to make data-driven decisions on coverage and payment—For decades health policy analysts have lamented the fact that airlines and other industries have used information technology to improve safety and efficiency in their industries, but not health care. Now, largely driven by federal policy, there has been a substantial increase in investment in the data infrastructure at the

individual provider level (e.g., electronic health records) and national level (e.g., Patient-Centered Outcomes Research Institute). Medicare coverage and payment policy may need to be adjusted to take full advantage of this growing capability.

Activity on the reform front – While there is never a shortage of reform proposals, this appears to be an especially fertile period of both experimentation in the health care delivery system, much (but not all) financed through federal research dollars, and in serious proposals to restructure Medicare. The SGR “doc-fix” problem has become so prominent that it is included in Simpson-Bowles and all major budget reform proposals.

Lower score – No Medicare reforms can be implemented without observance of the net cost to the federal government, the “score” estimated by the Congressional Budget Office (CBO), over a 10-year budget window, which is a major reason why SGR has not been eliminated already. Unexpectedly, the estimated 10-year cost of repealing SGR and replacing it with a fee freeze was reduced by CBO from \$243.7 B in November 2012 to \$138.0 B in February 2013. It is uncertain whether the cost of repealing SGR will be “on sale” indefinitely, but the lower score makes repeal more attractive (or, at least, less unattractive) from the federal budget perspective.

A POST-SGR MEDICARE WORLD

What will, or should, Medicare physician payment look like if SGR is repealed. When I was at GAO, I was often the “skunk at the picnic” in discussions of SGR’s repeal. While I agree that SGR is problematic, to say the least, I also believe that Medicare fee-for-service spending would have been greater without SGR. Therefore, I was an opponent of repealing SGR without putting substitute controls in place. Here are three “shoulds” that I believe need to be incorporated in any strategy to accompany SGR’s demise.

The movement toward global payment systems should be encouraged to occur naturally for beneficiaries and physicians – Several integrated delivery systems exist in all parts of the U.S., serving urban, suburban, and rural populations. At the same time, Accountable Care Organizations and other “hybrid” forms of health care delivery and financing are growing with support from federal

subsidies. These organizations have the capability of replacing or modifying the volume incentives of fee-for-service payment, which is a good thing. However, we don't want to repeat the mistakes of the 1980's managed care movement wherein many providers and beneficiaries believed they were being forced into systems they didn't choose voluntarily.^v A reformed delivery and financing system that focuses on population health and value in service delivery should be attractive to beneficiaries and providers alike.

The Medicare fee schedule, along with Medicare coverage policy, should be fine-tuned to reward value and discourage unnecessary utilization – With the blunt instrument of SGR out of the way, Medicare could have greater opportunity to use its extensive data to make distinctions between high-value and low-value care. Some of these opportunities can be accomplished under current law, such as more bundling of services together for payment and profiling physicians' utilization patterns and providing feedback when utilization (suitably adjusted for patient risk) appears excessive. Others may require new legislation, such as requiring prior authorization for expensive diagnostic procedures or tiering beneficiary copayments according to service value (both of which are used extensively in the private sector). The Medicare fee schedule is likely to be with us for years, perhaps indefinitely in some areas. It needs to be, and can be, improved.

Policy makers should never underestimate the incentives of fee-for-service payment to generate more volume and spending – Because spending increases in health care generally have been at low levels for the past few years, it is tempting to conclude that the “pressure is off” to limit spending.^{vi} I remind you that this was the situation during the 1990s when the SGR was born. It would be a supreme irony if SGR died during a similar low-spending period, only to have physician spending ramp up again in the absence of effective controls. In addition to making sure there are attractive alternative systems for physicians to go to that, for example, offer salaried employment, there is nothing wrong with ensuring that fee-for-service practice is attractive to leave.

In conclusion, I believe the post-SGR world should be one of decreasing reliance on fee-for-service payment but with effective controls in place to ensure that

value, not volume, is rewarded by the Medicare fee schedule. This may encourage some physicians to seek alternative delivery settings, thereby providing a boost to the reform movement.

Mr. Chairman, this concludes my prepared statement. I would be happy to answer any questions that you or Committee members may have.

ⁱ See, for example B. Steinwald, "Medicare's Sustainable Growth Rate," National Health Policy Forum, The Basics, June 21, 2011.

ⁱⁱ Volume refers to the number of services and intensity or complexity refers to the resources required to perform a particular service. For example, the number of imaging studies performed per 1000 beneficiaries has increased, and the proportion of such studies using advanced imaging technology, such as Magnetic Resonance Imaging, has also increased. Thus, in this case both the volume and complexity of services have increased.

ⁱⁱⁱ The law actually uses a 10-year moving average of real GDP growth to minimize year-to-year fluctuations.

^{iv} I realize this is a gross oversimplification and I apologize to the many individual physicians and medical organizations that have advocated fundamental reforms for many years.

^v Another gross oversimplification -- for an analysis of the failure of the managed care movement, see, for example, JC Robinson, "The End of Managed Care," *JAMA* 285:20, May 23/30, 2001.

^{vi} See, for example, DM Cutler and NR Sahni, "If Slow Rate of Health Care Spending Growth Persists, Projections May Be Off By \$770 Billion," *Health Affairs* 32:5, May 2013.

COMMUNICATIONS

Advancing Reform: Medicare Physicians Payments
Before the Committee on Finance
United States Senate
May 14, 2013

Written statement submitted jointly by:

AARP
AFL-CIO
AFSCME
American Federation of Teachers (AFT)
American Society on Aging
Center for Medicare Advocacy, Inc.
Families USA
Medicare Rights Center
National Academy of Elder Law Attorneys
National Association for Home Care and Hospice
National Committee to Preserve Social Security and Medicare
National Consumer Voice for Quality Long-Term Care
National Council on Aging
National Education Association (NEA)
OWL-The Voice of Midlife and Older Women
Services and Advocacy for GLBT Elders (SAGE)

Direct questions regarding this statement to:

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202-637-0961

May 13, 2013

United States Senate
Committee on Finance
Washington, DC 20515

Re: Advancing Reform: Medicare Physicians Payments

Dear Mr. Chairman and Members of the Subcommittee:

The undersigned organizations welcome the opportunity to submit a written statement in response to the U.S. Senate Committee on Finance hearing on advancing Medicare physician payment reform. Our organizations share a commitment to advancing the economic and health security of older adults, people with disabilities, and their families.

We agree the SGR formula is fundamentally flawed and permanent changes to the Medicare reimbursement system are long overdue. Under the current system, Congress must act on an annual basis to avert dramatic cuts to Medicare physicians and other providers. The threat of looming cuts creates uncertainty and needless stress for beneficiaries about their ability to see the physician of their choice.

We believe SGR reform must gradually replace the current volume-based payment system with a value-driven model. New payment models must reward quality, safety, value and coordination of care, as opposed to the number of services provided. At the same time, SGR replacement must strengthen primary care. Payment models which emphasize team-based care coordination, effective care transitions, and preventive care can lead to better care, better health and lower costs for Medicare beneficiaries.

On the whole, people with Medicare have multiple and significant health needs—40% of beneficiaries have three or more chronic health conditions, and more than one quarter of beneficiaries (27%) report being in fair or poor health. Nearly one in four people with Medicare live with a cognitive or mental impairment, requiring extensive, ongoing care. The health needs of the Medicare population demand a payment system that appropriately values primary care, care coordination and preventive services.¹

We appreciate that the Committee is exploring the long-standing need to revisit the SGR. Yet, we believe any attempt to repeal and replace the SGR must adhere to the following principles:

1. Protect people with Medicare from cost shifting. A legislative proposal to repeal or replace the SGR must not be paid for by shifting costs to Medicare beneficiaries. Half of all Medicare beneficiaries—nearly 25 million—live on annual incomes of \$22,500 or less. People with Medicare already contribute a significant amount towards health care. As a share of Social Security income, Medicare premiums and

¹ Kaiser Family Foundation, [An Overview of the Medicare Program and Medicare Beneficiaries' Costs and Services Use](#) (Statement by J. Cubanski before the Senate Special Committee on Aging, February 2013)

cost-sharing has risen steadily over time. In 1980, Medicare premiums accounted for 7% of the average monthly Social Security benefit compared to 26% in 2010.²

Given this economic reality, a permanent SGR solution must ensure beneficiaries are held harmless from payment adjustments that would increase Medicare premiums and cost sharing. To accomplish this, a new system must reduce overpayments and compensate for quality care, rather than the quantity of services provided. In short, a proposal to repeal and replace the SGR must not worsen the already tenuous economic circumstances facing many people with Medicare.

Proposals shifting costs to Medicare beneficiaries, such as by raising the Medicare age of eligibility, redistributing the burden of Medicare cost sharing through increased deductibles, coinsurances or copayments, and further income-relating Medicare Part B and D premiums, must be rejected as offsets to pay for a permanent SGR solution.

It is also important to note that current Medicare low-income protections are woefully insufficient. According to recent estimates from the Congressional Budget Office (CBO), only 33% of eligible beneficiaries were enrolled for Qualified Medicare Beneficiary (QMB) benefits and only 13% were enrolled for Specified Low-Income Medicare Beneficiary (SLMB) benefits. In addition, unreasonably low asset tests penalize beneficiaries by denying eligibility to those who set aside a modest nest egg of savings during their working years.

2. Extend the permanent fix to critical Medicare benefits. Averting steep cuts to physician payments is not the only Medicare policy revisited on an annual basis. Any permanent SGR solution must also account for these benefits, including the Qualified Individual (QI) program and therapy cap exceptions. We are very concerned that a permanent SGR fix could significantly diminish the prospects for continued bipartisan agreements on extenders packages, which always included extensions of these two critical provisions with expiration dates that correspond with the SGR.

We urge you to make permanent the QI program. The QI benefit pays Medicare Part B premiums for individuals with incomes that are 120% to 135% of the federal poverty level—about \$13,800 to \$15,500 per year. This benefit is essential to the financial stability of people with Medicare living on fixed incomes. Failure to make the QI program permanent alongside a permanent SGR solution raises the risk that vulnerable beneficiaries might be forced to drop Part B coverage outright, leaving them with significant, unaffordable out-of-pocket costs every time they need health care services.

Additionally, in the absence of full repeal of Medicare therapy caps, we request that you make the exceptions process permanent. Therapy cap exceptions ensure access to critical, medically necessary services that allow beneficiaries to live with independence and dignity each day.

3. Promote quality care. Payment policies must address the imbalance between primary and specialty reimbursement, as reflected in recommendations by MedPAC.³ Medicare beneficiaries often have multiple chronic conditions, may have cognitive impairments, and need extra attention from their health care providers. Time spent explaining treatment options or following up with patients is not adequately

² Kaiser Family Foundation, *Policy Options to Sustain Medicare for the Future* (January 2013)

³ MedPAC, *Re: Moving forward from the sustainable growth rate (SGR) system* (Letter to Congress, October 2011)

valued by current reimbursement policies. These nonprocedural services provided by primary care physicians, including geriatricians, are undervalued because the current system does not take into account the needs of older adults with multiple illnesses or the cost of providing coordinated patient-centered care.

As such, the current payment system discourages providers from pursuing or continuing careers in primary care, including those with the training and skills needed to meet the unique care needs of our nation's growing population of older adults. Reimbursement rates which appropriately reflect the demand for primary care services will strengthen the primary care workforce. Replacement payment models must build a strong primary care foundation to meet the current and future needs of the beneficiary population.

In addition, new payment approaches must encourage promising delivery models, such as Patient Centered Medical Homes and Accountable Care Organizations, to coordinate and better manage care. In order to provide reliable, useful data to practitioners, quality measures must be consensus based, and endorsed by such organizations as the National Quality Forum. Allowing non-consensus-based measures undermines the current measure-selection process used by other programs and limits the ability to share quality data across programs. Moreover, a multi-stakeholder process ensures acceptance of and confidence in the measures which are ultimately selected for payment and other purposes.

In recent years, considerable energy has been focused on the development of quality measures. Yet, these efforts are largely specific to a single disease or condition, with little attention paid to developing measures for those with multiple chronic illnesses. Further, some measures specifically exclude those age 65 and over (and people with diabetes age 75 and over) from being measured precisely because of the complexity they present. Any new payment system must include quality measures constructed for vulnerable and frail older adults, so that multiple chronic illnesses are accounted for and providers are rewarded for treatment that improves quality of life.

Any process to enact a permanent SGR solution must involve the beneficiary community, including people with Medicare, family caregivers, and consumer advocates. Staying true to the principles outlined above is critical to designing a reformed payment system that provides economic stability and ensures access to high quality care for people with Medicare.

Thank you for the opportunity to provide comment.

Sincerely,

AARP
AFL-CIO
AFSCME
American Federation of Teachers (AFT)
American Society on Aging
Center for Medicare Advocacy, Inc.
Families USA
Medicare Rights Center
National Academy of Elder Law Attorneys
National Association for Home Care and Hospice

National Committee to Preserve Social Security and Medicare
National Consumer Voice for Quality Long-Term Care
National Council on Aging
National Education Association (NEA)
OWL-The Voice of Midlife and Older Women
Services and Advocacy for GLBT Elders (SAGE)



101 East State Street
Kennett Square, PA 19348
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May 20, 2013

Honorable Max Baucus, Chairman
Senate Finance Committee
Room 219, Senate Dirksen Office
Washington, D.C. 20510

Dear Chairman Baucus:

On behalf of Genesis HealthCare, LLC and its subsidiaries, Genesis Rehabilitation Services and Genesis Physician Services, we submit the following comments regarding the request from the leadership of the Senate Finance Committee soliciting comments on the framework for reform of the Medicare professional fee schedules. We are most appreciative of this outreach and we applaud this effort to stabilize and reform the payment methodology.

Genesis HealthCare LLC (Genesis) is a leading provider of post-acute and long term care services operating over 420 care centers, most licensed and certified as Medicare skilled nursing facilities, in 30 states. Through our rehabilitation and recuperative support programs we facilitate the transitions from acute care and from the skilled nursing setting back to the community. On a daily basis, we meet the health services and shelter needs of nearly 50,000 residents. Assisting us in our care focus is our subsidiaries, Genesis Rehabilitation Services (GRS) and Genesis Physician Services (GPS). The over 15,000 professionals employed by GRS not only meet the needs of the GHC centers, but also provides physical therapy, speech-language pathology and occupational therapy services under contract to 1,600 locations spread across 44 states and the District of Columbia. Annualized, GRS provides rehabilitation services to over 350,000 Medicare beneficiaries. Through Genesis Physician Services, we employ over 125 physicians and 175 nurse practitioners and geriatric nurse specialists providing medical direction in our skilled nursing centers and coordinating the involvement of hundreds of attending physicians who have been credentialed to practice in our centers.

1. Stabilizing and reforming the Medicare professional payment methodology is very important for the delivery of quality care for nursing home residents:

Skilled nursing centers have become the predominant site for helping restore function and to prevent further deterioration in activities of daily living. CMS data affirms that of the 11 million Medicare beneficiaries successfully discharged from the acute setting in 2011, two out of five (39%) required post-acute interventions. Of those requiring post-acute services, 42% (1.8 m Medicare beneficiaries) were discharged to skilled nursing centers. Additionally, another 10% (400,000 Medicare beneficiaries) of those discharged for post-acute services, received their follow-through care through outpatient rehabilitation centers (ORFs). Only 9% of post-acute discharges (386,000 Medicare beneficiaries) were treated in inpatient rehabilitation facilities (IRFs). It is important to note that for those Medicare

beneficiaries older than 75 year of age, most were admitted to skilled nursing facilities for their post-hospital interventions.

Many of the services required by nursing home residents are reimbursed under the fee schedule methodology. We are dependent for physician involvement in both Part A and Part B. Physicians must order most clinical services and approve the plans of care. In the post-acute setting, nurse practitioners, geriatric nurse specialists, physician assistants, social workers, registered dietitians, clinical psychologists, and rehabilitation professionals (PT, OT and SLP) perform essential services. One of the keys to improving high value services for beneficiaries has been the strengthening of multi-discipline professional clinical involvement in the delivery of post-acute care.

Affordable healthcare is only attainable through strengthening the primary care platforms. Our models of center-based post-acute clinical intervention are designed to facilitate transitions from acute care, and transitions from the skilled nursing center to successful discharges back to home and community. Through patient-centered, goal directed, coordinated multi-disciplinary interventions, we help prevent hospital re-admissions. In our centers, we are offering Medicare beneficiaries comprehensive care at a much lower cost venue than accruing hospital days. Our professional interventions are delivered in an effective and efficient manner that optimize quality, and help reduce the aggregate health system burden of care costs.

- *We need to remove the threat of the physician fee schedule collapse.*
- *The Medicare Professional Fee Schedules impact more than physician services and, therefore, decisions made to stabilize funding for doctors must address other clinical specialties reimbursed through the RBRVS payment methodology.*

2. Considerations of a bifurcated conversion factor must adequately value primary care services:

We are aware that several of the legislative proposals advanced to reform the payment methodology move from a single conversion factor to multiple conversion factors. This concept of multiple conversion factors is not new, variations these ideas have been discussed during past Congresses. Should the committees move forward advancing legislation that bifurcates the conversion factor, we believe there is merit in the approach that certain legislative proposals have suggested providing preferential treatment for primary care services and that within the definition of primary care services include Healthcare Common Procedures Coding System (HCPCS) codes identified with nursing home, domiciliary, rest home or custodial care visits (codes 99304 through 99340) and those related to home service visits (codes 99341 through 99350). Within the definition of primary care services, the Secretary should have authority to include supervision of plans of care and care coordination. Moreover, attention would need to be given to assure that a system of multiple conversion factors fairly, equitably and appropriately addresses payment adequacy for non-physician services, especially rehabilitation professionals (SLP, OT, & PT), calculated under the payment methodology.

- *Services provided in the nursing home, hospice and home care settings should be included within the definition of primary care services.*
- *The Secretary should have authority to include supervision of plans of care and care coordination as primary care services.*
- *In a system of multiple conversion factors, special attention must be given to payment adequacy for non-physician services covered under the professional fee schedules.*

3. Medicare physician payment reforms should provide an alternative, episode based payment methodology for Medicare Part B Outpatient Therapy Services delivered in the inpatient setting:

Under current law, outpatient therapy services (Medicare Part B services) are cross walked into Section 1848, payment for physician services via Section 1834(k)(3), a provision which dates back to the Balanced Budget Act of 1997. CMS data document a very different pattern of utilization of Medicare Part B therapy services in the SNF, CORF and ORF settings than in private practice/physician office delivery. A compelling case is made that practice patterns and utilization are driven by differences in the underlying needs of the patients being served in each of these settings.

We note that legislation introduced in the House of Representatives, H.R. 574 (Neal/Schwartz) suggests an approach that would give the Secretary the authority to develop an alternative payment model for SLP, OT, and PT services *“on the basis of a treatment session, an episode of care, or other bundled payment methodology that takes into account varying levels of severity and complexity of patient diagnoses, conditions, and co-morbidities and the varying intensity of services needed for effective treatment of patients...”*¹ This legislative language offers a positive approach to address the payment issues for Medicare Part B therapy services.

Analyses of CMS claims data underscore sharp differences in practice patterns between independent practice delivery of Medicare Part B therapy services and Medicare Part B outpatient therapy services delivered in the skilled nursing facility setting. Thanks to cooperation among rehabilitation companies that service nursing facilities and the creative thinking of the Moran Company a viable template for moving forward has been designed in a study entitled *“A Prospective Payment System for Medicare Part B Therapy: Episode of Care Payment Adjusted for Patient Condition.”*²

- *Revisions of the Medicare Professional Fee Schedules should provide the Secretary with authority to develop alternative payment models for rehabilitation services (SLP, OT, & PT)*
- *To assure that such alternative payment methodology for rehabilitation services (SLP, OT, & PT) appropriately reflects beneficiary care needs; separate modeling should be done for outpatient therapy services delivered in the inpatient setting.*

4. Congress must direct CMS to assure the Physician Quality Reporting Initiative accurately captures Medicare Part B services mandated to be billed through providers using UB ‘04’s and to assure that provider employed professionals are eligible to receive incentives payment through the PQRI:

More than half of Medicare Part B outpatient rehabilitation services (SLP, OT, & PT) are delivered through providers: hospitals (29%), SNF’s (16%), CORFs (2%), and Outpatient Rehabilitation Clinics (11%). Since it began in 2007, the PQRI program has excluded eligible professionals providing covered therapy services to Medicare Part B beneficiaries in “provider” settings. While the law clearly states that physical therapists, speech-language pathologists and occupational therapists as eligible professionals to participate in the PQRI program, CMS has been inert in establishing a responsive program for therapists who provide services in skilled nursing facilities, home health agencies and rehabilitation agencies. Thus far, the CMS response has been that the only eligible professionals are those who bill on the CMS-1500 or 837-P claim form.

¹ 113th Congress, H.R. 574, Section 2 (d)(5)(A)

² Moran Company under contract with the National Association for the Support of Long Term Care (NASL), “A Prospective Payment System for Medicare Part B Therapy: Episode of Care Payment Adjusted for Patient Condition – Final Report, September, 2008.

Under current law, the Section 1848 (k) quality reporting system has been implemented in such a manner as to preclude services billed through UB-04 providers [by law outpatient therapy services delivered in an inpatient setting are billed through the provider] while physician and independent professional billing through the 1500 form are included. In fact, it is not transparent that Medicare Part B services billed through UB -04 (“providers”) have been adequately accounted for in the Physician Supplier Procedure Master File.

- *Proposals to leverage the PQRI to incentivize practice changes need to assure that CMS is adequately accounting for services billed through providers.*

5. Congress must repeal the arbitrary therapy caps and revisit the multiple procedure payment penalty for rehabilitation services (SLP, OT, & PT):

Rehabilitation interventions are cost effective geriatric care with the goal of restoring an individual to his/her former function status or alternatively to maintain or maximize remaining function in order to help them continue to live as full a life as possible. As Doctor T. Franklin Williams, former Director of the National Institute on Aging declared: *The real goal of geriatrics is fundamentally rehabilitative: to restore and/or maintain the maximum degree of independence possible for each older person. This is what every person, older or not, wants: to be able to choose and do what he or she prefers to do, to be autonomous in daily living and in short-and long range life choices.*³

Decisions made by both Congress and CMS are making it very difficult to deliver medically appropriate therapy services. When you combine the changes made under Part B with the payment revisions being implemented under Medicare Part A for post-acute providers (skilled nursing facilities, rehabilitation hospitals, home health agencies) coupled with the underfunding of rehabilitation services under Medicaid, what emerges is both an undervaluing of the importance of rehabilitation services and a disconnect between commitment and resources.

The Medicare Part B therapy cap continues to be one of the most frustrating examples of policy failure. It was bad policy when enacted; it remains bad policy. As an analysis funded by CMS documents: *Older beneficiaries continue to be more likely to be impacted by the outpatient therapy cap as they are more likely to surpass the cap benefit threshold, and when they do, they require more costly services than younger beneficiaries. This pattern is consistent across all three outpatient therapy disciplines.*⁴ We applaud Senators Cardin and Collins on the introduction into the 113th Congress of S 367 to repeal the arbitrary therapy caps. Hopefully, this will be the Congress that resolves this issue.

There appears to be little or no consideration of the clinical consequences of the multiple procedure payment reduction (MPPR) for rehabilitation services. Section 633 of the American Taxpayers Relief Act of 2012 increases the MPPR practice expense reduction to 50% which became effective April 1, 2013. There appears to be a total disregard that statute authorizes each of the three professional rehabilitative therapies as separate and distinct disciplines performing uniquely different skills. It is an affront to our therapy professionals to see CMS lump their efforts into some catch-all classification “always therapy services” without differentiation that they perform unique skills. The scopes of practices are different; and their professional interventions, delivered under physician order and documented as part of a plan of

³ T. Franklin Williams in Brody & Pawlson, *Aging and Rehabilitation II*, Springer Publication, NY, NY, 1990, p. 3

⁴ Computer Sciences Services, *Outpatient Therapy Services Utilization and Edit Report*, prepared as part of the Outpatient Therapy Alternative Payment Study (OTAPS) Task Order #HHSM-500-2005-00192G, 2006, p 80.

care, may augment, but do not duplicate. These actions are particularly disturbing as there appears to be little or no research to justifying the payment reductions.

The reality is that the real impact of the MPPR policy falls on the most frail and vulnerable of Medicare beneficiaries. Over half of nursing home residents receiving Medicare Part B therapy services receive multiple therapies. Indeed, the incidence of this ill designed policy has multiple times the impact on nursing home therapy provision than for the provision of similar services in the independent practice setting. In the institutional setting, rehabilitation interventions are part of the clinical response to help speed a successful transition from the acute to the community setting. Payment policies should incent efficient holistic delivery. Congress and CMS appear *penny wise and pound foolish*; interventions deferred impede discharge. It does not appear the clinical consequences of under resourcing these medically necessary beneficiary services received consideration. Moreover, it is very clear that the Congressional Budget Office scoring of the impact of Section 633 of the American Taxpayers Relief Act significantly understated the impact of the increase to 50% of the MPPR reduction for therapy services. The scoring appears to have made the assumption that rigid therapy caps would be imposed, and, therefore, it did not account for the extension of the exceptions process authorized under Section 603 of the same enactment.

- ***Medicare Part B Outpatient Therapy Caps Should be Repealed***
- ***Congress should reconsider the April 1 implementation of the increase of the multiple procedure payment reduction for rehabilitation services (SLP, OT & PT)***
- ***CMS must be directed to complete the report Congress mandated over a decade ago to establish a clinically driven, fair, equitable and cost effective policy for the delivery of Part B rehabilitation services (BBA-97).***

We appreciate this opportunity to share our views, and we applaud the committee leaders for reaching out for input. These are complex issues, and we look forward to working with individual members and committee staffs to help work through solutions.

Sincerely,

Dr. John Loome, MD
SVP Medical Affairs
Chief Medical Officer
Genesis Physician Services

Dan Hirschfeld, President
President
Genesis Rehabilitation Services

Laurence F. Lane
VP, Government Relations
Genesis HealthCare, LLC

Testimony Submitted to the Senate Finance Committee

Advancing Reform: Medicare Physicians Payments

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May 14, 2013

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Introduction

Senator Baucus, Senator Hatch and members of the Senate Finance Committee, thank you very much for your leadership on this critical issue. The need to reform Medicare’s physician payment system is profound and we are presented an opportunity to do so which may not come again. On behalf of Mayo Clinic, we appreciate the opportunity to submit written testimony as you consider this critical area of health care. Also, please know that Mayo Clinic stands ready to assist the Committee and the Senate during the deliberations on the critical issue of payment reform. The goal of our testimony is two-fold. We want to share some of Mayo Clinic’s experiences in providing high value health care and to provide some specific recommendations on Sustainable Growth Rate (SGR) reform.

As you are well aware, the SGR is anything but sustainable. It must be repealed and replaced with a structure that helps providers offer more efficient, higher quality care for Medicare patients. This is a journey but we cannot shrink from this opportunity and responsibility to reform Medicare payment, which sets the incentives and in many ways the ultimate design of the health care delivery system in our country.

Mayo Clinic Background

Mayo Clinic is a not-for-profit health care system dedicated to medical care, research and education. With more than 3,600 salaried physicians and 60,000 employees, Mayo Clinic demonstrates a relentless and unwavering commitment to excellence, which has spawned a rich history of health care innovation. Each year, more than one million people from all 50 states and 140 countries come to Mayo Clinic to receive the highest quality of care at sites in Minnesota, Arizona and Florida. In addition, we operate the Mayo Clinic Health System, a family of clinics, hospitals and health care facilities serving over 70 communities in Iowa, Georgia, Minnesota and Wisconsin. You can see the geographic scope of Mayo Clinic below.



Most recently, we established the Mayo Clinic Care Network in 2011, which consists of health-care organizations across the U.S. that share a commitment to improving the delivery of health care in their communities through high quality, evidence-based medical care. While retaining their autonomy, members of the Mayo Clinic Care Network have more direct access to Mayo Clinic's expertise, as well as Mayo Clinic's evidence-based disease management protocols, clinical care guidelines, treatment recommendations and reference materials for complex medical conditions.

In 2012, Mayo Clinic practitioners had more than one million patient visits with Medicare beneficiaries. Of the 2012 Medicare beneficiaries treated at Mayo Clinic's Rochester site, 44 percent were from outside of Minnesota.

With our unique and distinguishing characteristic, the Mayo Clinic Model of Care is a trusted and collaborative approach to medicine that is complemented by a constant quest for knowledge and innovation and dates back to the Mayo brothers who founded Mayo Clinic 149 years ago.

In 2013, Mayo Clinic, Rochester, was ranked among the top three U.S. hospitals by *U.S. News & World Report*. Of the 16 specialty areas reviewed by *U.S. News*, Mayo Clinic, Rochester, was ranked in the top 10 in 15 specialties, in the top five in 11 specialties, and was the number one ranked hospital in four specialties.

When it comes to research and health care innovation, Mayo Clinic has been a steadfast leader. In 1907 Mayo adopted a unified medical record – a stunning advancement that is now embraced by almost two-thirds of practices in the United States. Mayo developed the first and largest multidisciplinary, academic medical group practice, created the first microscopic system for grading cancer, invented the heart-lung machine, and was awarded the Nobel Prize for the discovery of cortisone. Mayo Clinic will continue to pursue innovative care and services as evidenced by the launching of three new research centers: the Centers for the Science of Health Care Delivery, Regenerative Medicine and Individualized Medicine.

Health Care Delivery in the U.S.

As Congress moves towards a permanent solution to the SGR, Mayo Clinic commends you for your efforts to tackle this challenge. We are committed to working with you as you seek to define a plan that ensures quality, efficiency and value for patients.

We must rethink how we pay for health care and develop differentiated reimbursement models across the continuum of health care – primary, intermediate and complex care. At times, patients require primary care and preventive services. This makes up the largest portion of the continuum.

Under different circumstances with more serious health issues, patients require elevated care—that may be delivered at hospitals or by providers with special expertise. Finally at the farthest end of the continuum, a small percentage of patients, perhaps one in 1,000 people each year across the U.S., have conditions that are extremely difficult to diagnose and treat. This cohort of patients is sick and cannot get an accurate diagnosis. They may need cutting edge therapies or require highly complex care that is integrated across a number of medical specialties or even sub-specialties.

Our health care system must be flexible and adaptable to the varying needs of patients across the entire continuum of care.

Without greater recognition of the continuum of care, consumers, payers and providers will never be able to experience, pay for, or deliver the goal of value: high quality care at lower costs. We propose the creation of a Medicare payment system that recognizes the different types of care along the continuum and differentially reward the value of each, whether primary, intermediate or complex care.

Our health care payment system should include incentives and rewards for the proper management of primary care to complex cases. One irony of our current system is that the financial return from mismanagement – needlessly bouncing a patient from specialist to specialist and lab test to lab test and sometimes even giving the wrong or no answers – can be far greater than the financial return when patients are correctly and efficiently diagnosed and their treatment is managed properly.

Americans deserve a Medicare payment system that rewards quality and value at each level of the continuum of care. Medicare payment models should allow providers to choose the payment option that best fits their health care practices.

The answers to the challenges we face will not be simple, but if we align how we pay for care with how well and efficiently we diagnose and treat patients, we can reach our goal of high-value health care for every patient.

The SGR and Payment Reform

The SGR is unsustainable. Medicare payments fall well below the cost of caring for America's seniors. At Mayo Clinic—where about half of our patients are Medicare recipients—current Medicare reimbursement covers just 60 percent of the cost of the care we provide to our seniors.

Further, the SGR has failed at its initial purpose. It has not controlled the volume of physician services. The SGR does not distinguish between those doctors who provide high quality care to beneficiaries and those who provide unnecessary services. In fact, as noted above, it institutionalizes perverse incentives and whether intentional or unintentional it actually penalizes providers' efforts to deliver high value care. We must move beyond the traditional indemnity model of fee-for-service (FFS). We must define a compensation model which is more dynamic and rewards patient outcomes, satisfaction and safety. One size does not fit all in terms of care and neither does it in terms of reimbursement.

Mayo Clinic SGR Principles

Congress must act to implement a permanent solution to the SGR. The industry cannot sustain another decade of temporary fixes. We strongly encourage Congress to adhere to the following principles as you seek to modernize and reform the current system:

- Repeal the Sustainable Growth Rate.
- Establish a one to three year transitional update reimbursement schedule at no less than the Consumer Price Index (CPI).

- Put in place a menu of new payment models that recognize the diverse business models of our nation's physicians that ensures adequate provider reimbursement.
 - These payment models should offer opportunities for physicians to choose innovative models alongside FFS that work for their patients, practice, specialties and geographic region.
 - The new models of physician payment methodology must reward value-based outcomes, quality and efficient medical practices.
- New Medicare payment models such as bundled payments and accountable care models – tested in both ACA demonstration projects and private sector initiatives—are among the options that should be considered.

The Accountable Care Organizations (ACOs) as defined by the Affordable Care Act (ACA) are designed to drive greater coordination in a far too fragmented health care delivery system, with an emphasis on primary care providers. We strongly support the importance of coordination and integration of care for the benefit of the patient. In fact, during the ACA debate, Mayo Clinic was often cited by bipartisan policy makers as a model for Medicare ACOs. Some saw us as an example because Mayo Clinic has been delivering team based care focused exclusively on the needs of the patient for more than a century. However, we do recognize that the ACO model is not a panacea for the entire delivery system.

We must be careful that ACOs networks are not structured so narrowly as to preclude patients seeking answers to major health issues from having the option to come to Mayo Clinic and other top-of-the-continuum of care centers. This is another example why it is essential to recognize the continuum of care delivery in our country. We must ensure that as we increase integration and efficiency in the primary care portion of the continuum of care, we do not adversely impact systems, especially academic medical centers such as Mayo Clinic, which are already designed to drive value and innovation in the health care system.

Patients with complex conditions often do not fit into neat categories, nor are two cases alike. For example, a cardiologist treating two patients with blackouts:

- In the first patient, the cardiologist found blackouts related to what is called neurocardiogenic syncope as well as signs of focal complex seizures.
- In the second patient with blackouts, the doctor recognized there was autonomic nervous system failure and Parkinson's disease with multiple system atrophy.

Both patients had blackouts, but the similarities ended there. The meticulous medical detective work that the cardiology team orchestrated succeeded in accurately diagnosing each patient's unique condition. Aligning how we pay for care with how we diagnose and treat patients must appropriately reflect the need for this type of complex care. An example of low-value and high-value cardiovascular care

Just as no two patients are alike, health care providers are also unique. Here is an example of a Medicare patient who turned to Mayo Clinic for answers:

- An older gentleman went to an emergency room because he fainted. A CT scan of the heart showed calcification. The patient underwent urgent heart catheterization followed by bypass surgery. Later, a stress test identified an abnormality, and a second heart catheterization showed a complication—one bypass was blocked. Cardiologists placed stents in the heart artery where the bypass was blocked. However, the fainting spells continued. With his issue unresolved, the patient came to Mayo Clinic, where we conducted a lengthy assessment by a team of physicians. We determined that all he needed was a medication adjustment. In the end, the tests, stents and surgery performed at the other facility were not needed, did nothing to help the patient, but were paid for by Medicare. However, the additional time spent by Mayo physicians in listening to the patient and assessing as a team his situation to ensure proper diagnosis and treatment was not covered by Medicare because it was not related to a procedure.

Within this part of the continuum of care, data and care outcomes, not simply process measures, must be used to create a sustainable continuum of care. These clinical outcome measures and cost metrics should be readily available to patients, families and payers to assist in making informed decisions about where to seek care.

Use of Data to Drive Cost Effectiveness

Public policy decision makers need to recognize, but more importantly reward, excellence across the continuum of care — primary, intermediate and complex — and do their part to create a competitive marketplace where data drives efficiency, excellence and innovation in health care delivery. Payment changes should include incentives and rewards for the proper management of complex cases. Patients, providers and taxpayers alike get into trouble when patients “churn” in the wrong part of the continuum of care, when health professionals fail to coordinate care or provide smooth transitions across the continuum.

Mayo Clinic’s work with Optum, a subsidiary of UnitedHealth Group, is an important and promising step in aligning health care delivery and the cost of care. By combining Mayo Clinic’s robust clinical information with Optum’s extensive claims data, we will better understand health care delivery over time, compare the effectiveness of care given by various health care providers and analyze the total cost of care for specific procedures or diseases. This will help Mayo Clinic provide better care to our patients, and help the industry reward value rather than volume. This is the largest effort of this type (combining clinical and claims data) in the country. Stripped of all personal identifying information to protect patient privacy, we will be poised to assess some fundamental questions about cost and quality of health care. As results are known and broadly shared, patients, providers and payers can seek and reward those who are providing the highest value.

The Optum Labs partnership is one aspect of Mayo Clinic’s Center for the Science of Health Care Delivery, which was initiated in January 2011. Through collaborative work and partnerships, the center helps create and diffuse high value, lower cost care delivery models throughout the country.

By creating the center, Mayo Clinic is emphasizing the need to invest more resources into this discipline and to accelerate the pace of improvement and value creation in health care. We constantly strive to perfect our own processes and procedures because we believe that health care providers have a responsibility to lead this effort.

Two examples of the work of the Center for Science of Health Care Delivery include:

- **Shared decision making** – To avoid patients getting caught in the “machinery of health care” – appointments, tests, procedures – without an opportunity to participate in their own treatment decisions, Mayo Clinic has developed and deployed decision aids for patients to help them define treatment goals and guide discussions with their physicians on treatment or medication preferences.
- **Blood transfusion program** - Mayo's patient blood management initiative has successfully reduced the number of unnecessary transfusions, ensuring that patients receive them only when medically necessary and thus avoiding additional costs but most importantly avoiding serious complications. A transfusion program using the revised standard protocols within Mayo Clinic's cardiovascular surgery practice resulted in a 50 percent reduction in red blood cell, platelets, and plasma transfusions. In addition, transfusion-related acute kidney injury diminished by 40 percent. Since the initiation of this program in late 2009, patient care has significantly improved and there has been a cumulative savings of \$15 million.

Conclusion

We applaud your leadership and willingness to contemplate reforming this complicated and historic issue. This is going to require a very different kind of analysis and possible solution set. We urge you to approach this issue with an open mind and recognition that a value based health care system will require a new reimbursement model that recognizes the various types of care, rewards the outcomes of care, and purges the perverse volume incentives from our health care system. For the sake of Medicare beneficiaries and providers who treat them, we strongly encourage you to examine all options with the goal of ensuring the sustainability of the Medicare program for now and for generations to come.

We applaud the Committee for your intense focus on the SGR and for making payment reform a top priority this year. We encourage you strongly in your effort and hope that a solution, which incorporates some of the principles we have outlined, is defined and can be enacted before the end of the year. Again, please know the depth of Mayo Clinic's interest and desire to be of service to the Committee as you do the important work in defining sustainable solutions for our country's health care future.



May 13, 2013

United States Senate
Committee on Finance
Washington, DC 20515

Re: Advancing Reform: Medicare Physicians Payments

Dear Mr. Chairman and Members of the Committee

We welcome the opportunity to submit a written statement in response to the U.S. Senate Committee on Finance hearing on advancing Medicare physician payment reform. Our organizations are committed to advancing the health and economic well-being of people with Medicare and their families. On behalf of the 50 million older adults and people with disabilities for whom Medicare provides a financial and health lifeline, we submit this statement of principles intended to guide Medicare physician payment reform.

We agree the SGR formula is fundamentally flawed and permanent changes to the Medicare reimbursement system are long overdue. Under the current system, Congress must act on an annual basis to avert dramatic cuts to Medicare physicians and other health care providers. The threat of looming cuts creates uncertainty and needless stress for beneficiaries about their ability to see the doctor of their choice.

We believe SGR reform must gradually replace the current volume-based payment system with a value-driven model. New payment models must reward quality, safety, value and coordination of care, as opposed to the number of services provided. At the same time, SGR replacement must strengthen primary care. Payment models which emphasize team-based care coordination, effective care transitions, and preventive care can lead to better care, better health and lower costs for Medicare beneficiaries.

On the whole, people with Medicare have multiple and significant health needs — 40% of beneficiaries have three or more chronic health conditions, and more than one quarter of beneficiaries (27%) report being in fair or poor health. Nearly one in four people with Medicare lives with a cognitive or mental impairment, requiring extensive, ongoing care. The health needs of the Medicare population demand a reformed payment system that appropriately rewards high-quality, patient-centered primary care, care coordination and preventive services.¹

¹ Kaiser Family Foundation, [An Overview of the Medicare Program and Medicare Beneficiaries' Costs and Services Use](#) (Statement by J. Cubanski before the Senate Special Committee on Aging, February 2013)

We appreciate the Committee's willingness to consider reforming the SGR. We urge you to follow these principles in your efforts to do so:

1. Protect people with Medicare from cost shifting. A legislative proposal to repeal or replace the SGR must not be paid for by shifting costs to Medicare beneficiaries. Half of all Medicare beneficiaries — nearly 25 million people — live on annual incomes of \$22,500 or less. People with Medicare already contribute a significant amount towards health care. As a share of Social Security income, Medicare premiums and cost-sharing has risen steadily over time. In 2010, Medicare premiums accounted for 26% of the average monthly Social Security benefit compared to 7% in 1980.²

Given this economic reality, a permanent SGR solution must ensure beneficiaries are held harmless from payment adjustments that would increase Medicare premiums and cost sharing. To accomplish this, a new system must reduce overpayments and compensate for quality care, rather than the quantity of services provided. In short, a proposal to repeal and replace the SGR must not worsen the already tenuous economic circumstances facing many people with Medicare.

Proposals shifting costs to Medicare beneficiaries, such as by raising the Medicare age of eligibility, redistributing the burden of Medicare cost sharing through increased deductibles, coinsurances or copayments, prohibiting or taxing Medigap first-dollar coverage and further income-relating Medicare Part B and D premiums, must be rejected as offsets to pay for a permanent SGR solution.

2. Extend the permanent fix to critical Medicare benefits. Averting steep cuts to physician payments is not the only Medicare policy revisited on an annual basis. Any permanent SGR solution must also account for these benefits, including therapy cap exceptions and the Qualified Individual (QI) program which tend to be extended in tandem with the SGR fix.

We urge repeal of the annual Medicare therapy caps which harm low-income and chronically ill beneficiaries. If this is not done, we request that you make the exceptions process permanent. Therapy cap exceptions at least help ensure access to critical, medically necessary services that allow beneficiaries to live with independence and dignity each day.

Additionally, we urge you to make permanent the QI program. The QI benefit pays Medicare Part B premiums for individuals with incomes that are 120% to 135% of the federal poverty level, amounting to about \$13,800 to \$15,500 per year. This benefit is essential to the financial stability of people with Medicare living on fixed incomes.

3. Promote quality care. First and foremost, payment policies must address the imbalance between primary and specialty reimbursement, as reflected in recommendations by the MedPAC.³ Medicare beneficiaries often need extra attention from their health care providers. Time spent explaining treatment options or following up with patients is not adequately valued by current reimbursement policies. Reimbursement rates which appropriately reflect the demand for primary care services will strengthen the primary care workforce. Therefore, replacement payment models must build a strong primary care foundation to meet the current and future needs of the beneficiary population.

² Kaiser Family Foundation, [Policy Options to Sustain Medicare for the Future](#) (January 2013)

³ MedPAC, [Re: Moving forward from the sustainable growth rate \(SGR\) system](#) (Letter to Congress, October 2011)

In addition, new payment approaches must encourage promising delivery models, such as Patient Centered Medical Homes and Accountable Care Organizations, to coordinate and better manage care. In order to provide reliable, useful data to practitioners, quality measures must be consensus based, and endorsed by such organizations as the National Quality Forum that include consumers, employers and other purchasers. Allowing non-consensus-based measures undermines the current measure-selection process used by other programs and limits the ability to share quality data across programs. Moreover, a multi-stakeholder process ensures acceptance of and confidence in the measures which are ultimately selected for payment and other purposes.

Any process to enact a permanent SGR solution must involve the beneficiary community, including people with Medicare, family caregivers, and consumer advocates. Staying true to the principles outlined above is critical to designing a reformed payment system that provides economic stability and ensures access to high quality care for people with Medicare.

Thank you for the opportunity to provide comment.

Sincerely,



Joe Baker
President
Medicare Rights Center



Judith A. Stein
Executive Director
Center for Medicare Advocacy, Inc.

