REFORMING MEDICARE'S PHYSICIAN PAYMENT SYSTEM

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

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REFORMING MEDICARE'S PHYSICIAN PAYMENT SYSTEM

THURSDAY, SEPTEMBER 11, 2008

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to call, at 10:10 a.m., in room 1100, Longworth House Office Building, the Honorable Fortney Pete Stark [chairman of the Subcommittee] presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

CONTACT: (202) 225–3943

FOR IMMEDIATE RELEASE
September 04, 2008
HL–29

Hearing on Reforming Medicare's Physician Payment System

House Ways and Means Health Subcommittee Chairman Pete Stark (D–CA) announced today that the Subcommittee on Health will hold a hearing on reforming Medicare's physician payment system. **The hearing will take place at 10:00 a.m. on Thursday, September 11, 2008, in the main committee hearing room, 1100 Longworth House Office Building.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

Medicare pays physicians and other practitioners on a fee for service basis using an administered price system. The fee schedule, which was established by the Omnibus Budget Reconciliation Act of 1989, sets prices for almost 7,000 discrete services using a methodology that places a value on each service relative to every other service. In determining the relative value for each service, three overall factors are considered: physician work, practice expense, and malpractice expense.

Since 1997, annual updates to payment rates for services furnished under Medicare's physician fee schedule have been determined by a formula known as the Sustainable Growth Rate (SGR). The formula sets target amounts for overall spending under the fee schedule, and the growth in target amounts is tied to growth in gross domestic product. If Medicare expenditures for these services exceed the target, Medicare payment rates are reduced. If Medicare expenditures for these services are less than the target, payment rates are increased.

Because the volume of services paid for under the fee schedule has consistently grown at a rate higher than GDP, as well as other factors, the SGR formula has called for reductions to payment rates for much of this decade. Since 2003, legislation has effectively overridden payment cuts called for by the SGR. Most recently, the Medicare Improvements for Patients and Providers Act (MIPPA) contained a provision to delay rate cuts that were being called for by the SGR formula for 2008 and 2009. However, unless further legislative action is taken, Medicare's payment rates will fall by more than 20 percent in January 2010.

In announcing the hearing Chairman Stark said, **"The SGR formula is clearly broken and needs to be fixed. But the problem is bigger than the SGR alone. The current payment system rewards physicians who increase the number or intensity of the services that they provide, irrespective of what is needed. This drives up spending. Unfortunately, spending growth has not been matched by an equivalent improvement in outcomes. Our recently enacted legislation provides a window of opportunity to look at how physician payment rates are updated. We need to use this time to examine pay-**

ment system reforms that encourage better care coordination, higher quality care, and more efficient use of resources. This hearing will be an important step in that process."

FOCUS OF THE HEARING:

This hearing will focus on Medicare's reimbursement policy for physician services. It will address ways of reforming the current fee schedule so that physicians are encouraged to furnish the appropriate amount of care while also improving the quality of care. Particular attention will be paid to reforms that Congress can and should consider prior to January 2010.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, *http://waysandmeans.house.gov*, select "*110th Congress*" from the menu entitled, "*Committee Hearings*" (*http://waysandmeans.house.gov/Hearings.asp?congress=18*). Select the hearing for which you would like to submit, and click on the link entitled, "*Click here to provide a submission for the record*." Follow the online instructions, completing all informational forms and clicking "submit". ***Attach*** your submission as a Word or WordPerfect document, in compliance with the formatting requirements listed below, by close of business **Thursday, September 25, 2008**. **Finally**, please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225–1721.

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1. All submissions and supplementary materials must be provided in Word or WordPerfect format and MUST NOT exceed a total of 10 pages, including attachments. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. All submissions must include a list of all clients, persons, and/or organizations on whose behalf the witness appears. A supplemental sheet must accompany each submission listing the name, company, address, telephone and fax numbers of each witness.

Note: All Committee advisories and news releases are available on the World Wide Web at *http://waysandmeans.house.gov*.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Chairman STARK. Good morning. This morning the Health Subcommittee will commence a hearing in the hopes that we can be enlightened on a system for reimbursing physicians in the Medicare Program.

Back in 1997 we created a formula called the sustainable growth rate, and whoever came up with that name—I know who came up with the idea—but that had an ironic sense of humor, because there is not much that is very sustainable about it. The formula called for cuts in Medicare fees every year since 2002. And each year we have intervened to prevent the cuts. And if we fail to act, next year the rates are scheduled to go down, the payment rates are scheduled to go down 20 percent. And I don't know of anyone who seriously advocates letting this cut take effect, but if we don't the budgetary cost is about 10 billion and if we repeal the whole thing the budgetary costs can get up into 100 billion and more.

This Committee and subsequently the House made the first real attempt this year to reform the SGR, and the CHAMP Act contained provisions that addressed some of the underlying problems and attempted to put the system on a path toward sustainability, but it was never considered in the other body. So we had just another short-term fix, we got an 18-month patch. And kicking the problem down the road I can tell you began when the Republicans were in control, but I have to acknowledge that we didn't do anything but continue the practice in the recently enacted Medicare bill, and I strongly suggest that we don't follow this practice anymore. And I am committed to using the time prior to 2010 to address the problems posed by the SGR. And I have no plan in mind, and quite frankly none has been offered. Many of our advisers, people we have worked with in the past, have come up with long lists of options, but nobody has been willing to say, start, go this way. And I'm waiting for Mr. Camp to do that, but we don't seem to be able to get there.

And so it is in that spirit that I am hoping, I know all of you, all the witnesses this morning have ideas about what we should do and shouldn't do.

I want to interject a prejudice here just so the witnesses and my colleagues understand at least where I am coming from now, and I would be willing to have people explain to me otherwise. I think it has been somewhat disingenuous on the part of the physicians to cry poverty based on what I call piecework rates. There is a major difference between the price per procedure and the gross income that is earned in any period, month or year. And I rather suspect that there are a large number of physicians making way north of a half million dollars a year whose income increased, even would have increased even with a 10 percent in a per fee; they would just quit taking Wednesday afternoons off and do a few more procedures. I suspect that is mostly in the higher priced procedural areas. Certainly I don't think it is as much in the primary care area. But the physician community is very close with that information. I have yet to see any sanitized tax returns comparing previous years for a few years to see how broke, how many Porsche dealers come in and tell me that they are having to repossess a lot of cars because the docs can't keep up their payments. I have heard all kinds of threats that oh, we are not going to deal with Medicare

patients anymore. I don't believe that for a minute. As I have often said, I have got three kids, all of whom have threatened when they don't get their second dessert to hold their breath, turn blue and die. And the last time I looked, they were still kicking.

So there is that concern, and that is not to say that I don't think we need some major changes. But I do think that as we think about reimbursing physicians we also have to think about the taxpayers and the survival of the Medicare system for those of us who want the Medicare system to survive. So that is kind of underlying some of my concerns. And I'd love to have anybody straighten me out on that, as I am sure Mr. Camp will in the opening remarks he has.

Mr. CAMP. Well, thank you, Mr. Chairman. And I want to thank you for having this hearing and I also want to thank our distinguished panel for being here today.

You know, I would like to just note that the importance of the doctor-patient relationship is critical, and there is nobody on this dais who thinks that physician payments should be cut by 20 percent in 2010. And the cuts called for by the SGR would undermine the foundation of the Medicare Program and the important doctor-patient relationship I referred to. There are a number of policy options open to us that I look forward to hearing about today.

I hope this hearing is an honest attempt to develop a long-term solution to the problem with Medicare physician payments. As I noted before, doctors serving Medicare patients are headed for a cliff of 20 payment reductions, and while that cliff has been pushed off for a few months, we did so by permanently cutting coverage care for some seniors. And I think kicking more than 2 million seniors out of their Medicare health plan permanently should not be viewed as an acceptable way to avert a cut in 18 months. The fact that these reductions and cuts were made to seniors should embarrass this committee and this Congress. There is another way.

I was disappointed that there wasn't any consideration of the Senate's compromise Medicare bill that was being discussed earlier in the summer. But to be fair, both parties are guilty of taking the short-term route on SGR. Since 2003 Congress passed six laws providing short-term Band-Aids that prevent physician payment cut rates called for by the SGR and many times making the following year's problems even worse, as was done in this last and sixth time.

We spent billions of dollars, billions in taxpayer dollars that have only magnified longer term problems. It is a bad habit that we have to kick once and for all. I am confident we don't need another 5 years to find a real solution to this problem. But as to the shortcomings of the SGR system, there are many, and I will simply say that the current system can tell us the total number of procedures performed, the tests administered and images taken have all increased. But it cannot tell us some of the information Mr. Stark referred to or whether beneficiaries have actually received better care. And we need a better system that rewards physicians who provide comprehensive, efficient and high quality care. And we will hear testimony today about how some physician practices have improved quality, provided more comprehensive care and reduced costs when placed under an alternative payment system.

When health care dollars are deployed in a rational way, it optimizes the whole delivery system, and we can then incentivize prevention, early assessment and disease management rather than only paying physicians to treat beneficiaries once they become sick.

So I look forward to working with the chairman of this Subcommittee to reform physician payments so that physicians are paid fairly and appropriately and that seniors also receive the high quality care that they deserve. And I thank the chairman again for holding this hearing and yield back my time.

Chairman STARK. If I could respond for all of the Members of the Committee, the Ranking Member, myself, I think in the periods that he mentioned over the last 5 or 6 years, these fixes that were put into the bills which we may have voted for or against were done without the input of any Member of this Subcommittee, in a room that we never understood where, by people with whom we had little contact. And that will be a different procedure at least with this Committee and thus far for what little legislation we have has been somewhat different, that there has been more conversation among Members of the Subcommittee than we did previously. I am not saying we came up with anything better, but I just think that it is something to understand that we have a lot of learning to do with how this process went along.

With that, I would like to introduce our panel. Dr. Bruce Vladeck, who is the Senior Health Policy Advisor and Executive Director of Health Sciences Advisory Services of Ernst & Young of New York, formerly Director of—what was it—HCFA or CMS when you were there?

Mr. VLADECK. It was HCFA.

Chairman STARK. HCFA, all right.

Dr. Gail Wilensky, who is aSenior Fellow at Project Hope in Bethesda, who was also Director of HCFA, with whom this Committee has written a great deal of legislation in the past, including—did we do catastrophic with you?

Ms. WILENSKY. That was right before I came.

Chairman STARK. Okay.

Dr. Nielsen, who is the President of the American Medical Association. And if her attendance record gets better they tell me they will let her become chairman of the board and make somebody else be president next year from Chicago.

Mr. Donald Crane, who is the President and CEO of the California Association of Physician Groups in Los Angeles.

If you all would like to enlighten us in the order that I called your names, please proceed.

Mr. VLADECK. Thank you very much.

Chairman STARK. I should say one other thing. We are going to try to cram your testimony into 5 minutes to review what you have. We all have written copies of it, and then we will have a chance for the other Members to inquire during questions here. Also we are faced with about an 11:30 possibility of a recess, and it will be up to the Members then if we want to continue through or we might have to ask you to stay for a while. And I want you to go ahead, but if we do recess, we will try and encourage you to stick around so that we can reconvene and finish the hearing.

Bruce, go ahead.

STATEMENT OF BRUCE VLADECK, PH.D., SENIOR HEALTH POLICY ADVISOR AND EXECUTIVE DIRECTOR OF HEALTH SCIENCES ADVISORY SERVICES, ERNST & YOUNG, LLP

Mr. VLADECK. Thank you very much, Mr. Chairman, Mr. Camp, Members of the Subcommittee. It is always a pleasure to be back here and to continue this conversation, the last stage in which we personally—it was about 18 months ago on very much the same subject. In the interest of time, and you do have my statement, let me just say one sort of general thing and then talk about some specific ideas and issues.

I don't think it is necessary to spend any amount of time on all the things wrong with the current system. In thinking about what to do about it, I would only emphasize the importance of being very careful not to overestimate the ability to change the way in which health care is delivered by tinkering with reimbursement systems. I think there are some things you can accomplish. You can move a lot of money around, but the difficulty of changing phenomena as complex and as multi-dimensional as the way in which physicians practice medicine—there is no better example for that difficulty than the existing Medicare physician payment system, which was launched 15 years ago with great hopes and expectations of accomplishing exactly the opposite of what it appears to have accomplished in a variety of ways.

So I think it is very important there be substantial changes in the way physician practices are organized and conducted in the United States, but it is not clear to me that you can do all the things you want to do by changing payment mechanisms. The best you may be able to hope for in changing payment mechanisms is to get the payment fairer and more equitable, get the signals going in the right direction, address some of the very serious income distribution problems we have in physician practice at the moment, and sort of do no harm in terms of other kinds of reforms in physician payment.

In that regard I have four very specific recommendations I would be so bold as to make to the Subcommittee for its consideration, and then a couple of additional observations.

First, for whatever reasons, the way in which the updating and evolution of the Medicare fee schedule has occurred, and the way in which it interacts with the SGR, has led to a gradual relative devaluation of primary care services relative to specialty services. Over time it would be desirable if we know how to fix that process. In the short run, everyone agrees on the effects and the impacts: that is it is harder and harder for physicians to make a living providing primary care services to Medicare beneficiaries at the same time that the fee schedule is probably encouraging the excessive proliferation of certain high technology diagnostic and procedural services. I don't think we have to be shy or sort of disingenuous about intervening in what appears to be an arbitrary way, because there are so many other forms of arbitrariness built into the system. And if everyone agrees, as I think—except for some of some of the specialty societies—everybody does, that we are now overpaying specialists and underpaying primary care physicians, I think it is perfectly appropriate for the Congress to say: let's shift some of that by changing some of the weights through legislative

action or authorizing the Secretary to make certain kinds of changes.

I think, ironically, you might even save some money in the process because in fact if we are able to keep more primary care physicians participating actively in the Medicare Program, all the theory suggests that their patients will use fewer expensive services and there should be some savings to the program.

In addition, I would very much support a form of a recommendation recently made by MedPAC, which is that Medicare recognize through data and technology it already has which physicians are really serving as primary care physicians to Medicare beneficiaries, that is not a questions of specialty labeling. It is a question of actually looking at the claims and seeing who is doing it, and there should be some additional adjustment for them. I think we are all concerned about the ability of primary care physicians and primary care practices to afford the infrastructure in terms of IT and in terms of support staff and so forth necessary to take advantage of the potential benefits of primary care. I think an adjustment to—again necessarily arbitrary because there is no data on either side of the issue—to the practice expense component of the fee schedule for those doctors who meet some objective criterion of being primary care physicians would begin to address that.

Third, I think this Subcommittee and the House did something very sensible last year in the CHAMP Act relative to its changes and modifications to the SGR formula, both by going back to the pre-1993 practice of having different update factors for different kinds of services or different allowable growth rates for different kinds of services, and by excluding some of the culprits driving the formula in the wrong direction in terms of incident to services, drugs, and laboratory, and so forth.

Again it is not a perfect system, it is not an ideal system, but starting from where you start, with what we know, I think it would be a major improvement.

And finally, there are a number of people who know more about this than I do, whose views I respect, who think you will never fix this system as long as you are stuck with the existing evaluation and management coding and the CPT system. And it may well be there are a lot of people who believe that there are underlying flaws in the entire coding process and coding system that we will never escape unless we look at seriously modifying or replacing it. With all the other studies going on of aspects of fee schedule, I would urge that attention be paid to that as well.

I will make two more points. All of these recommendations of mine assume at least for some period of time the maintenance of a fee-for-service payment system for most physicians services under Medicare. And I know that is sort of a minority view in health policy circles in Washington and elsewhere, but I would suggest that fee-for-service is a hearty beast in part because, as the chairman suggested in his opening remarks, nobody has really come up with a totally convincing satisfactory alternative to replace it with. I think most of the countries that do much better than we do of balancing primary care with specialty services still use a fee-for-service for paying the majority of physician services. There may be special add-ons or other adjustments for primary care physicians, but

the British model of paying a purely capitated rate for primary care is still the minority in national health systems.

Similarly, one of the things that has occurred in the last 15 years in the private health care market, even for plans that receive capitated payments for Medicare or other payors, have largely moved away from capitation in their payments to physicians, back to fee-for-service for a variety of reasons. So I wouldn't be so quick to assume if we did away with fee-for-service based payments, we would solve all our problems, until somebody had something absolutely better.

Finally, I couldn't agree more with some of the other testimony you are going to hear today and some of the other comments that if we lived in a world in which most physician services were provided through large multi-specialty group practices, we would be better off in a lot of ways. We have known for 20 years that those practices provide higher quality care at lower costs, often with higher patient satisfaction than atomized solo practice fee for service.

[The statement of Mr. Vladeck follows:]

STATEMENT

On
Reforming Medicare's Physician Payment System

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Before
The
Subcommittee on Health
Committee on Ways and Means
US House of Representatives

September 11, 2008

Mr. Chairman, Mr. Camp, Members of the Subcommittee, my name is Bruce C. Vladeck, and it is my great honor and privilege to have the opportunity to appear before you again today. I am currently Executive Director and Senior Health Policy Advisor in the Health Sciences Advisory Services of Ernst & Young, but I hasten to add that the views I will be expressing today are solely my own, and should not be taken for the opinions of Ernst & Young, or any of its affiliates or clients. Instead, I'm speaking today on the basis of my experience with the Medicare Physician Payment System during my four and a half years as Administrator of the Health Care Financing Administration, and my career-long involvement with the issues of providing primary care services, especially to residents of underserved areas.

I think we can all agree that the Medicare Physician Payment System, in its current form, is profoundly broken. The annual drama associated with the irrationality of the Sustained Growth Rate (SGR) system serves no one's interests very well. As has been frequently noted by this Subcommittee, as well as other authoritative bodies, preoccupation with fixing the effects of the SGR also diverts time and attention from other important dimensions of the physician payment issue, most notably the continuing reallocation of funds from primary care services to specialty procedures, precisely in the wrong direction. This reallocation, in turn, arises from a number of specific problems in the operation of the system, which have been widely discussed and in many instances previously addressed by the Subcommittee.

In my brief remarks this morning, I will quickly summarize some of the major problems with the current system. I will then offer some general observations about the

nature of payment systems, the operations of the Medicare program, and the difficulties faced by the Congress in seeking to legislate improvements in those systems. On the basis of those propositions, I will then offer my own suggestions for your consideration as ways to address these issues in the relatively near future. I note that many of those suggestions have already been made, or acted on, by this Subcommittee, MedPAC, the GAO, or other authoritative sources.

Problems With the Current System

The Medicare Physician Payment system was originally designed to shift payments from specialists and interventional procedures to primary care services, and thereby to help redress the imbalance in the American health care system between primary and specialty care; to provide greater control of program costs without impairing beneficiary access; and to provide a more rational, scientifically-based method for establishing the relative prices of different services provided by physicians. It is now meeting none of those goals satisfactorily.

In its first several years of operation in the early '90s, the Medicare payment system did indeed shift substantial resources from specialty to primary care, but since then the direction has been reversed, as a result of the process by which the Resource-Based Relative Value Scale (RBRVS) is revised and updated, the operations of the SGR formula, which ironically rewards fast-growing services while discouraging those that grow more slowly, and of changes in the physician marketplace. This is not just an abstract problem. Instead, there is widespread agreement that the current imbalance between primary and specialty services in the American health care system increases

costs and, perhaps more importantly, impairs the ability to improve the quality of care, particularly for individuals with significant chronic illnesses -- an especially important issue for Medicare, since Medicare beneficiaries are far more likely to experience such illnesses.

It has long been well-established that most of the countries that outperform the United States in health care quality and costs have higher ratios of primary care to total physicians than we do; more recent research by the group at Dartmouth has shown a similar pattern across American counties. The explanation offered for this phenomenon is that an appropriate balance between primary care and specialty physicians leads to more effective management of the care of chronically-ill patients, and more judicious use of specialty-provided procedures.

Yet over the last decade, the proportion of American medical graduates pursuing primary care careers has fallen alarmingly, in part because medical students and residents are sensitive to the income implications of specialty choices, in part because they see the growing frustration and discontent of active primary care practitioners. The impact of Medicare's payment system on this phenomenon is not limited, moreover, to Medicare payments in themselves; most private insurers use the RBRVS methodology, despite all its flaws, as the basis for determining relative physician fees, even if they use different conversion factors. In recent years, some private insurers, frustrated by the effects of RBRVS on the availability and quality of primary care services, have experimented with alternative payment methods for primary care services, but those experiments are not yet sufficiently developed or widespread to have had much of an effect on the overall organization of care.

It's important to understand that the disincentives for primary care extend beyond the relative weights in the RBRVS system. Analysis of the problems in primary care, especially for the management of chronic illness, increasingly focus on the need for infrastructure investment – in information technology, staff capabilities, and care management support – in primary care practices. The increasing migration of diagnostic and treatment technologies, including imaging, laboratory, and infusion services, to specialty physician offices makes available to them the technical component payment as a vehicle for financing investments; no such parallel exists in primary care practices.

The Medicare physician payment system has also not been especially successful at controlling costs. The SGR process produces unacceptably low updates in the conversion factor, which the Congress regularly feels obligated to override, but because the entire process runs through the conversion factor, the ironic result is to suppress payments for slower-growing services, such as Evaluation and Management, while maintaining the incentives to increase the volume of those services that are increasing more quickly, such as diagnostic radiology. At the same time, the process of updating the RBRVS has a probably unavoidable upward bias, so the well-established codes, like most of those for primary care, continuously fall relatively further behind.

Some General Considerations on Medicare Payment

When I last appeared before this Subcommittee approximately eighteen months ago on a similar subject, I offered a number of general observations about Medicare payment policy which I thought might inform thinking about possible changes to

physician payment policy. I think they still apply, but in the interests of brevity and completeness, I've updated them modestly:

- You can only do so many things at once. If we can change the Physician Payment System to get the right balance between primary and specialty care, maintain beneficiary access, and have reasonable cost containment, that would be enough of an accomplishment in itself. We also need to improve quality and better align incentives between physicians and other providers, but there are other mechanisms for pursuing those goals.
- It's important not to overestimate the ability of policymakers to fine-tune incentives to achieve the desired goals. A little more humility in this regard would serve us all well. The Medicare physician payment system itself perhaps serves as the best cautionary example of good intentions gone awry. Health care is very complicated, and the behaviors of health care providers are affected by many things; providers may "follow the money," but they follow other imperatives as well, such as public and peer pressure and their own aspirations to professional excellence.
- In the same vein, it's important not to overestimate how "scientific" the rate-setting process is, or can ever be. The Practice Expense component of the Medicare Fee Schedule has roughly as much weight as Work Effort, yet anyone who has lived through the fights over relative Practice Expenses knows how little real data underlies current policies. Similarly, the Committee responsible for updating the RBRVS is comprised of real experts, but it's still a committee.

- Finally, all these considerations point to the need to view payment policymaking as a continuous, iterative process, one that will necessarily – and perhaps desirably – be characterized by constant refinement, modification, and experimentation.

Specific Suggestions

In this context, I offer my own recommendations for short-term steps the Congress could take to begin to alleviate some of the current problems in the Medicare Physician Payment System. As I noted above, many of these specific suggestions are based directly on recommendations by others, including previous actions taken by this Subcommittee.

1. First, in the short run, the Congress should immediately increase the weights of Evaluation and Management codes by some necessarily arbitrary amount, as a pure policy adjustment. If these increases are "budget neutral," and the conclusions of most policy analysts who have studied Medicare Physician Payment are correct, doing so will actually save some money, since the budget neutrality adjustment will reduce the relative prices of procedural services, and thus the size of the incentives for physicians to increase the volume of them.
2. At the same time, the Congress should adopt a form of MedPAC's recommendation for a primary care "add-on" to increase the fees of physicians who are really providing primary care, as defined by the proportion of Evaluation and Management services in their total billings. Given my earlier comments

about the need for infrastructure to support effective primary care practices, this add-on should be constructed as part of the practice expense component, again on a budget-neutral basis. This adjustment would parallel the expanded Medical Home Demonstration project called for in MIPPA last year, but I think we should move forward without waiting for the results of that demonstration; the size and specifics of the adjustment can be further modified once demonstration results are available.

3. As it did last year in the House version of the CHAMP Act, the Congress should modify the SGR to provide for separate updates for as many as six categories of physician services; exclude drugs, laboratory, and other "incident to" services from the calculation; and provide a "glide path" for meeting budgetary targets over a period of years. Any remaining savings required by budgetary imperatives should be achieved by savings in other Part B expenditures, especially laboratory and DMEPOS.
4. In the view of many analysts, the problems with the RBRVS, particularly its treatment of primary care services, will never be completely resolved so long as the existing definitions and codes for Evaluation and Management services remain in place. In addition to all the other work now being done on physician payment, I would urge the Congress to request that MedPAC and the GAO give immediate attention to the evaluation and – if necessary – development of alternative coding systems for physician services, especially including primary care services.

I know that many others will argue that a more radical approach is needed, that we should scrap the fee-for-service system, with its inherent incentives for increased utilization and its lack of explicit support for care coordination, altogether, in favor of some other payment methods. I would note only two points in response. First, most of the other nations that provide high-quality medical care to their citizens at lower cost than we do, in part by relying more heavily on primary care services, continue to employ some variant of fee-for-service in their methods for most physician payments, although some use additional or separate mechanisms specifically for primary care. Second, despite the obvious theoretical advantages of capitation-based payment methods, most private insurers in the United States, including most HMOs, have increasingly moved away from capitation methods in their private business. They've learned, at a minimum, that capitation-based systems have their own limitations and shortcomings, especially in an environment in which most of the physician community is still organized around relatively small, single-specialty practices.

Over time, in my view, we will never develop adequately satisfactory alternatives to our current payment methods until a far larger proportion of American physicians are organized in multi-specialty group practices, whether free-standing or hospital-based. We now have two generations of data confirming that such practices outperform other models of physician organization in cost, quality, and care coordination. Despite the current Medicare Demonstration experiments in this area, I am skeptical that modification of payment systems will significantly accelerate movement in this direction, but I would also urge the Congress to explore other methods it might encourage in this regard.

Again, it has been a privilege and a pleasure to have the opportunity to share these views with you, and I'd be happy to respond to any questions you might have.

Thank you very much.

Chairman STARK. Let's let Gail have a chance for now. We will come back to you.

Ms. WILENSKY. Thank you, Mr. Chairman.

Chairman STARK. Is your mike on? Pull it closer to you.

Ms. WILENSKY. Now it is, thank you.

STATEMENT OF GAIL WILENSKY, PH.D., SENIOR FELLOW, PROJECT HOPE

Ms. WILENSKY. Thank you, Mr. Chairman and Members of the subcommittee. Thank you for inviting me here to testify on strategies to reform the way the Medicare pays physicians.

As you mentioned, I was a HCFA Administrator. I wasn't sure I should remind you I was actually the HCFA Administrator on duty when the RBRVS was implemented in January of 1992. I had spent the previous 2 years struggling with how that was going to happen. And subsequent to being at HCFA I have tried to help you with these issues in my roles as Chair of the Physician Payment Review Commission in the mid-nineties and then 4 years of chairing the Medicare Payment Advisory Commission. So while these are not new issues, they are very difficult ones.

I would like to remind you of the general movement in Medicare because I believe that Bruce has raised what I see as fundamental choice that you the Congress has to make with regard to where you want to go in terms of physician reimbursement reform. In general Medicare has moved increasingly toward the use of bundled payments such as DRGs, or APCs as a reimbursement strategy except for the way in which it reimburses physicians where Medicare uses a very disaggregated fee schedule paying for about 7,000 separate discrete services under the RBRVS.

The RBRVS was implemented to have a fee schedule that was more resource based and focused on relative values. But it basically is structured similarly to what existed before, many disaggregated discrete services. Because of correct concern about the potential for increased spending with such a disaggregated fee schedule, the spending limits, first the volume performance standard and then replaced by the sustainable growth rate, were introduced. This was a legitimate concern, based on the experiences of the 1980s where Part B spending increased faster than other parts of Medicare.

The problem, as I see it, with the SGR is that while it can in principle, if used, control total spending, behavior occurs at the level of individual physician or the physician's practice. And here the incentives are at best unhelpful, I would say as an economist actually perverse. The problem is that nothing the individual physician does can affect the overall SGR behavior, while at the same time physician fees are affected by what physicians do collectively, but this isn't where behavior occurs.

Conservatively practicing physicians continue with very low fees, aggressively practicing physicians make up for low fees by the volume mix of services that are provided, and therefore their incomes may indeed not decline. That is a very unfair system. Several short-term patches are possible. Physicians, I agree with Bruce and the comments of the committee, appears to be undervalued by any measure you might look at. The recommendation made by MedPAC that you use a budget neutral modifier for primary care physicians

targeting those individuals who are primarily providing primary care services is a reasonable first step. I also support the notion of a demo for a medical home. Medical home could be an important part of a longer term fix. We need to understand how it would work.

I very much support more aggressive reviews of physician claims for outliers that was allowed under the MIPPA legislation that was just passed, as I understand the legislation. I think it has to be done with care, and use clear processes, so that there is not a generalized chilling effect inappropriately for physicians, but I think it in principle is a very important step and I support it.

I regard the use of multiple SGRs, as was included in the CHAMP legislation, as a move in a better direction compared to where we are now, and I also think that separate SGRs for multi-specialty group practices is a good idea. I am indeed one of the many health policy people who believe moving in that direction, toward more use of multi-specialty group practices, would solve many of our current problems.

But ultimately the Congress has to decide what direction it wants to go in the future. If you want to stay with the current disaggregated fee schedule, then I believe you need to think about an SGR that operates at the level of the individual physician or the physician's practice. That is where the behavior occurs. That is the only way to have a system that is not unfair. We are not talking millions, we are talking maybe a couple hundred thousand SGR rates. I don't think that is undoable in this present day and age.

Or there is another option, which I actually prefer because I think it would be better in terms of encouraging quality as well as restraining spending, and that is to begin moving toward more aggregated bundles of payments.

I would propose that CMS be ready to start July of 2010 making single payments for the most important chronic diseases that our Medicare beneficiary population presents to physicians, either singly or in terms of multiple chronic diseases and, similarly, to make a single payment for the highest cost highest volume DRGs, that covers all the physician services provided during a particular DRG like heart valve replacement or heart bypass procedures, and that this become the strategy move going forward.

CMS and Congress will need to engage some serious work done regarding the redesign of a payment system, and in my testimony—I hope you do not regard it as presumptuous—I have laid out a calendar of events that if you choose to move in this direction, CMS could use developing an RFP, with two parts, initially to go out in 2009, getting some ideas laid out about the direction that a new physician payment system would take, with a second and more specific contract being let within a year, a final report due no later than June 30th of 2011 and an implementation start date of January 1st, 2013. I think this is as fast as you can realistically move to a different reimbursement system.

As someone who was there when the Congress passed a half developed RBRVS in November of 1989 and then directed HCFA to implement it January 1st, 1992, this schedule I am suggesting is not inconsistent with what has been done in the past. It will require additional support for the agency. But first, the Congress

needs to decide do you want to stay with a disaggregated fee schedule, in which case I urge you to think about individualized SGRs, or do you want to move toward more bundled payments, as you directed the agency to do in all other majors areas of Medicare, and you need to start directing the agency to do that, ready to start at the beginning of the following presidential term.

Thank you.

[The statement of Ms. Wilensky follows:]

Statement of Gail Wilensky, Ph.D., Senior Fellow, Project Hope, Bethesda, Maryland

Mr. Chairman and members of the subcommittee: thank you for inviting me here today to testify on strategies to reform the way Medicare pays physicians. I am currently a senior fellow at Project HOPE, an international health education foundation. I have previously been the Administrator of the Health Care Financing Administration, now known as the Center for Medicare and Medicaid Services and also the chair of the Physician Payment Review Commission and the Medicare Payment Advisory Commission. I am here today to discuss reimbursement strategies that could encourage physicians to provide the appropriate quantity of services as well as improve the quality of the services provided. My views reflect my background as an economist and also the experiences gained in the various positions I have previously held. This testimony reflects my personal views and should not be regarded as reflecting the views of Project HOPE.

My testimony reviews the ways in which Medicare has reimbursed physicians over its history, why it adopted the SGR as an expenditure limit on Part B spending, the fundamental challenges posed by the use of a RBRVS reimbursement schedule combined with SGR and alternative strategies to consider in its place.

Medicare's History Reimbursing Physicians

Medicare originally based its reimbursement to physicians on historic charges as it did for all of its reimbursements. In 1984, around the time that Medicare moved away from a charge-based per diem rate for hospitals, Medicare introduced the use of the Medicare Economic Index (MEI) to update payments to physicians. This began what has been an increasingly divergent way of reimbursing physicians under Medicare compared to the ways Medicare reimburses other providers. This divergence has profoundly effected the pressures being generated by the SGR and the increasing frustrations that the current system of reimbursing physicians seems to cause almost everyone—members of Congress, congressional staff, policy analysts, and most of the physician community.

The history of most of Medicare reimbursement has been to move to increasingly bundled services for purposes of payment. The adoption of a prospective payment system for in-patient hospital care in 1983 was the beginning of that process but it has now been extended to capital payments for inpatient care, outpatient hospital care, renal care, home care and nursing homes. The ultimate in bundled services is a single capitated payment that covers all Medicare services.

These bundled payment systems continue to use administered pricing to set the reimbursement which means they also require a methodology to update the payment. The bundled systems generally use a "bottoms-up" approach for their updates. Estimates are made for the components in the bundle that are believed to be associated with increasing costs. The inflation measure that results is usually in the form of an industry-specific input-price index called a "market-basket". In many cases, a downward adjustment is also made for a presumed increase in productivity.

Potential volume increases for services that are paid as part of a bundle have been regarded as less likely and thus less problematic than those associated with payments for unbundled services. There still are concerns and some prohibitions have been introduced to limit their likelihood, such as the 30 day prohibition on a hospital readmission for the same diagnosis.

The history of physician payments under Medicare is different. There was a period in the 1980's when physician DRG's (Diagnostic Related Group) were under some consideration but there has not been a serious move towards bundled payments for physicians—at least not one that is known to me. There are, of course, some bundled payments that are traditional in reimbursing physicians: surgeons receive a fixed payment that covers the pre-operative care, surgery and post-operative care, at least the care provided for a specified period of time and obstetricians (obviously not a Medicare matter) receive a single payment for prenatal, post-natal and

delivery. In general, however, physicians are paid for discrete services using a disaggregated fee schedule with approximately 7000 billing codes. Because the concerns about potential volume increases are much greater for a payment schedule that is as disaggregated and discrete as the Medicare physician fee schedule, the updates to the fee schedule has followed a "top-down" strategy—initially tied to the MEI and now the Sustainable Growth Rate (SGR).

The big change for physician payment, comparable to the introduction of DRG's for hospitals in 1983, occurred in 1989 when the fee schedule, which had been based on historical charges, was replaced with a resource-based relative value scale (RBRVS) combined with a spending limit—initially the Volume Performance Standard which was superseded in 1997 by the SGR. The period prior to 1989 had made it clear that using a disaggregated fee schedule without a spending limit leads to increased rates spending on physician services in excess of other parts of Medicare.

Frustration with reliance on historical charges which was perceived as under-valuing primary care and over-paying for procedures led to the adoption of the RBRVS. Under the RBRVS, relative values for each service are set by considering physician work effort, physician practice expense and malpractice liability. But while the RBRVS sets the relative prices, it is the SGR, through its impact on the conversion factor that converts relative weights to absolute dollars that sets the absolute reimbursement rates.

Problems with the SGR

A lot of the focus for reforming physician payment under Medicare has been on fixing the SGR. The reason is clear. It is the requirements of the SGR to keep the growth in spending on Part B services tied to the growth in the economy that has caused the downward pressure on physician fees for most of the decade. This happens whenever growth in the economy slows and/or increases in the volume and mix of services provided under part B increases. For much of this decade, both have been occurring. Any excess growth in Part B spending relative to the level suggested by the SGR is supposed to lead to compensating downward changes in physician fees. These scheduled reductions would have meant annual reductions in fees for about 5% for most years since 2002. In reality, however, except for 2002, all of the scheduled reductions have been mitigated by acts of Congress because of concerns that repeated reductions in fees would severely diminish access to physician services. Instead, fees either have been held constant or been increased by 1%–1.5%, much lower than the rate of inflation but much greater than the reduction that had been scheduled to occur. Legislating these annual patches has provided short term fixes but has also produced a very big hole for Congress to fill when it wants to move to another system of reimbursement.

The use of an SGR tied to the economy forces one share of Medicare to maintain a rigid relationship to the economy that does not apply to other parts of Medicare. As a result, one of the options that MedPAC has proposed is using expenditure targets like the SGR across all parts of Medicare, as preferable to only using a spending target for physician spending. While freezing the relative shares of Medicare spending that exist at a particular time would lessen some of the pressures produced by the SGR on physicians, there is no assurance that the relative shares of spending on Medicare that exist at a particular moment in time represent the best distribution of spending in Medicare as of that time—and certainly no assurance that they represent the most appropriate shares of spending on Medicare for the future. Expenditure targets across all of Medicare could keep Medicare spending within specified growth rates—something it has had difficulty doing throughout most of this decade—especially if the targets were actually enforced. But as the use of the SGR for physician fees has amply demonstrated, expenditure targets, per se, do nothing to improve quality, ensure clinical appropriateness or accomplish any of the other goals that have been set for Medicare—and they are usually not implemented anyway.

The most fundamental problem with the SGR is that the fulfillment of its objectives are inconsistent with the incentives it produces—which can and frequently does result in a very perverse dynamic. The objective of the SGR is to control ***total*** spending by physicians, which it will do if it is implemented. The problem is that it neither affects nor is driven by the volume and intensity of spending of any ***individual*** physician. In fact, there is concern that the SGR expenditure targets provide individual physicians with *even greater* incentives to increase the volume and intensity of services they provide because physicians know that nothing they do as individuals can affect overall physician spending and as a result, their fees and also that they will be affected by whatever other physicians do, irrespective of their own behavior.

Short Term "Patches"

There are a variety of changes that can be made in terms of how the SGR is defined and also strategies that would directly improve the valuation of primary care. These changes would better target fee increases or declines to areas that are considered over-valued or undervalued under the current system or could target areas of spending that have been or are at least thought to be particularly egregious.

By a variety of measures—including waits and difficulties in getting appointments with new primary care physicians, numbers of unfilled residencies, etc. it is easy to conclude that despite the intent of the RBRVS to recalibrate payments between primary care oriented services and procedure based services, primary care remains under-valued in the RBRVS. MedPAC recommended in their June 2008 report a fee schedule adjustment for primary care that would raise payments for selected primary care services. They have suggested using a modifier for billing codes for primary care services provided by practitioners who focus on primary care. The modifier would provide a mechanism to target increases in payment for selected services to practitioners who primarily provide primary care services and doing so on a budget-neutral basis so as to not increase total physician spending. It should be noted that this would change the orientation of the RBRVS from a fee schedule which was meant to reflect the differences in resource costs to one that directly promotes primary care but since the latter seemed to be an underlying rationale behind the adoption of the RBRVS in the first place, it seems a reasonable way to accomplish a goal that has clearly not been met to date. This could be considered for a mid year 2009 start.

The "medical home" demonstration, which MedPAC also recommended, seems like a good way to encourage more coordinated care in a world where most beneficiaries still receive care in a fragmented fee for service setting and could become an important element in improving the care of individuals with chronic disease. The medical home program pays a monthly payment to qualified medical practices that agree to coordinate the patient's care across various setting and providers. If combined with changes in the fee schedule, the medical home concept could become an important part of a longer term "fix".

Other short term patches have focused on the use of multiple SGR's rather than the single SGR which is currently in use. This seems somewhat of a "back to the future" proposal since when the RBRVS was first implemented, it was with three separate spending targets: for primary care, for surgery and for other services. Among the reasons that this strategy was abandoned was the concern that these differential updates were distorting the relative values in the RBRVS.

There have been several versions of separate SGR's that have been recommended. Kaiser Permanente's Jay Crossen, executive director of the Permanente foundation, and others have suggested that groups that are more accountable as systems, such as multispecialty group practices, could be allowed to have their own spending targets in order to reward and incent their membership and make participation in multispecialty practices more attractive to the physician population. Another somewhat differentiated system of SGR's was included in the Children's Health and Medicare Protection Act (CHAMP) passed in the summer of 2007 which not only distinguished between various types of service categories but also allowed the spending target for primary care and preventive services to be substantially greater than the spending target increases for the other categories of service. Like the use of three separate targets, this strategy would also push the RBRVS away from its relative value origins. It is an improvement over the current system but does not respond to the fundamental problems embedded in the current system of physician reimbursement.

A different way to improve the equity associated with an SGR type of mechanism and also to potentially reduce some of the downward pressure on fees caused by inappropriate increases in spending would be to have CMS or its contractors *more aggressively review* billing and medical records of physicians who are clear "outliers" in terms of their prescribing or use of medical procedures and ancillary services. It appears that the MIPPA legislation passed in July permits this type of behavior. Past periods when the Department of Justice or HHS Inspector General's office have made Medicare fraud priority activities have indicated a substantial potential to reduce spending but it can have a real "chilling" effect on providers who are not engaging in inappropriate behavior but who are uncertain of the rules. This appears to have been at least part of the reason that Medicare spending slowed so dramatically in 1998/99. However, if done with appropriate guidance from medical reviewers and following clear protocols, these types of reviews could reduce inappropriate spending and thus reduce the pressure for future fee reductions and I would strongly support such a move.

Next Steps

The Congress is under enormous pressure to decide how it wants to reform physician payment. The short-term patch passed during the summer has physician fees dropping off the proverbial cliff on January 2010. There are only a limited number of changes that can occur between now and then—most of them in the nature of the short term fixes discussed above. There are, however, some more significant changes that could occur over the next four years, which I have outlined below.

The most important next step is for there to be agreement on the basic direction of a future reimbursement system for physicians. As I have testified before, I believe that developing a more aggregative payment strategy for physicians is the key to resolving both the frustrations and the perverse incentives associated with the current fee schedule. While some have argued for simply removing the spending target, only doing this would open the program to unsustainable spending increases and would not promote the development of improved quality or accountability. The only way to continue with a disaggregated fee schedule without the perverse incentives in the current system is to develop an SGR or spending target at the individual practice level. Some type of risk adjustment would probably be necessary for small practices or for practices that had a small Medicare population.

While a spending target at the practice level could effectively impact physician spending levels, the continued use of a disaggregated fee schedule is not as an effective way to encourage and reward physicians who provide high quality, efficiently produced care as moving to a more aggregative way of paying for physician services. The question is how to begin moving in that direction quickly while laying the groundwork for a new physician payment system to be developed no later than the end of the next Presidential term.

In the near term, payments could be developed that would cover all services provided by a physician to a particular patient during a discrete period of time—presumably a one year period—for the care of a chronic disease. It may be desirable to establish bundled payments for multiple chronic diseases that have high co-morbidity rates such as congestive heart failure and diabetes or COPD although not necessarily on an immediate basis. These payments could include only the physician services but preferably would also include all ancillary services provided by the physician as part of the treatment of the chronic disease. In addition, bundled payments should be developed for high cost/high volume DRGS to include at the minimum the reimbursement for all physician services associated with the provision of care during the hospital stay. Consideration should also be given to including the cost of the hospital stay as well. CMS needs to be ready to implement these first set of changes no later than July 1, 2010. Group practices could be allowed to opt out and use their own negotiated SGR's.

In part of moving to a more aggregated payment system, CMS needs to have developed a two-part RFP that would result in strategies for a more fulsome redesign of an aggregated physician payment system, ready for release in the first quarter of 2009 and awarded before the end of the fiscal year. A selection of one or two of these proposals should be selected for further development, with a final report due no later than June 30, 2011. Implementation of the new system could be set for Jan. 1, 2013. I don't think a new system could be implemented faster than this and these dates assume agreement on the direction that the new payment system should take. This timing in generally consistent with the timetable that was used for the RBRVS where a partially completed RBRVS was passed into law in Nov. 1989 with an implementation date of Jan 1, 1992. The cost of developing the payment system and implementing it in a timely way will need to be recognized in future CMS budgets.

Conclusion

Medicare has increasingly moved towards the use of bundled payments—such as DRG's or APC's as a reimbursement strategy, except in the way it pays for physician services. For physician services, Medicare introduced the use of the MEI as an updating mechanism in the 1980's but has never moved away from a disaggregated fee schedule that pays for about 7000 discrete services. The RBRVS was implemented in 1992 to provide a fee schedule that was more resourced-based and focused on relative values but was structurally similar to what had been in use previously. Because of concerns about spending growth with such a disaggregated fee schedule, an expenditure target was also introduced, now known as the SGR.

The problem with the SGR is that while it can control (in principle) total spending, behavior occurs at the level of the individual physician or the physician's practice and here the incentives are at best unhelpful, if not actually perverse. The problem is that nothing the individual physician does affects the SGR; while at the same time physician fees are affected by what physicians do collectively—but this is not where decisions about behavior occur.

Several short-term patches are possible. Primary care, which continues to appear under-valued, could be helped by a (budget neutral) fee schedule adjustment as suggested by MedPAC although this would change the function of the RBRVS away from a resource-based system. Information about how and how well a "medical home" functions could be important part of a longer term fix and should be pursued now in demo form. More aggressive reviews of physician claims by "outliers" could (and should) also be pursued as the MIPPA legislation has authorized. Multiple SGR's such as were included in the CHAMP legislation could also be used as a strategy to target updates in a somewhat more directed way but only represent at best a short-term move in a "better direction". Separate SGR's could also be negotiated for multi-specialty group practices. Ultimately, however, the Congress has to decide on the future direction of physician reimbursement and it better do so in a hurry.

If the Congress wishes to remain with the current type of disaggregated fee schedule that allows for the billing of thousands of services, it should consider the concept of an SGR that operates at the individual physician/practice group level. This would not only be a fairer system but could affect behavior at the level where behavior occurs.

The other option is to begin the process of paying physicians for more aggregated bundles of services. Payments could be developed by CMS to begin by July 1, 2010 to cover all of the services provided for the most important chronic diseases, singly or for multiple diseases, provided to a patient over the course of a year. Similarly, single payments for a subset of high cost/high volume DRG's covering all of the physician services to a patient during their hospital stay could also be developed. While these inter-rim steps are occurring, CMS needs to be developing a two-part RFP to have produced a redesigned aggregative physician payment system. The initial contract needs to be let early in 2009, with a final report due no later than June 30, 2011 and an implementation start date of Jan. 1, 2013. This is a very aggressive schedule for the agency and it would need resources to support these efforts. The Congress has been digging an ever-increasing hole for most of this decade. It has got to start getting itself out and it had better do so fast.

Chairman STARK. Thank you, very much. Dr. Nielsen.

STATEMENT OF NANCY H. NIELSEN, M.D., PH.D., PRESIDENT, AMERICAN MEDICAL ASSOCIATION

Dr. NIELSEN. Good morning, Mr. Chairman. I am Nancy Nielsen, President of the American Medical Association and an internist from Buffalo. And I drive a previously owned Jeep.

We thank you very much both you, Mr. Chairman and Ranking Member Camp, for your help and your leadership in trying to make sure that the next few months are spent constructively with something that will replace what is clearly a flawed physician payment system. You all know the flaws, and so I am not even going to point that out.

We are facing a projected shortage of 85,000 physicians by 2020 and, as has also been in the news recently and alluded to by virtually everyone who has spoken, the big problems are not only—are primarily in primary care and we are very, very concerned about that. But there are some other shortages with surgeons with oncologists and geriatricians. So we are facing this, and the cliff about which we are going to go over unless something productive is done of a 20 percent or more cut is not going to help at all.

We are also on the brink of transformation of health care with information technology, and the problem there is the investment that is necessary, not only the interoperability. But you know all of that, so I won't go into that.

It is really important that we try to figure out what we are going to do over the next 18 months, and we need a stable payment sys-

tem that allows physicians to focus on what they want to do which is to take care of patients. We very much appreciate the help of Congress in buying us a little time so that instead of coming to Washington and fighting over stopping going off a precipice that nobody wants us to go over, we now have the opportunity to work together to try to achieve some real change.

The first thing that we would ask is to ask the Congress to rebase the projections for Medicare. The forecast baselines change every time Congress passes a bill to prevent the immediately pending cuts. With every single necessary congressional intervention, by the way for which we are eternally grateful, the chasm gets deeper. And everybody knows that that is not something that can be allowed. So we urge this Subcommittee to consider establishing a new baseline that erases the SGR deficit, reset the baseline to reflect actual spending which acknowledges reality and would establish a rational basis for designing a new system in which we would have appropriate incentives for quality of care, utilization and efficiency.

Even with rebasing the AMA understands that the need exists to ensure that physician services are both appropriate and properly valued. The RUC is reviewing potentially misvalued services and exploring opportunities to bundle services that are currently offered together most of the time. The RUC has also developed relative values for care coordination services outside of the face-to-face encounter, but CMS has not adopted those values.

We support confidential feedback to physicians, both on quality measures and on resource utilization. We also support funding for comparative effectiveness research so that physicians can make better choices for their patients and patients can make better choices for their own health care. We are working with State and specialty organizations to analyze the specific reform proposals that are out in the marketplace such as the medical home, quality incentives, bundling episodes of care, and one I haven't heard here, accountable health organization.

We look forward to sharing with the Committee more specific comments as our efforts proceed. It is important that we get widespread physician input and consensus because these reforms may have significant advantages and disadvantages. Some involve complex factors such as risk adjustment that might have unintended consequences for patients and physicians.

As we move forward we look forward to working with the Subcommittee and with Congress and with many others who have a large stake in the success of a strong and sustainable Medicare. Challenges abound. It may be that because the issues involving certain communities are diverse that a multi-pronged, multi-faceted approach may be necessary and it may not be one size fits all. On the other hand, we look forward to working with you to fulfill the promise of Medicare for our seniors.

Thank you very much.

[The statement of Dr. Nielsen follows:]

STATEMENT

of the

American Medical Association

to the

Committee on Ways and Means
Subcommittee on Health
U. S. House of Representatives

RE: Reforming Medicare's Physician Payment System

Presented by: Nancy H. Nielsen, MD, PhD

September 11, 2008

Division of Legislative Counsel
202 789-7246

STATEMENT

of the

American Medical Association

Committee on Ways and Means
Subcommittee on Health
U. S. House of Representatives

RE: Reforming Medicare's Physician Payment System

Presented by: Nancy H. Nielsen, MD, PhD

September 11, 2008

The American Medical Association (AMA) appreciates the opportunity to provide our views on "Reforming Medicare's Physician Payment System." We commend you, Chairman Stark, Ranking Member Camp and Members of the Subcommittee for your strong efforts and recognition of the critical need to reform the Medicare physician payment system.

We are grateful to Congress for enactment of H.R. 6331, the *Medicare Improvements for Patients and Providers Act of 2008* (MIPPA), which averted a 10.6 percent cut in Medicare physician payment rates, extended the 0.5 percent payment update through December 31, 2008, and provided a 1.1 percent payment rate update for 2009. This provides an 18-month window of opportunity to develop a solution to the Medicare physician payment formula, based on the flawed sustainable growth rate (SGR), and we applaud the Subcommittee for taking an immediate first step in holding this hearing. We also look forward to collaborating with the Subcommittee and Congress in designing a system that is fair to physicians and patients and that strengthens the Medicare program.

THE MEDICARE PHYSICIAN PAYMENT FORMULA IS FATALLY FLAWED

The Medicare physician payment formula is broken. The SGR is linked to factors that do not correlate to medical practice cost inflation, nor does the SGR take into account significant contributors to utilization growth in physicians' services, such as technological advances and shifts in care from the hospital to physician office, that are beyond physicians' control. Yet, when Medicare utilization of physicians' services exceeds the SGR target, physicians are unfairly penalized with steep cuts in their payment update. As a result of the flawed SGR, since 2001, Congress has repeatedly had to scramble at the 11th hour to forestall steep cuts in the Medicare physician payment rate. Despite these interventions, physicians face over 40 percent in cuts over the coming decade. Physicians cannot absorb these steep losses, especially when data released by the Centers for Medicare and Medicaid

Services (CMS) shows that physicians currently are only being reimbursed for two-thirds of the labor, supply and equipment costs that go into each physician service.

MEDICARE PHYSICIAN PAYMENT POLICY REFORMS NEEDED TO PRESERVE MEDICARE FOR FUTURE GENERATIONS

The Congressionally-created Council on Graduate Medical Education is already predicting a shortage of 85,000 physicians by 2020. Other studies forecast shortages in a number of specialties, including primary care, cardiology, emergency medicine, general surgery, geriatric medicine, oncology, neurosurgery and thoracic surgery. Multi-year cuts in Medicare are nearly certain to exacerbate these shortages by making medicine a less attractive career and encouraging retirements among the 35 percent of physicians who are 55 or older. Further, in the face of continuous projected cuts, the current physician payment system undermines policymakers' vision of a Medicare health care system that uses health information technology (HIT), as well as quality initiatives, to deliver the highest quality of care to Medicare patients. These initiatives require significant financial investment by physicians, and it is neither practical nor feasible to transition to a system that uses important initiatives, such as HIT and electronic medical records, when physicians, especially those in small practices, must first ensure that they can keep their doors open in the face of steep Medicare physician cuts.

To fulfill policymakers' vision of an HIT-based health care system, as well as prevent a serious physician shortage, Congress must ensure that Medicare payments are premised on a stable physician payment system that provides positive annual updates and accurately reflects increases in medical practice costs.

Further, since the SGR is not realistically linked to actual growth in utilization of physicians services, it sets up a continuous false picture of spending on physician services. This fallacy has been compounded by CMS, which has inappropriately included certain health care costs under the SGR that have exacerbated the problem. For example, if CMS had removed from its calculations of spending on physicians' services the costs of physician-administered drugs, as Congress repeatedly assured CMS it had the authority to do, we estimate that the budgetary score for replacing the SGR with MEI updates would be reduced by half. We also believe that CMS is required by law to adjust its estimates of allowable spending growth to reflect the impact of Medicare's own coverage expansion decisions, but CMS has declined to do so.

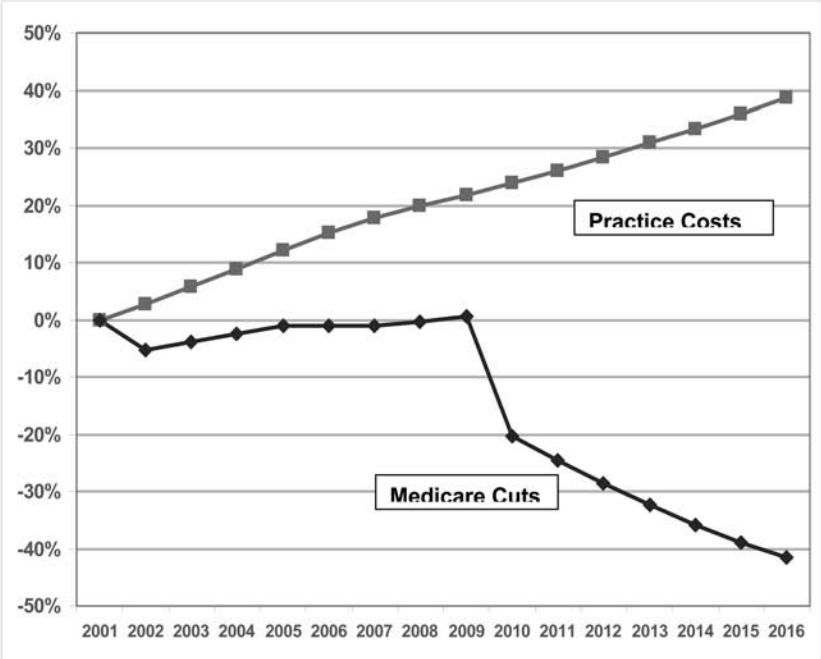
We urge the Subcommittee and Congress to address the projected spending fallacy presented by the current SGR baseline. One part of the SGR solution Congress should consider is rebasing the SGR. In the past seven years, Congress has repeatedly determined that the existing SGR baseline would result in harmful payment cuts and enacted legislation to override the SGR formula. In fact, half the cuts that are forecast are due to the way these legislative interventions were financed, and not due to the rate of growth in spending exceeding the SGR targets. The SGR baseline has been rejected on a broad bipartisan basis in both Houses of Congress. Rebasing the SGR would simply formally recognize these Congressional interventions, more accurately reflect projected Medicare spending and establish a rational basis for a reformed payment system that provides appropriate incentives to address value, utilization and quality of care.

MEDICARE PHYSICIAN PAYMENT REFORM IS NEEDED NOW

Due to the SGR, as discussed above, Congress has repeatedly had to provide 11th hour interventions to forestall steep Medicare physician payment cuts. Moreover, despite good intentions to do otherwise, Congress ultimately has had to use a financing mechanism in the last several interventions that results in deeper and deeper projected cuts for each subsequent year, thus making each legislative fix more costly and difficult to enact than the previous one.

Even with these well-intentioned Congressional efforts, Medicare's conversion factor is less than it was in 2001, and, as discussed above, physicians face over 40 percent in cuts in the coming decade. Yet, even by the government's own conservative estimate, physician practice costs will increase nearly 20 percent during this time period. To compound matters even more, once Medicare implements a payment rate cut, it has a ripple effect as other payers that tie their rates to Medicare (including Medicaid, TRICARE, and various private payers) follow suit.

The chart below shows the gap in Medicare payment to physicians from 2001 through 2016, as compared to increases in medical practice costs, as measured by the government's own Medicare Economic Index (MEI).



Note: Physician cost data is from the MEI, a conservative measure of practice cost growth maintained by CMS. Medicare cuts are from the 2008 Medicare Trustees report, with adjustments to reflect Sec. 131 of P.L. 110-275.

Physicians have shouldered a disproportionate burden for restraining Medicare spending. While physicians have been receiving below-inflation updates or a payment freeze, other Medicare providers' payment updates have kept pace with or exceeded their costs increases. For example, Medicare Advantage (MA) plans' payment rates have risen 32 percent since the program began in 2004. There is no rational basis for the significant disparity in updates for other providers and the steep payment rates cuts slated for physicians. Physicians and other health care professionals should have payment updates that keep pace with their cost increases, similar to the updates for other providers.

Numerous surveys project a crisis in patient access if Medicare payments fall further behind practice cost increases:

- In an AMA survey, 60 percent of responding physician said they would have had to limit the number of new Medicare patients they treat if this year's pay cut had not been stopped. Further, more than half of the surveyed physicians said they could not have met their current payroll with a 10 percent Medicare pay cut and would have been forced to reduce their staff.

- The Medicare Payment Advisory Commission (MedPAC) reports that 30 percent of Medicare patients looking for a new primary care physician already have trouble finding one.

- The Medical Group Management Association found that 24 percent of group practices already limit their acceptance of new Medicare patients.

The projected cuts also affect physician workforce issues. As discussed above, a serious physician shortage is expected by 2020, and an Association of American Medical Colleges workforce study found that 51 percent of physicians over 50 cite "insufficient reimbursement" as a "very important" factor in retirement decisions.

It is especially important that Congress act now to stabilize the Medicare program considering that the first wave of baby boomers will begin entering the Medicare program in 2011, with enrollment growing from 44 million in 2011 to 50 million by 2016. **Thus, the time is now for Congress to repeal the SGR and enact broad-based reform of the Medicare physician payment system.**

CURRENT AMA INITIATIVES TO ADDRESS PHYSICIAN PAYMENT REFORM

The AMA is actively committed to working with congressional leaders, the committees of jurisdiction, the new Administration and MedPAC to adopt and implement new payment policies that provide appropriate incentives to address the value, utilization and quality of care delivered to Medicare beneficiaries.

While we are not poised at this time to identify any single solution to the challenge of Medicare physician payment, the AMA is actively working with the physician community to move forward with alternative physician payment reforms that will have a broad base of support. We look forward to sharing more specific comments with the Subcommittee on these matters as our efforts proceed.

In the meantime, the AMA supports physician efforts to develop and implement clinical practice guidelines that promote appropriate utilization of services. As a key element toward achieving broad-based payment reform, we urge Congress to support funding for quality comparative effectiveness research that will improve health care value by enhancing physicians' clinical judgment and fostering the delivery of patient-centered care.

The AMA is also very aware that threats to the sustainability of the Medicare program have heightened policymakers' concern about growth in the volume of Medicare physician services. Some even have argued there is little evidence that patients benefit from increases in service utilization. We take such concerns very seriously. We also believe, however, that it is important to understand the reasons underlying changes in the utilization of specific services and categories of services, rather than applying across-the-board pay cuts based on an arbitrary volume growth target.

For the last several years, we have engaged clinical experts in analyzing emerging trends in utilization and identifying the various factors behind those trends. Based on this analysis, we now know that per beneficiary utilization growth for physicians' services fell to 3 percent in 2007, down from 4 percent in 2005 and 2006 and 6 percent in 2004. The 2008 Medicare Trustees report found similar trends, indicating that annual volume growth in Medicare physician services for 2005 and 2006 was half the growth rate that the Trustees projected in their 2006 report. These trends are due to such factors as a reduction in hospital and emergency room visits as physicians manage more patients in their offices. The growth rate for imaging services has also slowed significantly. The AMA is committed to continuing our efforts to analyze and take steps to help slow utilization growth.

We support the MIPPA provision requiring the Secretary of the Department of Health and Human Services (HHS) to implement a program by January 1, 2009, that provides physicians with confidential feedback reports on utilization of resources in furnishing care to Medicare patients. We understand that CMS is planning to begin with a limited number of conditions and test various designs as it initiates these feedback reports. For example, many episodes of care will involve services from several physicians and there are various theories as to which costs should be attributed to which physician. It is our understanding that CMS intends to test several different approaches, including some that attribute all cost to a single physician and some that would distribute costs among several physicians. We appreciate CMS' willingness to explore potential problems and test different solutions before broad implementation.

Further, the AMA/Specialty Society RVS Update Committee (RUC), in collaboration with CMS, is currently undertaking a review of physicians' services that are potentially misvalued. The RUC agrees with MedPAC that accurate payment can help ensure appropriate utilization. Since October 2006, the RUC has identified more than 320

potentially misvalued services, and has recommended reductions in work and/or practice expense values for 108 of these services. Many of the remainder of these services will require coding changes prior to any assessment of the valuation. The RUC is also assembling data on CMS' list of the 114 fastest growing services and has distributed the data to all specialty societies. The RUC is soliciting plans of action to address each of these services during its October 2008 meeting for action during the upcoming RUC recommendation cycle. Moreover, the RUC plans to review physicians' services that are commonly performed on the same day and make recommendations to CMS for a more efficient combined coding structure with respect to these services.

ALTERNATIVE PHYSICIAN PAYMENT REFORM APPROACHES

The AMA is working with other groups within organized medicine to explore other approaches intended to develop incentives for appropriate utilization, value and quality of care. Some of these approaches, which Congress and policymakers are also studying, include medical homes, quality reporting, bundling of services and accountable care organizations. Before finalizing our views on new reform proposals, it is important to garner widespread physician input, cooperation and consensus because all of these proposals can have significant advantages as well as disadvantages, with varying impact on physicians depending on many factors, such as medical specialty or size of practice.

For example, a fee-for-service system ensures that physicians have no incentive to withhold needed care, but does not encourage physicians to be judicious about the services they provide. In contrast, bundling payments provides more incentives for efficient care but also carries the risk that appropriate services are withheld or limited. The concept of bundling payments is complicated and encompasses many different possibilities, including the current bundling of physician surgical services and the much broader concept of coupling physician and hospital services in a single payment. While the AMA agrees with the need to provide appropriate incentives for physicians and hospitals to work together to deliver cost-effective, efficient and quality care, many elements of bundling must be addressed before implementing it on a broader scale. These elements include such critical matters as how to attribute care to individual providers, and risk-adjustment to appropriately pay for patients whose care exceeds what should be included in the bundled amount. Further, it will be important to ensure that decisions about patients' care remain in the hands of those who provide that care. Physicians must be able to tailor such care to the needs of individual patients, whose care often is influenced by such factors as whether a patient has a good family support network, can afford a particular medication or is capable of following a particular treatment regimen. **The AMA would support the development of demonstration projects that will help refine and determine those approaches to bundling that hold the most promise for all involved.**

Further, other policy reform proposals being discussed aim to provide incentives to physicians and hospital medical staffs to improve hospitals' clinical performance and quality outcomes and reduce their costs. These incentives can include directly paying for improved value or sharing a portion of the hospital cost savings based on the physicians' discrete, identifiable contributions toward these goals. The AMA believes that there are both significant benefits and risks associated with these approaches and it is important to design them carefully to: optimize the benefits and minimize the risks in order to facilitate

collaboration between physicians and hospitals; promote efficiency through greater access to needed services, quicker turn around time on procedure scheduling, and test results; provide new sources of funds to support quality initiatives; add incremental payments to augment physician fee schedules; return responsibility for the quality of patient care to physicians through their hospital medical staffs; improve the financial health of hospitals; and reduce the rate of growth in Medicare costs. It is important to design demonstration projects that will indicate how payment reforms can best achieve these goals while also ensuring that the new approaches avoid: achieving short-term cost savings at the expense of long-term health; limiting access to the most appropriate care; decreasing clinician control over patient care decisions; or penalizing physicians who treat resource-intensive patients with severe disabilities and chronic health conditions.

Further, the AMA, along with the entire federation of medicine, has made significant strides in facilitating federal and private quality improvement initiatives and we are vitally committed to continuing in these efforts. Finally, AMA policy firmly supports the concept of medical homes for improving chronic care, and we have also supported payment for care coordination and care management. Earlier this year, a RUC work group conducted weekly meetings to provide CMS with timely recommendations on how services in its upcoming medical home demonstration should be valued. If CMS adopts those values and moves ahead with the demo and a wider pilot authorized under MIPPA, primary care physicians should receive significant financial support for additional care coordination activities that will reduce fragmentation and improve medical treatments for millions of Americans with multiple chronic illnesses.

The success of any of the above reform proposals is also largely dependent on a well-developed risk adjustment methodology. Without adequate risk adjustment under these reform proposals, there can be unintentional adverse consequences for patients. For example, some cost containment and quality reporting programs can encourage patient de-selection for individuals at higher-risk for illness due to age, diagnosis, severity of illness, multiple co-morbidities, or economic and cultural characteristics that make them less adherent with established protocols. Yet, current risk adjusters do not generally adjust for factors such as obesity and smoking, and are not precise enough to identify certain complex patients. While the law of averaging may mitigate these weaknesses in payment systems applied to hospitals and health plans, they do not work as well at the individual physician level and have the potential to label physicians who specialize in treating the most difficult patients as inefficient. This will result in the physician being penalized through lower payments and/or patients being penalized with higher co-pays or facing limits on access to care. **To overcome these barriers, we urge the Subcommittee and Congress to direct CMS to work with federal policymakers, physician specialties and private entities to improve current risk adjustment techniques.** The comparative feedback reports that this Subcommittee recommended, and that CMS will be implementing next year, may help identify condition-specific factors that could enhance risk adjustment techniques as well as help physicians and policymakers identify problems such as inappropriate coding practices that could be addressed to constrain costs.

CONCEPTS CONGRESS SHOULD CONSIDER
IN DEVELOPING BROAD-BASED PHYSICIAN PAYMENT REFORM

As the Subcommittee, Congress and other policymakers debate physician payment reform proposals, we urge consideration of the following important factors:

- There is not one single magic solution to the SGR problem. Various reforms may be needed to achieve the appropriate incentives for the delivery of quality, cost-effective care. **Some reforms may be ready for immediate implementation, while others may require more time to develop and implement effectively.**

- **Physicians want to work with Congress and CMS to curb any care that can be shown to be inappropriate.** Not all growth in the utilization of physician services, however, should be viewed as inappropriate care. Many factors that are outside of physicians' control drive utilization growth in physicians' services. For example, increased life spans, rising rates of costly but treatable chronic conditions (such as obesity, diabetes, kidney failure and heart disease), medical advances and unprecedented drug development all result in higher use of physicians' services. There are also laudable developments encouraged by the government through expanded benefits for Medicare. Mortality rates in this century have been falling by about 3 percent a year for heart disease, stroke, and other cerebrovascular disease, while deaths from cancer have declined by about 1 percent a year over the last decade.

- **It is time to examine all of the factors affecting physician practice costs, and adequately account for those costs in the Medicare physician payment system.** The physician payment system does not take into account physician investment in important initiatives such as HIT and electronic medical records. Widespread HIT adoption could transform the practice of medicine. A study by Robert H. Miller and others put the per physician cost of these systems at approximately $44,000 for the initial installation and about $8,500 per year thereafter. (Health Affairs, September/October, 2005). Initial costs for 12 of the 14 solo or small practices surveyed ranged from $37,056 to $63,600 per FTE provider. Clearly, it is not practical or feasible for the many small and solo physician practices to transition to HIT (and electronic medical records) when they face steep payment cuts under the SGR that threaten the viability of their practices.

  Other important factors also affect practice costs. The current MEI measures increases in the prices of particular inputs used in physician practices. The actual composition of the inputs themselves, however, has not changed since the MEI was established in 1973. For example, the number of staff needed per physician has risen dramatically since the 1970s, but the MEI only takes into account increases in wages and benefits. **Accordingly, CMS should evaluate whether the inputs to the MEI accurately reflect the practice of 21st century medicine.** Further, in establishing the MEI each year, CMS adjusts it downward to account for assumed physician productivity increases. In 2008, the MEI is 1.8 percent, or just a little more than half of what it would have been if CMS had not included a 1.4 percent productivity

offset. With physicians spending more and more time and resources on administrative requirements, there is little opportunity to increase productivity. A productivity adjustment is not applied to the hospital or nursing home market basket, nor any other Medicare provider. **We have urged CMS to reevaluate the productivity adjustment to the MEI, but CMS has declined to do so. We urge the Subcommittee to press CMS to evaluate the productivity adjustment to the MEI and reduce or eliminate it accordingly.**

- **Payment reforms should be designed in a way that will improve coordination of care and accountability in Medicare. Further, mechanisms must be in place to ensure that Medicare fiscal resources are better coordinated and appropriately distributed among the current Medicare silos, *i.e.*, Medicare Parts A, B, C and D, especially to reflect the impact of initiatives that rely on physicians to provide more care in their offices to avoid costly hospitalizations.**

- **It is critical that the physician community and Congress work together to encourage healthy lifestyle choices that assist in long-term and costly disease prevention. Controlling these costs will also help reduce the increased utilization of physicians' services that results when an individual becomes eligible for Medicare at age 65.** In congressional testimony, Bruce Steinwald, Director of Health Care for the Government Accountability Office (GAO), has cited research by Kenneth Thorpe attributing 27 percent of the growth in inflation-adjusted per capita spending between 1987 and 2001 to the rising prevalence of obesity and higher relative per capita spending among obese individuals. The AMA has initiated many programs aimed at healthy lifestyles for disease prevention, and we will continue our efforts to address this important matter.

- When CMS revises the relative value units (RVUs) for physicians' services (which is a significant factor in determining payment for each service), by law, CMS must implement these RVU adjustments on a budget neutral basis. This means any increases in RVUs for certain services must be offset with decreased RVUs for other services. These decreases often apply across-the-board to all or many physicians' services, including the services that have been scheduled to receive an increase in their RVUs, thereby undermining the value of the increase.

  Further, in the past, Congress has legislated reductions to certain procedures and mandated that these reductions cannot be offset with increases to other services. In other words, these dollars were permanently removed from the physician payment pool. CMS has also chosen to implement certain legislative provisions in a manner that permanently removed dollars from the physician payment pool. This budget neutrality restriction, and the manner in which it has been implemented, complicates efforts to increase payments for primary care and other services that are generally recognized as undervalued. **We urge the Subcommittee and Congress to address the budget neutrality restriction as part of Medicare physician payment reform.** In addition, it is not reasonable to expect that certain payment reform proposals that increase payments for certain services should be made on a budget neutral basis since this only serves to reduce the value of all services. **Thus, as we move forward**

with physician payment reforms, we urge the Subcommittee and Congress to refrain from implementing any such reforms on a budget neutral basis.

- We appreciate that MIPPA contained provisions to help level the playing field between fee-for-service Medicare and MA plans. As shown by a September 5, 2008, report by the Commonwealth Fund, however, there still is much work to do to achieve a more complete level playing field. Payments to private MA plans will total $8.5 billion more than those for traditional fee-for-service plans in 2008, according to the report. Private MA plans will be paid at a rate 12.4 percent higher than for traditional fee-for-service Medicare, or an average of $986 more per enrollee, according to the report. According to Brian Biles, lead author of the report, Medicare Advantage was intended to save money through the use of private plans, but extra payments to these plans combined with rapidly increasing enrollment, has resulted in $33 billion in additional spending over five years. **We urge the Subcommittee and Congress to continue its efforts to achieve a level playing field between MA plans and fee-for-service Medicare. This is necessary to achieve fair competition, efficiencies among MA plans and equitable treatment of all Medicare beneficiaries.**

The AMA appreciates the opportunity to provide our views to the Subcommittee concerning Medicare physician payment reform. We look forward to working with the Subcommittee and Congress over the next 18 months to achieve a solution to the fatally flawed SGR as this is critical for ensuring that our seniors and disabled patients have access to a health care system that provides them with high quality, cost-effective care.

Chairman STARK. Thank you, Dr. Nielsen.
Mr. CRANE.

STATEMENT OF DONALD M. CRANE, PRESIDENT AND CEO, CALIFORNIA ASSOCIATION OF PHYSICIAN GROUPS

Mr. CRANE. Thank you, Mr. Chair, Ranking Member Camp, and thank you, Members of the Committee. I am Don Crane. I am the President and CEO of CAPG, California Association of Physician Groups. We thank you for this opportunity to address this very important issue that is so near and dear to our hearts, which is physician payment reform.

I represent a professional association located in California, confined to California, that is comprised of about 150 multi-specialty medical groups that employ or contract with about 59,000 physicians, well over half the practicing physicians in the State of California, that provide services to approximately 12 million patients in coordinated care, or managed care as it is also known, plus another approximate 5 million patients in fee-for-service models, original Medicare and PPO.

So we straddle both of the payment systems that predominate in California, capitation and fee-for-service. And so we see these two systems, we live them day in and day out. We see their impact on behavior. We know how they affect performance, and we think we have a unique perspective on this issue of payment reform as a result.

To go to the bottom line really of my comments to the Committee, we think the prepaid capitated coordinated care systems produce a much more efficient system and ultimately result in more affordable care which is what we are all going to need to achieve if we are going to succeed going forward. And the reasons for that are many, we have heard some of them discussed today, so I will be brief in summary in outlining a few of them. They really all relate to financial incentives and the way humans, which are really economic creatures, respond to financial incentives.

Capitation incents frugality. That is its chief virtue. We see it manifest itself in many ways. Perhaps most importantly the emphasis on prevention. When a physician group and a physician is able to prevent the onset or the worsening of a disease they save money downstream and that is in their interest, and so there an enormous premium and emphasis paid on prevention, early intervention, early assessment. All good for the quality, all good for the patients, and all resulting in more affordable care.

It also incents coordination and the development of systems, systems of all kinds, personnel systems, technology systems, and systems are more efficient than nonsystems.

It also provides the capital that fee-for-service does not for the acquisition of infrastructure, and maybe the most important of which these days is IT. That is why you see in California, California leading the rest of the Nation, in the implementation and adoption of electronic medical records. Forty of my members, large members, will be fully implementing their electronic medical records within a short year and a half from now, bringing digitized medical records for the benefit of their patients to about 10 million Californians. This is way out in front of the rest of the Nation, and the ultimate reason is prepaid capitation.

We also have in California a very robust pay for performance program that involves 35,000 physicians, all the health plans. It is

a collaborative that is the darling really of pay for performance systems across the United States and it exists principally because of the virtues of prepaid capitation.

On the other side of the ledger and by stark contrast there is the fee for service system. We see that as well because we sometimes receive capitation, we sometimes receive fee-for-service payments. In turn, we pay capitation and we also pay fee-for-service and so we see both systems.

In a word, as we have heard repeatedly today, a fee-for-service payment methodology induces churning. We facetiously refer to it in California as fee for volume, because it is well-known to maximize one's income you need to produce more units of service. The more you do, the more you get paid. That is the incentive. And so it produces the overuse we see, the duplication of procedures and services. It creates a fragmented, non-network of physicians operating in a million different little silos in a disconnected way. Episodic care, not what we want.

A couple of quick proof points that I think bear mentioning here. If you look at the cost of health care in California versus other States in the rest of the Nation, California is very much less expensive. Just a short couple years ago I was able to crow that we had the lowest commercial premiums in the United States. This is HMO and PPO included together. That has changed, but we are still down in the bottom four or five. Much, much less expensive, for example, than New York. And the reason is managed care, prepaid capitation. It produces a more affordable product. Looking even within our borders and in my own business, I as an employer pay for benefits for my employees. The commercial HMO product is anywhere between 15 and 30 percent less expensive than a comparably comprehensive full PPO product. So it is less expensive, which is a critically important fact we will need to pay attention to going forward.

So in conclusion, again more affordable and really higher quality care, and that is really the essence of the paper we have submitted before you, and that is triply so in connection with chronic disease management where the coordination of multiple providers operating out of a single medical record, single medical chart is critical here, and that is what we find in our system. It produces better access frankly. My members are leaders among urgent care, same day access. All these systems are developed and it really emanates from prepaid capitation.

And I will finally conclude by saying it is really fairly popular. The HMO product in California is rather durable. It is here, we hope it is here to say. We think it ought to be migrated across the rest of the Nation.

So I thank you for the opportunity to address this. I would be happy to answer any of your questions.

[The statement of Mr. Crane follows:]

Statement of Donald M. Crane, President and Chief Executive Officer, California Association of Physician Groups, Los Angeles, California

Good morning. My name is Don Crane, and I am the President and Chief Executive Officer of the California Association of Physician Groups (CAPG). On behalf of CAPG, its 150 member groups, the 59,000 physicians who practice in those groups, and the 12 million patients, I would like to thank Chairman Stark and Ranking

Member Camp for inviting us to participate in this important hearing on Reforming Medicare's Physician Payment System.

The medical groups and physicians of CAPG are working on many of the same issues that you are grappling with here on Capitol Hill—how best to provide high quality health care, improve efficiency of the care model, ensure that the system can adjust to complex problems with innovative solutions, reduce health care costs, and improve the quality of life for our patients.

On the issue of Reforming Medicare's Physician Payment System, CAPG offers a unique perspective. For more than 25 years, California physicians have been able to care for their senior patients through both a Medicare managed care model and through the traditional Medicare fee-for-service system. In fact, more than 50 percent of Californians receive their health care through some form of capitated payment model. Our history and experience with both forms of payment has given us a unique perspective of their various strengths and weakness.

CAPG finds that a organized health care delivery, through a capitated payment model, provides greater incentives for high quality, efficient, and cost effective health care. Organized Delivery functions according to the following management principals—the same type of principals which make any business successful:

- **Strategic Resource Allocation:** Ensures that capital is invested in areas that reduce the cost of care (i.e. urgent care centers developed to reduce hospital cost)
- **Staff Recruitment:** Workforces are developed to ensure that patients receive the highest quality, most cost efficient form of care.
- **Data Driven:** By measuring activities and outcomes, we can identify ways to systematically improve our care.
- **Optimizing the Whole:** Focus on managing the totality of the health care dollar, not just maximize an individual part (i.e. one type of service).
- **Leverage Technology:** Develop information systems in a group or organized setting to coordinate care, capture relevant system data and provide for documented outcomes.
- **Leverage Volume**: Maximize purchasing power for everything from supplies to specialty services.

An organized delivery model is built on a culture of conservatism. It encourages provides to work within a budget, identify those employees and services that improve quality of care, and invest in systems and infrastructure to reduce costs and improve efficiency. Conversely, a fee-for-service system incentivizes episodic, acute care. Under this system, providers seek to maximize their units of service, leading to even more prescriptions, treatments, and procedures. This creates a health care "churn" that emphasizes volume over efficiency, overuse over prevention. And it is clear, in this case, that more health care does *not* equal better quality health care.

As Congress considers reforms to the physician payment system, we encourage you to consider reimbursement methodologies that will help sustain the Medicare program. These policies must use economic incentives to ensure that physicians and other health care providers adopt practices that ensure quality and efficiency—essentially, using payment methodologies to modify physician behavior.

To demonstrate the benefits of this approach, we draw from a study we did last year, entitled "From the Point of Care." This report highlighted the perspective of CAPG members—those physicians on the front lines in America's health care system—and their experience with capitated payment systems.

In summary, CAPG physicians found that they are able to provide better health care to their patients who are in organized delivery plans than those in traditional Medicare. This report was the first of its kind, in that it discussed value not just in economic terms, but in human terms. CAPG's members were able to assess these payment systems on other key characteristics, including quality, efficiency, flexibility, and modernization. Against this backdrop, CAPG members found that capitated payment systems produce significant benefits for its enrollees, especially in the area of care coordination, pay for performance, adoption of health information technology, and evidence based medicine.

Chronic Care Coordination

According to a recent study by the Commonwealth Fund, an estimated 20 percent of Medicare beneficiaries have five or more chronic conditions. These beneficiaries are treated by an average of 14 different physicians, leading to medical costs that equate to two-thirds of the Federal program's spending. It is the experience of CAPG physicians that the traditional fee-for-service model is ill equipped to manage seniors with multiple chronic conditions.

For many chronic illnesses such as diabetes, arthritis, congestive heart failure, hypertension and others, there are a range of proven interventions and therapies. These therapies can minimize, delay, or entirely prevent a range of secondary complications, resulting in improved comfort, productivity and quality of life for the beneficiary while reducing the cost of avoidable crisis intervention. Unfortunately, the current reimbursement structure cannot respond to the treatment needs of chronically ill patients. Multiple studies have pointed out that many patients in traditional Medicare receive chronic care oversight in a sporadic and incomplete fashion.

Organized delivery systems have embraced a chronic care model that employs a fundamental redesign of the care delivery system. This model requires computerized, centralized registries that allow providers to know which patients have certain diagnoses, when their services are due, their lab results and personal measures, and when those results indicate the need for intervention. These care management services are only possible in the context of an organized delivery system and are virtually non-existent in traditional Medicare.

Pay for Performance (P4P)

California medical groups have led the nation in the development of clinical performance measurement programs and economic incentives which reward high-performing providers. Under the auspices of the Integrated Healthcare Association, these efforts have set the foundation for California's annual Pay for Performance ("P4P") bonus payment system. These bonuses have created economic incentives which have resulted in health care improvement strategies being implemented across the entire state.

Our P4P program has been closely studied by the Centers for Medicare and Medicaid Services to determine which components can be exported to geographic areas where traditional Medicare payment methodologies predominate. Two characteristics seem essential to a successful P4P program: 1) medical groups need to be effectively integrated with their local provider community and 2) population-wide care improvement is the criterion for a financial reward.

The benefits of California's P4P program are demonstrable in under capitated payment systems, resulting in a new culture of measurement, public reporting, annually improving quality, an objective assessment of efficiency, and better personal experiences and clinical outcomes for patients. There is no comparable P4P program in traditional Medicare, and given the importance of organized systems of care and populations based measures, P4P in traditional Medicare is likely to be unsuccessful in stimulating meaningful changes in practice patterns.

The Use of Health Information Technologies to Improve and Manage Care

California's organized systems of care are widening the application of electronic health registries, which help with the management of chronic illnesses, particularly those requiring cyclical oversight. They are also used to assure routine screening and preventive services such as mammography, cervical cancer screening, colorectal cancer and screening for other treatable illnesses.

Furthermore, California's medical groups are deploying electronic health records (EHR) well ahead of the national trend. The use of EHRs in seniors has resulted in:

- Physicians managing multiple simultaneous conditions with complete access to clinical information necessary for the best medical decision;
- Electronic prescribing and subsequent tracking to assure accuracy, continuity and safety,
- Coordination of care among multiple providers with instantaneous sharing of information to support clinical decision making to avoid redundancy, missed opportunities, and mistakes; and Providing patients with portable access to critical medical records when away from home.

Capitated payment systems greatly contribute to the development and adoption of Health IT. The use of EHRs, electronic registries, electronic prescribing and other Health IT is not nearly as prevalent in traditional Medicare.

Evidence Based Medicine

Providing evidenced based medicine is another area where capitated payment systems have been able to make significant progress. California physician groups have worked to avoid inappropriate utilization by focusing on scientifically justifiable clinical decisions.

Physicians who are part of physician groups routinely submit clinical rationale and justification for procedures, especially those with "gray areas," clinical controversy, or complex choices. This exercise does not replace a physician's clinical judgment nor is it an excuse to thwart necessary care, but rather a quest to deliver

the right care, at the right time, at the right place. Objective, scientific, and ethical oversight is the cornerstone of the efficient use of finite resources in a costly environment.

I think we can all agree that our health care system should promote prevention, chronic care management, and avoidance of unnecessary and unjustifiable health care. Organized delivery plans have made considerable progress on these, and other fronts.

Summary and Closing

For more than two decades, CAPG's members, their physicians and their patients have directly experienced the clinical and administrative successes of capitated payment systems. As Congress considers ways to reform the Medicare provider payment system, we encourage you to consider expanding this approach, and providing incentives for higher quality, more efficient health care delivery. We look forward to working with you on this effort.

Chairman STARK. Thank you very much. Mr. Crane, approximately what percentage of your members are in staff model programs as opposed to other types of group practice?

Mr. CRANE. It is approximately 50/50, maybe 45/55.

Chairman STARK. What other staff model groups besides Kaiser?

Mr. CRANE. There's the two Permanentes that belong to CAPG and they are huge. Then there is probably 40 percent of my members which are medical groups with employment relationship with their physicians. And then I am guessing approximately 60 percent of my members are IPAs, independent medical.

Chairman STARK. Okay. If we went to capitation as you suggest, why do we need insurers in the middle anymore, why don't we just capitate directly to the groups?

Mr. CRANE. Good question. Of course there are those who advocate that. In California our system works well in a delegated model with the insurance companies handling the——

Chairman STARK. No, it doesn't. The insurance companies in California rip us off and charge more than they do in, say, Minneapolis for less good care. So that doesn't wash. California is the most expensive, but we don't produce anything to brag about in terms of results.

Mr. CRANE. Agreed. They are overpaid and I would agree with you there, but they are performing some important functions that need to be performed. There is the marketing, advertising, sale, brokerage, there is the delivery of the insurance that they do. I won't defend them. I am saying that that model is working moderately well in California frankly.

Chairman STARK. Okay. You do support and you mentioned that you have 40 member groups who are moving toward information technology. Will each of those 40 groups be able to talk to each other and swap sanitized records and combine them all for purposes of research or will they be independent reports records that will not be shared?

Mr. CRANE. Unfortunately the latter. Indeed they are silos as well, and until we have a Calrio utility across California we won't achieve that important goal.

Chairman STARK. Would you support some kind of payment incentive to get physicians and other providers into an information technology system that would be interoperable and in a sanitized

way aggregate all of the medical records so that they could be used by people with a need to know for research?

Mr. CRANE. Absolutely, yes.

Chairman STARK. Okay, thank you.

Dr. Nielsen, there is, as I alluded to talking with Mr. Crane, a huge regional variation and I am stealing some of Mr. Ramstad's thunder here, but the evidence seems to suggest that there is a correlation between the number of specialists in an area and the amount of care provided by those specialists, but the quality and outcome don't indicate that people living in those areas receive any better care. What do we do with the regional variations? Mr. Ramstad would like me to raise Minneapolis to the Los Angeles-San Francisco levels and I am suggesting to him no, that I want Minneapolis to lead the charge and we will lower California to the Minneapolis rates. When the spread gets such that you can get on Northwest Airlines and go to Minneapolis and get the same treatment for the same money, I think that is where we cross the divide. How do we deal with this?

Dr. NIELSEN. You are absolutely right. We have been very concerned about the information we have received and those regional variations need to be studied, and if there are aberrations they need to be corrected.

Part of our approach to that has been to develop performance measures so that the consortium with the help of virtually all the specialties have looked at what is the best thing to provide to a patient, not more, not less, the right service at the right time. And we also need comparative effectiveness trials to help us decide what is the best approach. But you are right and physicians can no longer claim that this is because of variation in patient mix. It really is not.

Chairman STARK. I thank you. I wholeheartedly agree, and I hope I will come back if I get a second round and talk to you about medical homes and how we might use that, as I think Dr. Wilensky has suggested, to encourage more activity in the primary care area. I will interject, we have talked in this Committee, we have come close on the comparative effectiveness scale. Gail can remember when Bill Gradison and I talked about outcomes research before we really thought we had the ability for broad information technology aggregation of medical records. I don't see how until we have a completely interoperable system bowing to the privacy needs to keep it out of the hands of unscrupulous drug companies and things like that, but—and then once we have comparative effectiveness we can at least deal with your members, we could deal—you know, should you use Lipitor or Zocor? How do you know? I think those are things we can prove with some effectiveness and then move to fit that into a reimbursement program. I don't think until we get to all of that that all of your 40 members can talk to each other, Mr. Crane, and we can decide how a primary care physician can reasonably, at a reasonable cost manage 500 or a 1,000 patients in a practice as a medical home. I don't know.

Gail, your theme is with everyone else's greater reliance on primary care. And as I recall, that was the intent.

Ms. WILENSKY. Yes.

Chairman STARK. Originally, when—I think it was another gentleman from the Twin Cities, a distinguished former Senator and I who worked, and we thought we had the system locked up. Gail even signed up to it. Where did we go wrong?

Ms. WILENSKY. There were several problems that arose. One had to do with the use of separate volume performance standards which at the start changed some of the relative value weights. Part of it has been in the mix of services that people use. And I think the system has not been sufficiently robust to be able—because of the attempt to keep things budget neutral—to reward the primary care physicians' activities.

A lot of it relates back to the use of a disaggregated fee schedule where some of the activities that a primary care physician wants to provide, such as education to his patients, as well as a lab test or a visit, is not able to be handled well when you have billing at a very discrete level. And it is why, either through the use of a medical home or some other way of combining payments for taking care of a diabetic or someone with congestive heart failure, it would allow that physician to receive a fairer payment and be able to make decisions within that payment as to how best to treat the patient.

Every indication we have in terms of residencies filled, in terms of difficulties, for people who don't have ongoing primary care physicians to get an appointment with a new primary care physician, includes a shortage of primary care physicians. And we need to at least make it possible for people who finish school to be able to practice primary care.

Congressman Becerra and I have had discussions for I think at least a decade about using selected loan forgiveness as a way to encourage people who want to practice primary care. I have a daughter-in-law who finished a OB residency last year and is discovering the difficulties of trying to pay back 4 years of medical school and a year of an MPH while practicing primary care. In addition there are a lot of concerns about malpractice. So this would help, but it won't solve the whole problem.

Chairman STARK. Just for a moment I want to—who brought up the accountable care organization. I am going to defer that if Mr. Pomeroy is here, or when he comes out, we will talk about that later. But remind me, if you will.

And Bruce, you suggested short-term steps to change the E&M codes. If we do it a budget neutral way, then we have to take it out of the hides of the proceduralists, right? How would this effect physician spending? Do you want to elaborate?

Mr. VLADECK. Well, again I would only suggest that, if everyone is right and what appears to be true sort of cross-sectionally actually works in real life over time, then raising the relative price for primary care services and increasing the volume of primary care services provided to Medicare beneficiaries should reduce the utilization of at least primary care referred specialty services and create some offsetting savings which would permit, under the current or modified SGR, some greater increase in the conversion factor than you would otherwise be able to afford.

Chairman STARK. Thank you.

Mr. Camp, would you like to inquire?

Mr. CAMP. Thank you, Mr. Chairman.

Mr. Crane, right now Medicare has this somewhat fragmented fee for service system and yet we have this wave of baby boomers that are retiring and will put a great deal of demand on the system. Do you believe that that system is capable of absorbing this influx?

Mr. CRANE. I do not.

Mr. CAMP. And what changes do we need, for example, like a coordinated care system to protect Medicare so that we can ensure that it is there for our seniors?

Mr. CRANE. Some of those that had been mentioned today, bundled payments and a greater emphasis on primary care of course would be included in the mix, but the chief argument I would make, I recognize it is controversial, was that we have a platform now in Medicare Advantage that can be built upon and improved that serves very, very well the seniors certainly in California and can be expanded and should be expanded, providing the really excellent medical home to them now. It is a model that is working well. So expand it is what I would say.

Mr. CAMP. How would a capitated system help control costs and physician spending in Medicare compared to the current fee-for-service?

Mr. CRANE. Well, capitated groups have to operate within the budget they are allotted, via the capitation. And so by reasonably setting that capitation you are going to be able to incent the frugality that I mentioned earlier, far more so than you will in an unbridled fee-for-service system. So where cost is a big consideration you need to the kind of payment methodology that moderates cost and yet preserves quality. We have that. That is what I would recommend.

Mr. CAMP. Thank you.

Dr. Wilensky, the prospective payment system for inpatient hospital care began in 1983, and after moving from a cost-based system to a bundled, capitated payment system, the length of hospital stays has declined 32 percent from 1990 to 2001. And do you believe a bundled payment in the physician arena could result in similar efficiency improvements, obviously saving Medicare significant money while still ensuring quality care?

Ms. WILENSKY. It would move in that direction. I don't have a prediction as to how much. I believe there is a reason the Congress has directed the agency to use bundled payments for home care, the episode payment and for skilled nursing facilities for inpatient and for outpatient hospital care, and it needs further consideration in the area of physician reimbursement.

Mr. CAMP. And Dr. Nielsen, I mentioned the millions of baby boomers that are about to enroll in Medicare. If significant changes are not made to the SGR, will physicians have to consider whether they will take new patients?

Dr. NIELSEN. There is no question. And I must say that I disagree with your chairman about this not being a very real consideration. You heard that. It was not empty rhetoric in early July. It was very serious. People are really having trouble, particularly those in primary care but some in other specialties as well. So I think that we do have to fix this.

If I may, can I just add one thing because, I must say, I never heard, when I heard Mr. Crane make a comment, I have never ever heard anybody equate Medicare Advantage with the medical home. And I have to tell you that one stretches my very credibility. I hope that I misunderstood what he said. But there is no relationship between a Medicare Advantage plan, some of which do very good things, and the medical home. The medical home is very different and is a home with a physician or other health care providers——

Mr. CAMP. I understand that.

Mr. Crane, do you want to comment? I think you were referring to the wellness and coordination of care.

Mr. CRANE. That I am.

Mr. CAMP. That is what I understood you to say.

Mr. CRANE. Certainly, I am not referring to health plans. What I am referring to is what he have in our multi specialty medical groups in California that are presently medical homes both in the commercial model and, yes, in the senior model as well where you have essentially a primary care system that involves coordination and a concierge for patients to help navigate through the labyrinth of specialty care hospitals, prehospitalization, post hospitalization. We have primary care directed groups that provide that medical home across the spectrum of products, and that is the point I was trying to make.

Mr. CAMP. Getting back to my point, Dr. Nielsen, you mentioned that the concern about physicians taking on new Medicare patients. If the Medicare eligibility age were dropped to 55 years old, would the current problem with Medicare physician payments be made worse or better?

Dr. NIELSEN. The problem now is reimbursement in many specialties, keeping up with practice costs. And it is very well known that private plans tie their fee schedules, one way or another, to Medicare. So, frankly, the reality is if what is happening now in Medicare and Medicare anticipated to go broke in a few years, if you expand the eligibility, it will worsen the problem earlier. So I think it is important that we get to a better solution.

Mr. CAMP. Thank you very much.

Thank you, Mr. Chairman.

Chairman STARK. Thank you.

Mr. Thompson would you like to inquire.

Mr. THOMPSON. Thank you, Mr. Chairman thanks to all the witnesses for being here today. Dr. Nielsen I agree with you on the issue of providers and what kind of predicament many of them would find themselves in if we allowed these cuts to continue. I represent a rural district, a lot of solo practitioners, a lot of small group practices. All of these folks are feeling the strain right now without the cuts. So if there were, I think it would be devastating.

In your written testimony, you talked about accurate risk adjustments and how we don't want to discourage docs from taking the tough cases, and applying that to the area that I represent, as I just described. How do we accurately measure that risk so that we don't provide more disincentive for people to practice in rural areas?

Dr. NIELSEN. Let me give you an example that I am very familiar with. I am in Buffalo. In Buffalo, we have had experience with

capitated pre-paid reimbursement, and the private plans have done away from that model. But there was a single per-member per-month assignment of a fee to a physician. Just as there are problems——

Mr. THOMPSON. A fee from whom, to the physician?

Dr. NIELSEN. From the health plan would pay the physician a fee for a person, per member, per month. The problem was there was no distinction between a healthy 19-year old and a 92-year old, and there is a very big difference. And what one has to be careful about and the reason we need to very quickly test some of these models that have been mentioned is we have to see what the unintended consequences were in that, in the circumstance that I gave you, the obvious thing they did wrong was not to just risk adjust. There should have been a higher payment for the 92-year old than the19-year old. That is my point.

Mr. THOMPSON. Anyone else on that issue?

Dr. Vladeck, you had mentioned that we should look at some foreign models and learn from them. What sort of things are they doing in other countries that we should be doing? Or what are the lessons learned looking at those foreign models.

Mr. VLADECK. I was suggesting I think that in much of the rest of the industrialized world, they have managed either through their payment systems or other mechanisms to have a better balance between primary care and specialty care.

Mr. THOMPSON. Is there someone that is doing something that we are not? Or are we doing something that we shouldn't be doing?

Mr. VLADECK. Well, many of them are doing it, it is outside Medicare and indeed only loosely within the jurisdiction of this Committee. But many other relatively affluent nations are doing what we used to do in this country, which is taking some greater responsibility for medical manpower policy or personnel policy, both by more generous financing of medical education so that young physicians don't have the kind of debt loads they have in the United States, which may limit their options, but also by intervening more aggressively in issues of availability of specialty slots for training and things of that sort. And we to a much more limited extent used to do a lot more of that in this country than we do now, and again, there was some reference made earlier by Dr. Wilensky to even the question of using targeted loan forgiveness, for example, for young physicians so that they can afford to practice in underserved areas or to provide primary care. We do a lot less of that as a matter of public policy right now than we did a decade ago, and I think as part of the strategy to improve the primary care specialty balance, we ought to look at reviving some of those things.

Mr. THOMPSON. Is preventive health care practiced more diligently in other places than here? Someone had mentioned that. It seems to me we could make up a lot if we had better preventive care practice. Any comments on that?

Mr. VLADECK. Let me just make one quick comment on that. It is true that primary care practitioners, particularly when you have explicit guidelines and explicit data and reporting systems to evaluate their compliance with the guidelines, whether you are paying more or not, will provide more preventive services or more clinically accepted preventive services than other physicians. But in

the context of incentives, I really want to just make an observation relative to one of the earlier comments. If you have an enrolled population that turns over at the rate of 20 or 25 percent a year, as is the norm in much of the private commercial insurance market, the economic incentive to provide preventive services is extremely attenuated. And we do better by expecting physicians to meet professional performance standards with or without financial incentives than we do by incenting plans to invest in patients who will be long gone when the benefits of prevention begin to be felt.

Chairman STARK. Thank you.

Mr. Johnson, would you like to inquire?

Mr. JOHNSON. Thank you.

Thank you, Mr. Chairman.

I welcome you all.

Gail, it is nice to see you again. We all know the current system of how we pay our doctors is unsustainable and docs in my district talk to me all the time about how frustrating it is to try to run a small business, which is what they do, when year after year their payment rates for Medicare are up in the air until the last minute. I am struck by the fact that so many ideas center on just trying to take the current process apart and make it better.

However, I think one of the greatest problems is the current process. We can't fix the problem by just tweaking it. We need a new process. I think we have got to think out of the box. And I don't know what it actually costs for an office visit or an x-ray, and it is different all over the country. We don't know because we have formulas, not market forces, setting the price.

I would like to ask Ms. Wilensky and Mr. Crane to discuss ways that you think we can get bureaucrats and formulas out of the process and introduce real market forces in determining what physician services are worth. I mean, thinking out of the box, maybe rich guys like our chairman could opt out of Medicare for example, for life. And I know another guy in my district that would do that in a New York minute, and that is Ross Perot. He keeps asking me, why in the hell am I on Medicare?

Well, I think we need to take lessons learned, maybe from a part D benefit and apply it to part B, but would you all discuss that?

Gail, you want to start?

Ms. WILENSKY. You raise some very large, very controversial issues. Let me try to respond to a couple of them.

Going forward, the Congress at some period will need to look at the financial viability of the Medicare Program on a long-term basis. That did not happen when part D was passed into law, and we have added to the substantial unfunded liability of the program.

As part of a long-term reconfiguration of Medicare, we may look at whether income relating the Part D program; the way we do part B, which the Congress passed in 2003, is an appropriate strategy. The age of retirement for a country that lives as long as people live here is another potential change. Of course, it depends on the kind of insurance that is available for the under-Medicare population as to how realistic that is. These are big issues. And I encourage the Congress to look at them.

I am very worried about what is going to happen to physician participation and basic fairness under the program as it exists

right now. You are in a bind. Physicians charge Medicare using 7,000 fees. They bill for very discrete services. The reimbursement for the individual services is not reasonable. And the reason I can say that without actually knowing very much specifically is fees have been essentially flat since 2002, maybe 1 percent; in 2002, it went down 4 percent. Inflation has clearly increased. So physicians that are playing it straight, not trying to make up in volume and mix what they lose in fees, can't be having their expenses covered. And that is why I think the Congress has to make a fundamental choice about what direction it wants to go.

Now some physicians are doing very well under Medicare, not because of the fees, but because they are very aggressive in the volume and mix of services and the kinds of services they provide. But physicians that aren't doing that really are not being treated fairly. If you want to stay with a very disaggregated fee schedule, 7,000 codes, I really think the notion of thinking about having these spending limits at the level of the practice makes some sense. Then you can at least reward the conservatively practicing physicians, paying them more, and not the ones that don't.

But if you don't want to go in that direction I think you need to think about having payments for bigger sets of services. And you can decide how to set those payments, whether you want to use historical fees, whether or not you want to have it be more market-based, whether you want to have it administratively based. Typically when the bundles exist, when they were created, they were based on historically what existed in the area. But that is your choice.

Mr. JOHNSON. Mr. Crane, do you have a comment?

Mr. CRANE. Very briefly. I agree with what Ms. Wilensky said. You know capitation is the ultimate aggregator. It is a good starting point. In California, we have competitive bidding, and the groups are paid different amounts by the health plans who are—so there are market forces at work. It raises the question of whether there is overfunding or overfunding from the top, a separate subject we can talk about, but there is a market at work there, and I think it is a good platform for us to build on frankly would my answer.

Mr. JOHNSON. Thank you, sir.

Thank you, Mr. Chairman.

Chairman STARK. Let's see who we have got here on the list.

Mr. Pomeroy, would you like to inquire, sir?

Mr. POMEROY. Thank you, Mr. Chairman.

I want to commend this panel. It has been incredibly interesting. It is my pleasure professionally to have worked with both Dr. Vladeck and Dr. Wilensky for many years.

And I must say I find some of the testimony surprising. I hear Dr. Vladeck saying, well, maybe we ought to return to fee-for-service, and I hear the physicians, clinics, the professional groups saying they like capitated. Now, to me that is like Bizarro World. I would have thought that is 180 degrees off from what I expected from each of you.

Mr. Crane, did I hear you say that California has achieved cost, low-cost medicine relative to other States?

Mr. CRANE. Well, we are struggling with an affordability problem. So we haven't declared success. But on a relative basis, California's health care costs are lower than other States. So, relatively, the answer is, yes, we have got a problem in California, as well. And we are wrestling with it at the same time. I mean, health care costs are rising precipitously. It is a problem everywhere.

Mr. POMEROY. I might want you to provide, subsequent to this hearing, information substantiating what you have just told us. Not that I am accusing anything, but it is contrary to other data that I have seen. This is a CMS chart. You can't see it, but you have seen perhaps this chart before where they basically plot on a matrix cost and quality. And I would point out, North Dakota is right here at the top of the graph in terms of costs and quality. And unfortunately, California is down here toward the bottom where the costs are more, but the quality is less in terms of outcome.

I also believe that another chart here, Medicare spending per capita in the United States by hospital referral region shows California in a high category area, and as plotted in terms of cost, per capita cost, of final 2 years of life, California again is a nation leader on a per capita basis with a cost of $57,914 compared to just, for example, North Dakota, which happens to be below lowest, $32,523.

So all of the information I have led me to exactly the opposite conclusion that you gave. One of the reasons that I had had this impression was because of a practice pattern in multi-specialty clinics that is very specialty intensive. This is discussed in some of the Dartmouth type reviews, and a chart that I have here shows that, for example, spending, physician payments per decedent, as tracked by those who have passed within a care system: UCLA Medical Center, $6,671; for comparison, Mayo Clinic, well known Minnesota-based highest quality, $2,935. So these are cost differences that are about the opposite of what the impression you have.

Mr. CRANE. Sure. Well, I was referring to commercial HMO premiums. You are looking at, if I am hearing correctly in the main, aggregated numbers, California in the whole against other States products. It is the commercial HMO premium that is lower, showing its virtues of being more affordable.

Mr. POMEROY. The commercial HMO's also underwrite. They medically underwrite who they write. Is that correct?

Mr. CRANE. Well, yes and no. They are not supposed to.

Mr. POMEROY. I used to be a State insurance commissioner. And I don't know California's law. I expect the individual market does, and maybe the large group market doesn't. I don't know about the small group market.

Mr. CRANE. I think that is the case. I, frankly, don't have an answer to that question.

Mr. POMEROY. Because this is looking at Medicare payments focused on, for example, that chart showing cost and quality is more germane to the topic under consideration by this panel because that is looking at the population we are considering in my view.

Mr. CRANE. Our hospital costs are high. There is no question about that. We have the variability problems that Wenberg has discussed. I was focusing on the commercial HMO premium.

Mr. POMEROY. You said something in your testimony about incentives under fee-for-service versus capitated rates; I completely agree with you. I don't mean to be putting you through a vigorous cross exam.

I would like, Mr. Chairman, if I might throw out if I have a question for Dr. Vladeck and Dr. Wilensky as former CMS administrators albeit named HCFA at the time. Are there reforms that we can do that basically give more of a fair shake to these places for achieving better value under the system?

Let me say, I define value by health outcomes as well as dollars expended.

Ms. WILENSKY. It will mean delegating a lot more authority. There is a good start in MIPPA allowing for a review of outlier physician records so that there is an ability to see whether or not there are reasons supporting the outlier behavior, or whether or not this is just a problem. If the Congress wants to allow, for purposes of setting reimbursement, the cost of services to be considered, that is something that cannot be even considered as an element, in decision-making. This issue with regard to the direction of payment that you want to go, whether to keep it disaggregated, making it more focused in terms of the spending limit, is a matter of fairness to physicians in inducing the kind of behavior that we should want. It would require additional support to the agency. If payments are going to move in a different direction, either toward bundling services or toward maintaining disaggregated payment, but doing so on a much more individualized basis, CMS will need both additional authority and support, financial support, in order to take on these roles. I don't see how the program can stay where it is now. The problems of continuing to have physicians participate by having fees that are held so low is just something that is not going to go away. I am sympathetic with the rebasing notion. In the end of the day, if you have a fix, I suspect you will have to do something like that because I can't begin to image where you would get the money to pull yourselves out of the hole that has been dug since 2002.

Chairman STARK. Mr. Ramstad would you like to inquire?

Mr. RAMSTAD. I would, Mr. Chairman, and I would first of all like to thank the distinguished panel for your testimony here today.

And I want to say, Mr. Chairman, not only do I hear thunder whenever the subject of the SGR formula is brought up, but I also hear voices. I hear specifically the voices of our former great Senators Paul Wellstone and Dave Duremberger who years ago consistently said and told the Senate how Minnesota providers are being punished, how Minnesota seniors are being cheated by this SGR formula.

Unfortunately, that situation has only been exacerbated over the recent years. Minnesota, specifically Hennepin County, where 33 of the 34 cities I represent lie, Hennepin County providers deliver some of the highest quality health care in the Nation at some of the lowest costs, and the reimbursement levels are unconscionably

low, vis-a-vis States like California, Mr. Chairman, Florida, New York, and so forth.

One of the distinguished Senators I just mentioned, I won't say which one, used to use the now overused metaphor in describing the SGR formula, and that is, there is no way to put lipstick on that pig. Again, I am not going to tell you which one, but you can guess.

Well, my point, Mr. Chairman and Members, is that, in my judgment, after serving here 18 years, about ready to leave the Congress, unfortunately, the situation has only gotten worse, and we need to scrap the SGR formula. I mean, any formula that is designed to reward utilization and not quality is going to provide this result. Why should anybody be surprised when we effectively reward and very directly reward utilization and not quality?

So my question for the distinguished witnesses would be along the lines of what we heard from MedPAC representatives when they testified before this subcommittee and they—MedPAC suggests reforming physician payments by creating financial incentives for quality. And I would be interested to hear first of all, as to that general thesis of introducing quality as the primary determinant of reimbursements, what your opinion is and how we would measure quality. Start to left to right or however.

Mr. VLADECK. Well, I think it is very important that the payment system be consistent with efforts to increase quality, but I think our experience on the hospital side at least over the last decade or so suggests that, with the right kind of information collection, with the right kind of openness and transparency about data, with the right kind of professional leadership, you can achieve very substantial increases in quality without messing with the payment system. And I think, given the range of technical and operational problems with most so-called pay-for-performance systems, they may actually make it take us longer to get to where we want on the quality side than accelerate the process.

Mr. RAMSTAD. Let me just interrupt. Doesn't the corollary question apply? That is, you said you can't—well, can we make the formula fair and reflect efficient care without introducing quality?

Mr. VLADECK. I think there is a real problem when you provide incentives to provide lower-cost care or to underprovide, as through capitation, to make sure that you protect the quality of services that are being provided. And I think that is why, under any payment mechanism, we need substantially greater information and substantially greater transparency about the quality of services that are actually being provided. I would only suggest that, to some extent, given all the other equity concerns you are trying to address, like regional disparities in payment systems that we can get more mileage in the direction of quality without trying to get too fancy in payment incentives. I would say, however, that you absolutely have to have a floor. My idea of good pay-for-performance policy is what the Congress has recently adopted relative to so-called "never events".

Mr. RAMSTAD. My time is up.

I would like to hear from the other witnesses just briefly.

Ms. WILENSKY. Your problem in Minnesota is more with the relative value scale and not with the SGR. The reason is because

Minnesota is very conservative in its practice style. Physicians don't do as much; that is, the spending per person is low. Medicare and physician payment focuses only on the reimbursement per unit, and that is what the problem is. I believe with all of my heart, you are focusing on the wrong part of the problem. If we had more use of capitation, that would go another way. Capitation forces you to look at the spending per person. But it is why, if you stay with this very disaggregated fee schedule, you have to think about what is going be done with to try and control spending. That gets you into the SGR. That is what makes it so unfair. You have to decide which way to go. But it is not the SGR. It is the RBRVS that produces the unfair results for Minnesota and Iowa and North Dakota and South Dakota.

Mr. RAMSTAD. I am going to wrap this up because I don't want to intrude on others' time, but notwithstanding what I have said today or what the situation is in Minnesota with respect to the formula, Minnesota was recently ranked, and I am sure you saw this, as the healthiest State in the Nation and also as the State having the lowest rate of uninsured people in the Nation. So notwithstanding these tremendous obstacles, our providers need to be saluted for doing a tough job well, given these limitations especially, it is nothing short of incredible.

I yield back Mr. Chairman.

Chairman STARK. I thank the gentleman.

And I just want to say it is the Chair's intention to recess at 11:45. Members who want a front seat at the memorial service may want to leave early. But I will keep going until we recess at 11:45 and ask if Mr. Kind would like to inquire.

Mr. KIND. Thank you, Mr. Chairman I appreciate it and thank you for holding this hearing and thank the witnesses for your feedback here today. It is something we need to delve into because the numbers are huge as far as what is coming up with SGR, and we have to work on where we are going to do as a community, as a Congress and as a nation to deal with it. Unfortunately, my colleagues from Minnesota and I are kind of in the same basket when it comes to regional disparities. I hail from La Crosse, Wisconsin, and you look at La Crosse and Mason City, Iowa, and Dubuque, and we are at the bottom when it comes to reimbursement but very high, fortunately, in quality of care. I think Minnesota's health suffered a little bit after the Packers defeated the Vikings Monday night, but we are not going to go there, since he left the room.

But in all seriousness, here is a question. I have come to the conclusion I am convinced we have got to be focused on outcomes and quality, not just because it makes sense but because politically I think it is the only way we can deal with this in this framework. I am so tired, and I know my friend sitting next to me is, too, with all the regional fights that we have over the reimbursement formulas around here, whether it is rural, suburban or urban, West Coast to East Coast, middle America. And if we can focus on outcomes or a performance-based reimbursement system in both the public and private sphere, it will put many of us in a much stronger position to argue because we can argue against it. We can argue against having a comparable performance-based objective in the

health care whether you are in New York City or L A or North Dakota.

But my question is how soon can we get there? And that is the real rub, because we are having this bill on HIT right now, and we are trying to figure out a way to further incentivize it to get that happening. And the Chairman is right that it all has to, at the end of the day, it has to be, interoperable and the concern is the numbers are going to start hitting us very soon here if we don't do something. If the goal is try to get to an outcome and quality-based system, how long is that going to take in order to put in place, establish the baseline and the data and the coordination that is going to be required? I would be interested to hear any of your thoughts on that.

Bruce?

Mr. VLADECK. I think it is important to not get carried away with the end point. We are making very substantial progress. There are ways to accelerate that progress, and Congress I think can play a vital role, particularly in terms of more rapid adoption of IT in physicians' offices and incentives to do it and the absolute need for a larger Federal role on interoperability and on privacy in regional data sharing and all those things. That would help accelerate it.

But I just want to, for my friends from the upper Midwest, I just want to suggest that we can do a lot with the quality of care in individual physician practices and individual hospitals. In order to move the community, we have to know a whole lot more about what affects the health of populations than we do. And we have to be very careful, as Dr. Nielsen suggested, to deal with issues of risk adjustment but not only at the individual level but at the community level as well.

Because the fact of the matter is that all the data shows that while we talk all the time about how much excess utilization there is in the American health care system, lower income and minority Americans are still significantly underserved on many dimensions of care. And communities with higher proportions of those folks tend to actually look expensive because they use emergency rooms; they don't get preventive services and so forth. But if we started to punish them because they have bad outcomes in those communities, we would be moving policy in exactly the wrong direction.

Mr. KIND. Is this the ideal system we should be striving for to begin with?

Ms. WILENSKY. We need to find a way, to use what has now become a very popular term, a way to get to some kind of accountable system. And it will vary, depending on where you are. In California where there are a lot of multi specialty groups in place, where there is a lot of capitation, it is a lot easier. You live in a place that is much less densely populated. Groups need to be formed here as well; physicians who are working with the hospitals can be a perfectly good accountable unit, or physicians working across specialties can, in an informal virtual way, be a perfectly good accountable unit.

I am a big proponent of recognizing outcomes in payment. Yes, of course, you need to age adjust and health risk adjust. It is too foolish to think that should not be done. I have just completed 3

years on the WHO Commission on Social Determinants. Which raises the notion that if you want to look at population health, as important as it is to focus on the health care system, that is your charge, you need to consider other things like education in early childhood——

Mr. KIND. I am also a big believer in the feedback tools, what I refer to as peer pressure out there.

Ms. WILENSKY. That is one of the reasons people think multispecialty groups are so effective is that there is constant peer feedback by the very nature of how people practice.

Mr. CRANE. Very briefly, to answer your question, we could come to an outcome quality system fairly quickly if we brought pay-for-performance into Medicare Advantage as in California. There needs to be a business case for quality. There is not a business case for quality right now in original Medicare, nor is there really Medicare Advantage frankly, but in California, there is that platform, and we have long asked that we have Medicare Advantage be folded into that program. It can be done fairly quickly. It is a model. It be could replicated elsewhere.

Dr. NIELSEN. It is cost that is driving all of this discussion and has been for years. But it has got to be primarily about quality because if it isn't, you can save a lot of money by withholding services, and nobody wants that. We want the best value. We want the appropriate service. The barrier in much of the rest of the country, as Gail has alluded, is that many physicians are not in large groups. They are in small groups. They all have computers that do billing, but they do not have what we are talking about. And some other countries have made enormous investment in that HIT infrastructure so that in fact people practicing in solo practices can become the care coordinator. You don't have to have a disease management company employed by a health plan to do care coordination. That is what doctors do all the time. They could do it better if they had more information and if they had feedback. So, frankly, that is where we really need to go. We need to test these very, very quickly. And what will work in California may not work in Idaho for sure.

Mr. KIND. Thank you.

Thank you, Mr. Chairman, I see my time has expired. Thank you.

Chairman STARK. Thank you.

Mr. Becerra, would you like to inquire?

Mr. BECERRA. Thank you, Mr. Chairman.

Thank you to all the panelists for their testimony. There was a recent article published by JAMA, the Journal of the American Medical Association, which indicated that only about 2 percent of students in medical schools intend to pursue a career in primary care, which obviously goes to the heart of the problem we are talking about right now. I think both Dr. Vladeck and Dr. Wilensky talked a little about the difficulties with primary care and treating areas that have very low-income populations. We have problems with over-utilization of specialty care services. And we know we need to emphasize much more the utilization of primary care services. But we also know that, and I think Mr. Pomeroy tried to get to this point to some degree as well, that in rural areas it is tough

to get a lot of primary care services. That same notion or point applies to urban low-income areas. Mr. Pomeroy and I always have discussions about how North Dakota and California really do differ. I point out that, just as he always likes to point out how UCLA and the Mayo Clinic differ, I tell him, you don't have to go more than 5 miles away and UCLA Harbor Hospital differs dramatically from UCLA's principal hospital or L A County USC Medical Center, which is in my district, which is providing great services but hardly any Medicare services. So its reimbursement is based solely on Medicaid and the DSH moneys that we get for disproportionate care hospitals and to some degree private insurance but very little. And so my question becomes, how do we not only deal with the issue of getting more medical students to want to go into primary care services, and how do we then make sure that we increase the number of primary care physicians and services available throughout the Nation; but how do you encourage the distribution of those services to go into the areas where there they are woefully lacking? Because you can go to Los Angeles, and Mr. Pomeroy loves to point out the discrepancies is in Los Angeles, but I don't have to travel all the way to North Dakota to find a discrepancy between a hospital in Los Angeles and a hospital in North Dakota. I can go 15 miles away from a hospital in Los Angeles to another hospital in Los Angeles. So how do we try to distribute those primary care services which we all agree we need to emphasize far more to make sure that not only do we increase the supply but distribute it well? And I would first go to Dr. Vladeck and Dr. Wilensky, but certainly Dr. Nielsen and Mr. Crane, if you like to also comment.

Mr. VLADECK. I don't think there is one quick answer, and I don't think there is one easy solution. I think there is a demonstrated track record through supportive community health centers and through the development of both hospital-based and freestanding community health centers in bringing primary care to underserved communities. I think the irony is if you talk to people who run those centers now in metropolitan areas around the country, they are able to hire primary care physicians; they can't get specialists because they can't afford them and they can't compete.

Mr. BECERRA. They also rely a lot less on Medicare reimbursement——

Mr. VLADECK. They get very little reimbursement.

Mr. BECERRA. So we are talking Medicare here, and while we are trying to increase the supply in these community clinics, they are going to get not a dime out of our whole discussion here.

Mr. VLADECK. I would make one suggestion. I think over the years quite appropriately, and it is complicated to do, but the Congress has recognized the need for additional payments or categorization of facilities in the Medicare Program of which central access hospitals are the most dramatic, to make supplemental payments in order to attract or keep providers in rural communities. And I think if we figure out how to define the boundaries of the most highly impacted urban communities, we ought to build on that model and expand the very limited payment adjustments we make for certain kinds of inner city, in particular, practitioners to look more like the rural model in that regard.

Ms. WILENSKY. The notion that it will take a number of steps to respond to the complex problem of a shortage of physicians, particularly the primary care and low-income and rural areas, I think is obvious. I continue to like the strategy of selected loan forgiveness, not only for the specialty choice but also location choice. And that has to be quite finely defined. Sometimes we tend to focus on differences in geographic areas, but they tend to be very large metropolitan areas, big geographic units. As you are pointing out for a different reason, what goes on within that unit may be as diverse as between these units. That is also true in terms of aggressive behavior by the way. So if you think about ways to increase the supply, if you think about ways to have special targeted payments, you might be—I am a big fan of community health centers as we have discussed before. I don't know if there is anything that prevents community health plans from being Medicare Advantage players as a way to have them, available particularly in areas that are either underserved in general or in rural areas. I know, there are a lot of rules as in terms of who can be a federally qualified health center, and we need to make sure that what was done presumably to protect patients isn't keeping this mechanism from providing care to other underserved. And finally, just as an observation——

Mr. BECERRA. Gail, before you move, let me ask, do you believe that the health plans are interested in going into these community health centers given that most of the population going into these centers is the uninsured with little health care previously and possibly the type of patient that have will have to utilize services quite a bit?

Ms. WILENSKY. No, what I meant was opening up who could be a Medicare Advantage plan to include a federally qualified health centers, and not limited only to insurance plans. So it is to allow them to come in, and that would begin to expand who would be there.

We need to be careful; if we give increased payments for targeted areas, rural or underserved, that we not fall into what I observe happening with the critical care access hospitals, which is what starts out as a very tightly defined group, over time, for political reasons, it tends to encompass a much larger group and, therefore, loses its ability to actually target expenditures. I don't know how you get politicians to not behave politically. But it is a change that I observed happening before.

Dr. NIELSEN. I am going to give you a different answer based on my day job, which is that I am a dean of a medical school, and I deal with medical students making career decisions every single day. The money is very, very important. The loan forgiveness is a very important issue.

There is more to it. There is not a great deal of apparent respect for the enormity of the work done by primary care physicians, and I say that because clearly things that people do every day on the phone with patients, on e-mail with patients, really critical, not valued by anybody. It does not take students any time to figure that out.

And so while I would absolutely support everything that Gail said—I am going to get to what I don't support in just a second—

loan forgiveness is one. Workforce planning is another if there were residency spots, and that gets controversial.

But let me tell you what won't work because this is America, and that is what Canada has done and has tried to do in a more tightly controlled way, and that is to force people to practice in a certain area. They tried that in Toronto just across the border. It didn't work. Doctors in Canada are now restricted to the province where they live. They cannot move to another province. This is America. That is not what you do. I think you incentivize. You don't mandate.

Mr. BECERRA. But Dr. Nielsen—and Mr. Chairman, I know my time has expired.

If you provide the incentive, that is okay. Can you provide a disincentive? If we are going to have money for incentives, we need to find money to pay for those incentives. Can we then on the back side say, we are going to provide incentives to do these things which we think is very valuable, get into rural, low-income urban areas, and we are going to provide a disincentive for you to go to the other areas which helps us pay for the incentives. Is that okay?

Dr. NIELSEN. We have already done that. That is exactly what you have done to primary care. You have provided a disincentive. Does that work? Yes, it works.

Chairman STARK. I am going to recognize Ms. Schwartz for a statement, and we will then have to adjourn very quickly.

Ms. SCHWARTZ. Thank you, Mr. Chairman.

And I appreciate hearing your comments and appreciate the chairman's graciousness in including me in the hearing.

I just want to just emphasize something that you all said in your answers, and that is, one, there is not a single solution, that there really is going to take increased reimbursements, recognizing medical home. But I want to reinforce the issue of the health IT and the ability—I am from the Philadelphia area, very fragmented traditional health system, not the multi-group of specialties at all—the fact that we could do more to incentivize the use of electronic medical records with clinical protocols, interoperable, and that a along with some of the other points you have made around loan forgiveness and medical home and other on kinds of reimbursement could really address some of the issues in both rural and urban areas and across population concerns as well. So I wanted to thank you for recognizing that and look forward to working with you in the future to be able to make sure we do that as well and scale that up as quickly as possible.

And with that, I will yield back.

So thank you.

Chairman STARK. Thank you.

I want to thank the panel, and the hearing is adjourned.

[Whereupon, at 11:55 a.m., the Subcommittee was adjourned.]

[Submissions for the record follow:]

Introduction

This statement is submitted to the Ways and Means Health Subcommittee on behalf of the nearly 94,000 members of the American Academy of Family Physicians as part of its hearings on Medicare Physician Payment held September 11, 2008. The AAFP appreciates the work this subcommittee has undertaken to examine how Medicare pays for the services that physicians deliver to beneficiaries. Family physicians also share the subcommittee's concerns that the current system is inefficient, inaccurate and outdated. For this reason, the AAFP supports the restructuring of Medicare payments to value appropriately quality improvement and care coordination. AAFP believes that this restructuring should be done with the needs of Medicare patients foremost in mind. Since most of these patients have two or more chronic conditions that call for continuous management and that depend on differing pharmaceutical treatments, Medicare should focus on how to pay for the coordination of the care these patients need and on how to prevent expensive and duplicative tests and procedures.

Most people in this country, including Medicare patients, receive the majority of their health care in ambulatory care settings, i.e., in the office of their physician. About a quarter of all of these office visits in the U.S. are to family physicians, and Medicare beneficiaries comprise about a quarter of the typical family physician's practice. Currently, 82 percent of the Medicare population has at least one chronic condition and two-thirds have more than one. These are conditions which are managed with the physician's guidance and for which the patient adapts his or her behavior. Successful management of these conditions means fewer trips to the hospital and doctors' offices and less expensive medical care. But currently, Medicare does not compensate physicians' practices for care management and care coordination that does not involve a face-to-face encounter with the patient. Coordinating the care that patients receive from a multitude of other health care providers is critical to the successful management of patients with chronic conditions.

Finding a more efficient and effective method of paying for physicians' services delivered to Medicare beneficiaries with a large variety of health conditions is a difficult but necessary endeavor, and one that has tremendous implications for millions of patients. The AAFP, therefore, is committed to participating in the design of a new payment system that meets the needs of these patients and the physicians' practices that serve them.

The AAFP believes that there are three elements that should be part of the effort to make Medicare more responsive to quality improvement and efficiency of service. These are allowing beneficiaries to designate their patient-centered medical home, staging quality measurement and reporting, and using health information technology to support the medical home and to collect and report useful quality data.

Current Payment Environment

The environment in which U.S. physicians practice is challenging. Medicare, in particular, has a history of making disproportionately low payments to family physicians and other primary care physicians, largely because its payment formula is based on a reimbursement scheme that rewards procedural volume and fails to foster the comprehensive, coordinated management of patients that is the hallmark of primary care and effective health systems throughout the industrialized world. More broadly, the prospect of steep annual cuts in payment resulting from the flawed formula is discouraging for all physicians and health care providers. In the current environment, physicians know that, without annual (and more recently semi-annual) Congressional action, they will face Medicare payment cuts in the range of 5–10 percent. Clearly, the Sustainable Growth Rate (SGR) formula belies its name and is not a workable, acceptable formula.

Under the SGR, physicians face steadily declining payments into the foreseeable future—nearly 40 percent over the next nine years—even while their practice costs continue to increase. According to the Government's own calculations, the Medicare payment rate for physician services has for several years not kept pace with the cost of operating a small business which delivers medical care. Physicians are being paid at 2001 rates.

From the outset, the Medicare program has based physician payment on a fee-for-service system. This system of non-aligned incentives rewards individual physicians for ordering more tests and performing more procedures. The system lacks incentives for physicians to coordinate the tests, procedures, or patient health care generally, including preventive and health-maintenance services. This payment method has produced expensive, fragmented health care.

The Patient-Centered Medical Home

To correct these inverted incentives, the American Academy of Family Physicians, the American Academy of Pediatrics, the American Osteopathic Association, and the American College of Physicians recommend that Medicare compensate physicians for care coordination services. Such payment should go to the personal physician chosen by the patient to perform this role. Any physician practice prepared to provide care coordination could be eligible to serve as a patient's personal medical home.

The AAFP recommends that Medicare incorporate the patient-centered medical home concept into the program because to do so will not only improve quality but also make delivery of health care more efficient. An efficient payment system should place greater value on cognitive and clinical decision-making skills that result in more effective use of resources and that result in better health outcomes. The work of Barbara Starfield, Ed Wagner and others has shown that patients, particularly the elderly, who have a usual source of care, similar to a medical home, are healthier and the cost of their care is lower because they use fewer medical resources than those who do not. An abundance of evidence shows that even the uninsured benefit from having a usual source of care (or medical home). These individuals receive more appropriate preventive care and more appropriate prescription drugs than those without a usual source of care, and do not get their basic primary health care in a costly emergency room, for example. In contrast, those without this usual source have more problems getting health care and neglect to seek appropriate medical help when they need it**.** A more efficient payment system would encourage physicians to provide patients with a medical home in which a patient's care is coordinated and expensive duplication of services is eliminated.

The AAFP concurs with a June 2008 recommendation of the Medicare Payment Advisory Commission (MedPAC) that Congress should establish a budget-neutral payment adjustment for primary care services billed under the physician fee schedule and furnished by primary-care-focused practitioners.

We also support the MedPAC recommendation that the Congress should initiate a medical home pilot project that includes a physician pay-for-performance program. The pilot must have clear and explicit thresholds for determining whether it can be expanded into the full Medicare program or should be discontinued. The AAFP believes the strength of the existing literature describing the effectiveness (both health and economic) of the medical home warrants expeditious incorporation of this care coordination concept into the Medicare program.

We believe that eligible medical homes must meet stringent criteria, including at least the following capabilities:

- furnish primary care (including coordinating appropriate preventive, maintenance, and acute health services),
- conduct care management,
- use health information technology for active clinical decision support,
- have a formal quality improvement program,
- maintain 24-hour patient communication and rapid access,
- keep up-to-date records of beneficiaries' advance directives, and
- maintain a written understanding with each beneficiary designating the provider as a medical home.

AAFP also believes Congress should encourage Medicare beneficiaries to identify and use a personal medical home by providing incentives such as reduced copayment and deductible amounts.

Measures of quality and efficiency should include a mix of outcome, process and structural measures. Clinical care measures must be evidence-based. Physicians should be directly involved in determining the measures used for assessing their performance.

Improving Quality

Beyond replacing the outdated and dysfunctional SGR formula, a workable, predictable method of determining physician reimbursement—one that is sensitive to the costs of providing care—should align the incentives to encourage evidence-based practice and foster the delivery of services that are known to be more effective and result in better health outcomes for patients. Moreover, the reformed system must facilitate efficient use of Medicare resources by paying for appropriate utilization of effective services and not paying for services that are unnecessary, redundant or known to be ineffective. Such an approach is endorsed by the Institute of Medicine (IOM) in *Crossing the Quality Chasm* (2001).

Another IOM report, **released in 2006 entitled *Rewarding Provider Performance: Aligning Incentives in Medicare,* states that aligning payment incentives with quality improvement goals represents a promising opportunity to encourage higher levels of quality and provide better value for all Americans. The objective of aligning incentives for quality improvement is to support: (1) the most rapidly feasible performance improvement by all providers; (2) innovation and constructive change throughout the health care system; and (3) better outcomes of care, especially through coordination of care across physician practice settings and over time. The AAFP concurs with these IOM recommendations:**

- **Measures should allow for shared accountability and more coordinated care across physician practice settings.**
- **Quality measurement programs should reward care that is patient-centered and efficient, and reward providers who improve performance as well as those who achieve high performance.**
- **Providers should be offered incentives to report quality measures.**
- **Because electronic health information technology will increase the probability of a successful quality measurement program, Medicare should explore ways to assist physicians in implementing electronic data collection and reporting to strengthen the use of consistent measures.**

Information Technology in the Medical Office

The AAFP believes that quality, access and positive health outcomes must be the primary goal of any physician payment system. Prevention, early diagnosis and early treatment will simultaneously improve quality of life and ultimately save valuable health care dollars. But implementing data collection and reporting requires an initial investment from the health care provider in the form of electronic data and decision support systems. The AAFP urges the subcommittee to explore ways of making funding available for small physician practices to obtain and maintain adequate electronic health records and other tools that will enable such collection and reporting without the considerable administrative burden we fear it will be.

Using advances in health information technology (HIT) also aids in reducing errors and allows for ongoing care assessment and quality improvement in the practice setting—two additional goals of recent IOM reports,. We have learned from the experience of the Integrated Healthcare Association (IHA) in California that when physicians and practices invested in electronic health records (EHRs) and other electronic tools to automate data reporting, they were both more efficient and more effective, achieving improved quality results at a more rapid pace than those that lacked advanced HIT capacity.

Family physicians are leading the transition to EHR systems in large part due to the efforts of AAFP's Center for Health Information Technology (CHiT). The AAFP created the CHiT in 2003 to increase the availability and use of low-cost, standards-based information technology among family physicians with the goal of improving the quality and safety of medical care and increasing the efficiency of medical practice. Since 2003, the rate of EHR adoption among AAFP members has more than doubled, with over 30 percent of our family physician members now utilizing these systems in their practices.

In any discussion of increasing utilization of an EHR system, there are a number of barriers and cost is a concern for family physicians, especially those in small and medium sized practices. The AAFP has worked aggressively with the vendor community through our Partners for Patients Program to lower the prices of appropriate information technology. The AAFP's Executive Vice President serves on the American Health Information Community (AHIC), which is working to increase confidence in these systems by developing recommendations on interoperability. The AAFP sponsored the development of the Continuity of Care Record (CCR) standard, now successfully balloted through the American Society for Testing and Materials (ASTM). We initiated the Physician EHR Coalition, now jointly chaired by ACP and AAFP, to engage a broad base of medical specialties to advance EHR adoption in small and medium size ambulatory care practices. In preparation for greater adoption of EHR systems, every family medicine residency will implement EHRs by the end of this year.

To facilitate accelerate reporting, the AAFP joins the IOM in encouraging Federal funding for health care providers to purchase HIT systems. According to the RAND corporation and the U.S. Department of Health & Human Services, billions of dollars will be saved each year with the wide-spread adoption of HIT systems. The Federal Government has already made a financial commitment to this technology; un-

fortunately, only a few dollars trickle down to where the funding is not directed to these systems that will truly have the most impact and where ultimately all health care is practiced—at the individual patient level. We encourage Congress to include funding in the form of grants or low interest loans for those physicians committed to integrating an HIT system in their practice.

Conclusion

It is time to modernize Medicare by recognizing the importance of, and appropriately valuing, primary care and by embracing the Patient-Centered Medical Home model as an integral part of the Medicare program.

Specifically, the AAFP encourages Congressional action to reform the Medicare physician payment system in the following manner:

- Repeal the Sustainable Growth Rate formula at a date certain and replace it with a stable and predictable annual update based on changes in the costs of providing care as calculated by the Medicare Economic Index.
- Adopt the patient-centered medical home by giving patients incentives to use this model and compensate physicians who provide this function. The physician whose practice has been recognized by an independent third party and designated by the beneficiary as his or her medical home should receive a per-member, per-month care management fee in addition to payment under the fee schedule for services delivered.
- Phase in value-based purchasing by providing a bonus payment to physician practices that report data related to specific quality measures. This additional payment should cover costs associated with the program and provide sufficient incentive to report the required data. Move to payment for the use of information technology to collect and submit appropriate quality improvement data.
- Offer a program of low-cost loans to small and medium sized physician practices to purchase health information technology necessary to collect and report quality measurement data. Health information technology is a public good that ultimately will benefit all Americans.
- Ultimately, payment should be linked to health care quality and efficiency and should reward the most effective patient and physician behavior.

The Academy commends the subcommittee for its commitment to identify a more accurate and contemporary Medicare payment methodology for physician services. Moreover, the AAFP is eager to work with Congress toward the needed system changes that will improve not only the efficiency of the program but also the effectiveness of the services delivered to our nation's elderly.

Dear Committee Members,

I am a family physician who has practiced many years with different populations many of whom have been on and Medicare as well as Medicaid.

In order to improve Medicare beneficiaries health outcomes reform needs to commit political will and resources to the following three measures:

1. Primary care providers should be reimbursed at a higher rate than specialist for the difficult care that they deliver.

For example: a dermatologist who spends two minutes with a patient, and may freezing something, may be reimbursed the same amount as a family physician who spends 30 minutes with a patient who has severe depression. Specialist are often pain more than twice the salary of primary care physicians. It is absolutely crazy.

We need more primary care physicians-not because I am one-but because the health of this nation will improve!! Data shows that countries with more primary care (and perhaps, less specialty care) and well coordinate care leads to better health outcomes. In this country that means creating the right financial incentives. Medical students are going into specialty residencies more and more—the wrong direction.

Medical students have learned about the ROAD (radiology, ophthalmology, anesthesia, dermatology) to happiness: high paying specialties with less work stress. It turns out that these are also the most competitive residencies for medical students to enter.

2. Medicare should take an active role in recruiting and subsidizing primary care residencies programs. Because subspecialty fields are so lucrative, the residency programs tend to be

3. Public health should drive Medicare reform decisions, not special interests. As long as special interests are the ones sitting before committees, and have the most

successful lobbyists, they will continue to benefit. However, the public's health should be the only guide and the amount of money available should be the only guide.

Thank you for my submission,

Charles Mayer MD MPH
Group Health Cooperative

Harborview Medical Center, Department of Family Medicine

Dear Representative Stark:

I appreciate being able to submit these comments on Reforming Medicare's Physician Payment System. I am writing *only as an individual*, but with a perspective on physician payment that may be of help relating to primary care services and approaches being taken to a "Medical Home" model. In addition to being a Medicare Contractor Medical Director, I served on the AMA/Specialty Societies RVS Update Committee ("RUC") for twelve years, six as its Vice-Chair, and have been many years a Co-Chair of Washington State's Advisory Committee on RVS and related payment issues. I also sit on the CPT Assistant Editorial Panel, am a general internist and have been an NCQA physician reviewer for years, including specifically for Disease Management accreditation, which relates to this topic. I am hopeful my perspective may be of help.

It is absolutely certain that the Medicare fee-for-service system is experiencing a worsening problem with access to services, particularly for primary care. The Medical Home concept, and its demonstration planned to start next year have been proposed as a possible solution. There is clear evidence that the types of close-communication with *selected* individual patients can result in improved clinical outcomes, and even some preliminary evidence that a portion of these may, over time, result in total service utilization savings for the system. This was a premiss of the adopted Medical Home demonstration.

There is no possibility however, that such an approach can be successful for a large portion of Medicare enrollees, with a requirement to demonstrate three-year "budget neutrality". To require *both* a large portion of Medicare enrollees *and* a three-year timetable will prevent any chance of a successful outcome.

A much fairer "demonstration" of the potential of a Medical Home model would be a much more selected patient population (likely based on relatively high recent utilization and significant disease burden), where care and attention by a clinical team will have some chance of achieving a measurable gain within such a narrow timeframe.

The RUC did a good job (with much work) in developing Medical Home codes that might be used for providers following large panels of patients in such a category. If, however, the demonstration continues to require a three-year budget neutrality, it would be greatly more likely that a much more selected, smaller patient panel would have some chance of success.

A large problem in using Medicare payments for such patients is that Medicare disallows "screening" and (other-than-statutory) preventive care and makes it hard to utilize time-based billing to obtain a fair return on the time-consuming services these patients most need. If instead, the E&M codes were used as they are now, but allowing time-based billing of services for patients in a Medical Home demonstration, just as are now allowed for "counseling and coordination of care", this might have a chance of success. The only additional requirement should be that the record must clearly document both the total time by that individual provider for that patient on the date of service and the necessity for that time (subject to retrospective review).

Such an approach focused on *selected* patients with *high* probability of utilization, paying for the time necessary to work with such patients, could demonstrate a change in utilization within the (very-short) three-year timetable. Otherwise, it is certain that the "demonstration" as presently structured cannot succeed, and it will be a true loss to have some then come to a conclusion that a Medical Home model will not work, were it structured and phased differently with a way to assure providers had sufficient return for the work necessary to affect behavior and utilization. The Medicare system *needs* a successful approach to the Medical Home concept to be able to address worsening access problems, especially in primary care!

I appreciate the opportunity to offer these comments, and will surely be glad to discuss any aspect with any who might find this of help. Thank you.

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I would first like to thank Chairman Stark and Ranking Member Camp for holding this important hearing today on the way Medicare pays physicians, and I also would like to thank them again for their leadership in passing H.R. 6331, the "Medicare Improvements for Patients and Providers Act of 2008," this past July.

As you both are well aware, this vital legislation prevented a devastating 10.6 percent payment cut for Medicare physicians in 2008 as mandated under the woefully misnamed Sustainable Growth Rate (SGR). In addition, the Medicare Improvements for Patients and Provider Act provided physicians with an important payment increase of 1.1 percent for 2009, which followed the recommendation of the Medicare Payment Advisory Payment Commission (MedPAC). As evidenced by the overwhelming bipartisan support in both chambers of Congress to override President Bush's short-sighted veto, blocking these cuts was the right thing to do.

Now that we've given our physicians an 18-month reprieve, I respectfully urge this subcommittee to work again in a bipartisan way to establish a new payment system for physicians. Central to any plan must begin with scrapping the SGR.

Clearly, this ill-conceived system doesn't work. Enacted in 1997, the SGR was, in my opinion, an attempt to balance the budget on the backs of doctors and other providers. Not only has it failed to curtail spending, but it incentives volume of services instead of quality of care, and may be expediting the shift from primary care services to specialty and sub-specialty services.

Since 2003, Congress has enacted six "patches" to prevent cuts under the SGR. Although I have only been a Member of Congress for two of them, I can say that it is frustrating spending valuable time crafting fixes for this fundamentally flawed system. I cannot imagine the frustration that the Members of this subcommittee along with their staffs must feel spending countless hours crafting these legislative fixes when other crucial healthcare issues, like our shortage of primary care physicians, are left unresolved. So let us once and for all end all talk of patches or fixes, and come together in a bipartisan way to find a permanent solution to the way we pay our doctors.

The distinguished panel assembled here today, which includes the President of the American Medical Association, will provide this subcommittee with a macro perspective of the Medicare payment system, offering numerous recommendations that I think are worthy of this subcommittee's consideration.

However, my purpose for testifying today is to provide the subcommittee with a view from the ground. The 22nd Congressional District of Florida is literally on the front lines of the Medicare debate with one of the largest populations of senior citizens in the country and a dedicated group of physicians serving this vulnerable population.

When I was elected as their Representative, one of the first things I did was to convene a physician advisory group so I could hear firsthand the unique needs of both seniors and physicians in South Florida as well as better understand the distinct healthcare issues for this region.

This advisory group has been consistently critical of the SGR. Medicare used to be known as the "Gold Standard" for physicians because it provided them with fair and sustainable reimbursement rates, but not anymore. As a result of this and other issues, we're currently facing a severe shortage of qualified physicians in South Florida, potentially leaving many elderly and other vulnerable populations without

doctors to treat them. Failing to restructure the physician payment scheme under Medicare could hasten this exodus when the looming 20 percent cut arrives in 2010.

We owe it to our seniors, to the men and women who helped to make this country the greatest in the world, to ensure that when they are sick, a doctor will be there to see them. It's a fair deal, and one we must not turn our backs on.

Thank you again, Chairman Stark and Ranking Member Camp, for holding this hearing today, and I look forward to working with you as well as the rest of Members of this subcommittee, toward crafting a permanent solution that pays physicians fairly for their services while maintaining the highest levels of quality for our nation's seniors.

The National Business Group on Health (Business Group) appreciates the opportunity to submit written testimony for today's House Ways and Means Health Subcommittee hearing on reforming Medicare's physician payment system. The Business Group strongly urges Congress, employers, and health plans to implement pay-for-performance on a widespread basis for hospitals, physicians, and other health care facilities and professionals.

Founded in 1974, the Business Group is a member organization representing 300 members, mostly large employers, who provide coverage to more than 55 million U.S. employees, retirees and their families and is the nation's only non-profit organization devoted exclusively to finding innovative and forward-thinking solutions to large employers' most important health care and related benefits issues. Business Group members are primarily Fortune 500 companies and large public sector employers, with 64 members in the Fortune 100.

As you know, it is estimated that Medicare will be bankrupt by 2019, seven years earlier than previously expected and 23 years earlier than Social Security. In July, Congress delayed cuts to Medicare physician payments for 18 months. However, unless further legislative action is taken, Medicare's payment rates will be reduced by more than 20 percent in January 2010. We believe it is necessary for the financial future of Medicare as well as for the quality and safety of care received by beneficiaries that pay-for-performance be used to harness the Government's leverage as the largest purchaser of health care in the U.S. to move Medicare and all other payers towards paying for effective health care and quality outcomes rather than units or volume of services, as is currently done.

Too often, payment under Medicare and throughout the health care system in the U.S. is made without regard to whether services are needed or are performed well. Fisher and colleagues (Annals of Internal Medicine, 2003) estimate that under the current system up to 30% of Medicare spending may be for excessive and unnecessary care. While cost is tied to quality or performance in most other industries, in health care, including in Medicare, the opposite tends to happen—we end up paying more for poor service and the additional health care needed to "correct" poor quality. Fortunately, Medicare is beginning to reverse this tendency in by not paying for so-called "never events" occurring in hospitals.

CMS' effort to stop payments for "never events," is a significant first-step to improving the quality of care in the Medicare program and should be extended to physicians' payments. As you know, a landmark 1999 Institute of Medicine (IOM) report estimated that preventable medical errors in hospitals might cause as many as 98,000 deaths annually. Many more people are injured by providers and countless more preventable deaths and injuries occur in outpatient settings.

With the clinical comparative effectiveness research conducted by the Agency for Healthcare Research and Quality (AHRQ), the Federal Government and its research partners are producing important information that will help eliminate inappropriate treatments and ensure that the Government only pays for effective, high quality health care that works. It is important that the public and private sectors act together to develop the research evidence base for treatment and coverage policies so that clinicians, policy-makers, and consumers are able to make decisions that improve the quality of care and quality of life.

Pay-for-performance promises to advance evidence-based medicine, improve the quality of health care for beneficiaries and improve the efficiency of the Medicare program. Under the Physician Quality Reporting Initiative (PQRI), CMS is taking the steps towards moving from being primarily a ***passive payer*** for health care to an ***active purchaser*** for health care, using its enormous power to buy the best possible care for millions of beneficiaries, just as Congress has asked it to do. Initial data reports that 15.74 percent (99,319 providers) of all professionals eligible to participate in the 2007 PQRI program attempted to do so. Of those providers, 92,218 individuals submitted at least one measure successfully. The report also shows that

on average, providers attempted to report slightly more than three measures. More than half of the participating professionals so far appear to be on track to receive bonuses. The initial data also provides a glimpse of where participants are making errors in the reporting process, and that will guide future educational efforts by CMS. For example, the data shows that for one of the three diabetes measures covered, nearly half of the PQRI claims submitted were rejected because of "denominator mismatches," which means the patient did not match the age or gender descriptor for the measure. In addition, more than 10 percent of claims were filed without the required National Provider Identifier number. Clearly, we have a long way to go. However, by using its huge purchasing power to drive excellence in care delivery, Medicare is not only beginning to protect and help its beneficiaries but it will also make the health care delivery system in the U.S. better and safer for all Americans, all of whom will be beneficiaries once they turn 65 or disabled.

It is vital for the Federal Government to fully transition Medicare to a pay-for-performance system based on quality and efficiency. A recent study by CMS in Health Affairs reported that U.S. spending on health care is expected *to double* (over the next 9 years). It is urgent that the Federal Government work with employers and other purchasers to change the current system. The pay-for-performance movement continues to rapidly expand in the private marketplace. In recent years, employers and other health care purchasers have developed and adopted payment programs to reward quality in the health care system. As sponsors of health plans, employers currently use their flexibility, under ERISA, to innovate and close the gap between the quality of care that we have and the quality of care that we should have and need.

Medicare should learn from the lessons of many of our nation's employers who are already developing and implementing strategies aimed at improving the quality and value of the health care they purchase. Many National Business Group on Health members have taken the lead in promoting pay-for-performance, health care quality and transparency by participating in initiatives such as the Bridges to Excellence and the pay-for-performance programs of the Integrated Healthcare Association to make true health care transparency and quality a reality. Today, most large insurers and health plans already have a provider incentive program based on performance.

Pay-for-Performance Successes in the Private Sector:

1. Bridges to Excellence (BTE) Programs: BTE, a not-for-profit company, led by a multi-stakeholder board of directors comprised of physicians, employers and health plans, has published lessons learned and best practices of pilot region pay-for-performance programs that included: rewarding physicians for practicing re-engineering and adopting health information technology; improving outcomes for patients with diabetes through preventive care (including more cost-efficient care); improving intermediate outcomes for patients with diabetes, hypertension, hyperlipidemia, coronary artery disease and cardiovascular disease; and implementing measures of effective ambulatory care treatment protocols for patients with recent cardiac events. To date, BTE programs have been successfully implemented in more than 18 states with over 80 employers and eight business coalitions, recognizing more than 10,000 physicians throughout the U.S. and paying more than $12 million dollars in incentives. BTE analyzed diabetes episodes among claims data from 352,722 United Healthcare members in the Cincinnati and Louisville area from 2002–2004 and found that BTE-recognized endocrinologists and Primary Care Physicians (PCPs) had $3,480 and $3,820 respectively in lower average inpatient costs per episode than non-BTE recognized physicians. BTE-recognized physicians also took care of more episodes and more patients per physician than their non-recognized peers. This was true for endocrinologists (45 vs. 26 episodes per physician; and 35 vs. 20 patients per physician) as well as for PCPs (14 vs. 9 episodes per physician and 11 vs. 6 patients per physician). BTE-recognized endocrinologists had significantly lower average costs ($370 lower) for an episode of diabetes care than non-recognized endocrinologists ($770 vs. $1,140). Another analysis of the costs associated with diabetes from the City of Cincinnati's employees and dependents found that those who received care from BTE certified providers are 7.8% healthier on average than members cared for by non-BTE certified providers based on prospective relative morbidity scores for both populations in 2004 and 2005. A BTE pilot program from 2003–2006 for diabetes and cardiac care in New York had the highest number of patients seeing BTE recognized physicians, up from under 2% to 25%, which is significant given the savings of $350 per patient per year.

The BTE programs have identified a number of key lessons learned and best practices to implement a successful pay-for-performance program, including:

- Using standard performance measures of clinical quality, focusing mostly on intermediate outcomes derived from medical chart reviews, not just claims;
- Giving providers clearly defined costs and benefits of the program, which helps them determine the value of participating;
- Using independent third-party organizations to measure the performance of providers, reviewing the data reported by these providers from medical records in their practice;
- Bringing together many payers and/or purchasers to make rewards meaningful to providers;
- Encouraging providers to adopt better systems of care, including health information technology, to systematically improve the delivery of care;
- Assisting small practices which need significant help in re-engineering, as there are not many resources available to help them;
- Understanding that a focus on a single disease may limit program uptake among primary care physicians;
- Realizing that providers that become recognized in BTE's programs are happy to get more patients—even those with chronic illness; and that
- Employers and plans should combine a pull (bonus) with a push (steerage) to maximize the impact of a pay-for-performance program among their plan members.

2. Integrated Healthcare Association (IHA): IHA, a multi-stakeholder association based in California consisting of major health plans, physician groups, and hospital systems, academics, consumers, purchasers (including employers), pharmaceutical and technology representatives has established uniform quality performance measures, incentive payments to physician groups and a public report card. Stakeholders have made progress towards improving clinical quality reporting, patient experience, use of information technology (IT) and patient care. Eighty-seven percent of physician groups reporting all clinical measures improved their overall clinical score by 5.3 percentage points from Year 1 to Year 2. One-hundred and thirty physician groups participating since the beginning of the program improved from 3 to 5 percentage points on patient experience measures and from Year 1 to Year 2 there was a 54 percent increase of physician groups qualifying for at least a partial credit for IT adoption.

The Business Group Believes That a Pay-For-Performance Program Should Include the Following:

- Medicare should continue to adopt performance measures developed by nationally recognized quality measurement organizations, such as the National Committee for Quality Assurance (NCQA), researchers, and practitioner groups that have been vetted and recommended by consensus-building organizations that represent diverse stakeholders, such as the National Quality Forum (NQF) and measures established by the AQA Alliance and the Hospital Quality Alliance (HQA) Steering Committee.
- Rewarding quality is paramount but rewarding quality care that is provided efficiently is also important and should be an essential part of any pay-for-performance initiative.
- When measuring quality, focusing on misuse and overuse is equally important as underuse. There is plenty of evidence that more care is not always better for patients or even good for them. We also want to help people understand that choosing healthy lifestyles and evidence-based disease prevention and screenings can do as much or more for their health and quality of life as health care. Medicare has taken some excellent first steps with its "Welcome to Medicare" program and preventive services but more can and should be done.
- To the extent possible, performance measures should incorporate outcomes of care in addition to structure and process measures.
- CMS should improve the meaningful disclosure of easy-to-understand performance results to the public, including Medicare data, which will reinforce the value of pay-for-performance.
- The health care system will need sufficient health information technology infrastructure to report performance measures. Some providers, particularly solo and small group physician practices and those serving low-income urban and rural areas, may need financial assistance to purchase needed systems, software, training and related services.

Why the Business Group Believes Purchasers Should Implement Pay-for-Performance:

- A 2003 RAND study found that patients received only 55 percent of recommended care for fairly common medical conditions for which a broad consensus exists on care standards.
- A single set of quality measures will reduce the administrative burden of data collection and make it easier for consumers and purchasers to compare quality among providers and facilities.

Pay-for Performance Will Empower Consumers and Purchasers to Make Better Decisions on Their Health Care Providers:

- According to the National Committee for Quality Assurance (NCQA), people enrolled in health plans that measure and publicly report performance data were more likely to receive preventive care and have their chronic conditions managed in accordance with clinical guidelines based upon medical evidence.
- These improvements in clinical quality over time, the direct result of performance measurement and reporting, have saved the lives of 53,000 to 91,000 Americans and prevented hundreds of thousands of serious complications.

Again, thank you for allowing us to submit written testimony for today's hearing on reforming Medicare's physician payment system. We look forward to continuing to work with the Committee and CMS to transition our health care system to one based on performance, value, quality, efficiency and transparency that we can all be proud of and that serve its beneficiaries well for exactly the kind of health care and quality of life they deserve.

Dear Chairman Stark:

Thank you for holding a hearing on Medicare physician payment on September 11. The Society of Thoracic Surgeons (STS) greatly appreciates your dedication to finding a long-term solution to the flawed sustainable growth rate (SGR) payment system and for working to prevent Medicare payment cuts to physicians for the second half of 2008 and in 2009.

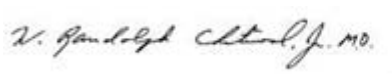
We agree with your assessment that we must examine policy options that will encourage improved quality of care and efficient use of health care resources. The repeated need for congressional "rescue" of physicians from Medicare payment cuts as a result of the SGR is strong evidence that the current system of economic incentives and disincentives has failed to modify physician practice or control the growth of physician services.

Our experience with data collection has shown that physicians are motivated to change the way they practice medicine when provided with credible clinical outcomes data. The result of providing performance feedback to physicians is improved outcomes and cost savings. The STS National Cardiac Database (NCD) captures 100 percent of the procedures performed by each participant at more than 85 percent of the adult cardiac surgery programs in the country. The collection and reporting of this data for nearly 20 years has resulted in reductions in mortality rates in cardiac surgery by 70 percent below previously expected rates. The STS has spent approximately $15 million on the development and maintenance of this database, and participants have expended tens of millions in additional dollars which have to date been uncompensated by CMS and most other payers.

The STS believes that physicians and their professional societies have an obligation to responsibly control health care expenditures. We believe that Medicare must support professional medical societies in the development and expansion of clinical databases. When risk-adjusted clinical outcomes data is linked with information on resource use based upon administrative claims data, we can assess the effectiveness and appropriateness of current and future treatment algorithms. The STS encourages you and members of the Subcommittee to consider a payment and regulatory framework that will incentivize meaningful self-regulation and will rely upon clinical databases as the mechanism by which self-regulation can be accomplished. Toward this end, I want to draw your attention to an editorial authored by John Mayer, Jr., M.D., Immediate Past President of STS. The editorial, published in the November 2007 issue of *The Annals of Thoracic Surgery*, emphasizes responsible use of health care resources through self-regulation and underscores the importance of providing physicians with clinical outcomes data.

I hope that as you continue your exploration into ways to correct and improve upon our current payment system you will draw upon the experience of STS and its members. Should you have any questions, please do not hesitate to contact me.

Sincerely,



W. Randolph Chitwood, Jr., M.D.
President
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The American Health Care System and the Role of the Medical Profession in Solving Its Problems

The Annals of Thoracic Surgery

In the current issue of The Annals, two authors present opposing viewpoints on the optimal organizational structure for healthcare insurance in the U.S.[1] Himmelstein and Woolhandler argue that a single-payer national healthcare insurance system would solve many of the current problems in financing, access, and delivery of healthcare, while Goodman suggests that reform should remove the current private and public health insurance third-party payer structures from the equation in order to promote *competition* among "providers" on price and quality and restore the doctor-patient relationship. I agree with both Himmelstein and Goodman that reimbursement may be at the root of many of the problems that the American healthcare system is facing. However, neither of these authors' proposals would engage the medical *profession in providing solutions*, despite the fact that physicians' pens and keyboards are still ultimately responsible for much of what American society spends on healthcare.

Historically, members of a profession have had a number of important prerogatives and societal responsibilities, which include adhering to a code of ethics that includes the moral imperative to serve others,[2] *advancing a body of knowledge and transmitting it to the next generation*,[2] *setting and enforcing its own standards and values*,[2] *cherishing performance above personal rewards*,[2] *self-regulation*,[3] *and fairly distributing finite medical resources*.[4] Gruen et al recently noted that physicians have a "responsibility to address the rising costs of health care, which are a key threat to access."[4] A conceptual model of the relationships between the professions, market forces, and society has been proposed by Krause.[5] He describes the privileges and prerogatives of the professions as inherently in conflict with the forces of the free market, but notes that these "anti-market" privileges are granted to a profession by the state, representing society, only as long as society believes and trusts that the profession is acting in the societal interest and not in its own. Others have reached similar conclusions.[6] At the same time, competition is proposed as a solution for the healthcare system [1] and physicians are then pulled in opposite directions by their responsibilities to society as members of a profession and by this societal imperative to "compete." Added to this mixture is the centrally controlled administered pricing system used by Medicare, which has placed all physicians, but particularly cardiothoracic surgeons, under significant economic pressures by reductions in reimbursements for the services that they provide. The problem is exacerbated by the use of the MFS by a large number of third-party private payers.

The question arises whether the medicine can survive as a profession in this environment. Although the MFS has important conceptual flaws, which are responsible for the declines in physician reimbursements, changes to this system could actually address some of the inherent conflicts that the medical *profession* and the American healthcare system are facing. The current MFS system is based on the Resource Based Relative Value Scale, which assigns relative value units (RVU's) to each physician service. By law, each year Medicare sets a single "conversion factor" (in $/RVU), based on the "sustainable growth rate" (SGR) formula, and this conversion factor is multiplied by the RVU's for each service to yield the Medicare allowed charge.[7] By controlling the conversion factor, the Federal Government has a simple mechanism to control aggregate Medicare physician payments, but since the total physician payment expenditures are capped by the SGR, a "zero sum game" results.[8] When aggregate expenditures increase faster than called for by the SGR for-

mula, then physician payments in subsequent years must be reduced by decreasing the conversion factor to "pay back" the "overspending" on physician services that occurred in prior years. The SGR mechanism required reductions in the 2007 Medicare conversion factor [9] that were offset by last-minute legislation, but a 9.9% reductions in fees for each service are projected for 2008 without repeat Congressional action.[10] The SGR formula that prescribes the annual Medicare physician payment update is "widely recognized as being fatally flawed and, if not greatly reformed, may result in reduced access to beneficiaries." [11] However, SGR revisions require billions of dollars in additional Federal funding over the next ten years, a difficult hurdle with projected Federal budget deficits for the foreseeable future. From the physician perspective the fundamental conceptual flaw in the SGR mechanism is the economist's assumption that individual physicians' patterns of practice will be influenced by their recognition that current "over-utilization" will cause future reductions in the conversion factor. In a "zero sum game" [8] each participant attempts to maximize their own benefit, despite the negative effect that the aggregate behavior of all participants has on the subsequent year's conversion factor. Each physician currently has no information or mechanisms to influence the concurrent behavior of other physicians, and there is no mechanism by which physicians can cooperate to husband society's health care dollar. *Thus, there is little ability to fulfill the profession's self-regulatory responsibility to society.* Situations where there is a conflict between "individual gain and the common good" and in which the participants are unable to communicate are characteristic of the "Prisoner's Dilemma" [12] in game theory and the related case known as the "tragedy of the commons." [13] The "commons" has been described as a "paradigm for situations in which people so impinge on each other in pursing their own interests that collectively they might be better off if they could be restrained, but no one gains individually by self-restraint." [13] The recurring "crises" in Medicare physician reimbursement, which are directly related to the growth in the volume and complexity of physician services, would seem to indicate that the current Medicare reimbursement mechanism is providing the necessary elements for a tragedy of the commons to continue.

However, modifications to this Medicare reimbursement mechanism could serve as an initial step to more effectively engage the medical profession in fulfilling its responsibilities to society and in addressing the societal problem of unsustainable increases in healthcare expenditures. The key concepts involve an ability to assess the effectiveness of the care that is provided and the ability to self-regulate. Ultimately, all physicians should wish to provide the most *effective* care for their patients, and ideally, the reimbursement system should promote effective care. I propose two changes to the current healthcare system to further these goals. First, *each medical specialty or subspecialty should have a separate Medicare conversion factor*. This change would create a significant incentive to self-regulate and exert some control on the growth in the number and complexity of medical services, and it would place the level of self-regulation at a level where such self-regulation could actually be effected. Second, *Federal financial and administrative support for the establishment of clinical registries and databases should be provided* so that a robust, credible assessment of individual physician performance and of the effectiveness of the diagnostic and treatment modalities being utilized would be possible. Free access to Medicare claims data would be essential to provide cost information. The Society of Thoracic Surgeons has taken an important leadership role in this area through its clinical database efforts [14] and the development of performance metrics.[15] By taking these these two steps, each medical specialty would have the incentives and the mechanisms by which to self-regulate, the major missing factor in the current "tragedy of the commons" situation in the American health care system.

One result of these changes would be an annual allocation of Medicare physician payment resources to each individual medical specialty rather than the current aggregate allocation for all physician services. It would be more effective to place these allocations at the individual specialty or subspecialty level for several reasons. First, each specialty would have an incentive to develop and implement the *most effective* practices, since all members of that specialty and their patients would benefit from more effective use of physician resources. Ineffective and excessive uses of physician resources would penalize the members of that specialty, rather physicians of all other specialties, as occurs under the current system. Second, this restructuring of the reimbursement system would also provide both an incentive and resources for specialties to develop and maintain *outcomes-focused registries and clinical databases*, which can provide feedback of risk-adjusted outcomes to individual practices and institutions with peer comparison data, and which can lead to improved patient care and clinical outcomes.[16,17,18] Such a mechanism would provide needed data by which to judge effectiveness and would be essential to assessing resource utilization. It would also allow each specialty to monitor and attempt to improve the perform-

ance of all physicians in the specialty, to identify and disseminate best practices, and to develop mechanisms to identify and assist institutions, practices, or individual physicians that have less favorable outcomes. In so doing, there would likely be a reduction in the variation in practices and outcomes that have been found to exist [19] and which have been the basis of many criticisms of medical practice in the U.S.[20]

An important change that *could* also result from this proposal is that Medicare allocation decisions for physician services could be made *overtly* rather than by the almost random allocations resulting from the collective action of individual physicians each acting in their own or their patients' interests. Such allocation decisions must be made based on where an investment of societal resources is judged to be needed and, equally importantly, on *what the results of previous investments of resources have been*. A data-driven body responsible for making these Medicare allocation decisions would have to be created with significant representation from both the public and from the profession. However, even if one simply started with the current allocation levels and only allowed each specialty's conversion factor to change annually in response to utilization, the proposed system would ameliorate the "commons" problem between specialties and would strongly encourage professional self-regulation by making specialty members accountable to their closest colleagues.

Critics may question the placement of the resource allocation at the medical specialty level, but it is at the specialty level where organizational structure and the most natural alignment of physicians' interests already exist. At this level, there is the greatest likelihood that collaboration and sharing of information on best practices, monitoring of clinical activity, and feedback of risk-adjusted outcomes data could be accomplished. Alternatives such as resource allocation by disease management category or by expansion of global payments (pooling Medicare Part A and Part B) for complex hospital services could allow allocation decisions to be made at the local institutional level for tertiary services, but there is currently little organizational structure at either the national or local level to allow self-regulatory activity to occur, and it does little to address the office-based imaging and evaluation and management services, which are the fastest growing and largest volume physician services for which Medicare pays.[21] Furthermore, professional peers from the same specialty are arguably in the best position to develop clinically appropriate outcome measures and risk adjustment algorithms, and physicians are reliably motivated by comparative national peer data. This proposal would also not preclude collaboration among specialties to pool resources in dealing with complex patients, such as those with heart failure, in a coordinated and collaborative fashion.

A second potential criticism is that while this proposal might be applicable for a smaller specialty, those with large numbers of practitioners may still have the conditions for the "tragedy of the commons" to occur. For these specialties, organizations exist at the state or regional level where the peer pressures and data collection could be effectively managed.

Two other significant issues should be addressed. First, some specialties will argue that they have no control over their volume of services, including emergency room physicians, radiologists, anesthesiologists, and pathologists. These specialists have less control over how frequently patients present to them, but they would have an incentive to manage their services to provide the most effective use of physician resources. If resource allocation updates were made annually, then an increase in patient volume in the previous year that is outside the control of the specialty, e.g. an influenza epidemic, could be considered in making the subsequent year's allocation. An equally important question is how physician services associated with new technologies and therapies could be funded to allow continued development of more effective therapies. The process of annual resource allocation decisions would have to include new funds for clinical "research and development" activities by physicians, but clinically based outcomes registries could facilitate the acquisition of information about the effectiveness of such new treatments and services. Notably, CMS currently links payment for expanded indications for cardioverter-defibrillator implants to a required submission of clinical information to a registry.[22] Current Government and private healthcare funding mechanisms invest heavily in bench research, but far less Federal funding exists for the assessment of the *effectiveness* of therapies that are in the "gap" between the bench and accepted clinical practice. Expanded funding should support the acquisition of clinical effectiveness data on both "established" and new treatments through expansion of professional society based outcomes registries.

The most fundamental change resulting from this proposal is an expanded role for individual professional societies in not only developing guidelines and best practices, but also in monitoring and actively improving the clinical performance of their

members. The movement by medical specialty boards toward "maintenance of certification" is already underway. Incentives for each specialty to engage in monitoring members' clinical performance and the effectiveness of treatments could enhance these maintenance of certification efforts. Pellegrino and Relman argue that "medicine is, in essence, a moral enterprise and its professional associations should therefore be built on ethically sound foundations"[6] but also noted that "the history of professional medical associations reflects a constant tension between self-interest and ethical ideals that has never been resolved."[6] If physician payment allocations were placed at the level of the individual medical specialty or subspecialty, the role of professional societies would expand to include the responsibility to husband the healthcare resources of American society. In so doing, medicine will have taken an important step toward resolving the tension between self-interest and ethical ideals and to better align our interests with the interests of the American society that we serve. In so doing, medicine could fulfill an important professional responsibility to society and simultaneously regain something of what it means to be a profession.

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