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OPTIONS TO IMPROVE QUALITY AND EFFICIENCY AMONG MEDICARE PHYSICIANS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

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CONTENTS

	Page
Advisory of May 10, 2007, announcing the hearing	2

WITNESS

A. Bruce Steinwald, Director, Health Care, government Accountability Office	6
Herb Kuhn, Acting Deputy Administrator, Centers for Medicare and Medicaid Services	25
Glenn M. Hackbarth, Chairman, Medicare Payment Advisory Commission	37
Robert A. Berenson, M.D., Senior Fellow, the Urban Institute	60
Rick Kellerman, M.D., President, American Academy of Family Physicians, Shawnee Mission, KS	66
Anmol S. Mahal, M.D., President, California Medical Association, Freemont, CA	73
John E. Mayer, Jr., M.D President, Society of Thoracic Surgeons	79

SUBMISSIONS FOR THE RECORD

American Academy of Ophthalmology, statement	90
American College of Physicians, statement	92
American College of Radiology, statement	98
American Health Information Management Association, statement	100
American Occupational Therapy Association, statement	102
Renal Physicians Association, statement	103
University of North Carolina at Chapel Hill, statement	105

OPTIONS TO IMPROVE QUALITY AND EFFICIENCY AMONG MEDICARE PHYSICIANS

THURSDAY, MAY 10, 2007

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

The Subcommittee met, pursuant to notice, at 10:00 a.m., in room 1102, Longworth House Office Building, Hon. 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

FOR IMMEDIATE RELEASE
May 10, 2007
HL–10

CONTACT: (202) 225–3943

Chairman Stark Announces a Hearing on Options to Improve Quality and Efficiency Among Medicare Physicians

House Ways and Means Health Subcommittee Chairman Pete Stark (D–CA) announced today that the Subcommittee on Health will hold a hearing on options to improve quality and efficiency among Medicare physicians. **The hearing will take place at 10:00 a.m. on Thursday, May 10, 2007, in Room 1100, Longworth House Office Building.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from the invited witness 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 spending for physician services will likely exceed $60 billion in 2007, more than 14 percent of spending on program benefits. Spending for physician services has grown considerably in recent years, largely due to the 5.5 percent average annual increase in the number of services provided per beneficiary (volume) and the increase in the average complexity and costliness of services (intensity). Analyses by the Medicare Payment Advisory Commission (MedPAC) and the government Accountability Office (GAO) have suggested that some of the higher volume and intensity that drives spending growth may not be medically beneficial. In fact, the wide geographic variation in Medicare spending per beneficiary—unrelated to beneficiary health status or outcomes—provides evidence that health needs alone do not determine spending. Furthermore, recent analyses by GAO, MedPAC and others indicate the growth in volume and intensity of physician services varies dramatically across providers and specialties. Excessive volume and intensity not only increase program spending, but also may represent unnecessary services that can put beneficiaries at greater risk.

Strategies to evaluate growth in volume and intensity, and address unnecessary spending are currently being explored. One such strategy would bundle services in the physician fee schedule to create a global fee for patient care management. Bundled payments are used for most of part A through various Prospective Payment Systems that use Diagnostic Related Groups and other similar mechanisms. In Part B, Medicare bundles payments for End Stage Renal Disease and for certain surgeries. Bundled payments could facilitate more careful patient management, while reducing administrative burden for physicians.

Another strategy being used to address growth in volume and intensity relies on providing feedback to individual physicians about how their practice patterns compare with their peers. This approach is intended to generate dialog so that Medicare physicians can learn from each other how to achieve the highest quality outcomes with efficient use of resources. Such programs have been used effectively in the private sector.

In announcing this hearing, Chairman Stark said: **"As Medicare's steward, Congress needs to ensure that Medicare resources are being used effi-**

ciently and effectively to achieve high quality outcomes. This hearing will bring out some concrete actions we can take to achieve this important goal."

FOCUS OF THE HEARING:

The hearing will focus on potential methods to improve efficiency among physicians in Medicare. In particular, witnesses will review the potential of bundling services in the physician fee schedule and the effect of providing feedback to physicians on how their clinical practice patterns and resource use compare to their peers.

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." Once you have followed the online instructions, completing all informational forms and clicking "submit" on the final page, an email will be sent to the address which you supply confirming your interest in providing a submission for the record. You MUST REPLY to the email and ATTACH your submission as a Word or WordPerfect document, in compliance with the formatting requirements listed below, by close of business **Thursday, May 24, 2007**. 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.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any supplementary materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission or supplementary item not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

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, and 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. We'll proceed with a hearing that we hoped would build on our recent hearing with MedPAC, trying to outline the possibilities to reform or change the physician payments in Medicare, and we'll focus today on possible long-term solutions to improve efficiency among the Medicare physicians.

Hoping, our goal is to move from the sustainable growth rate, henceforth SGR, to a more refined system that still contains volume control but may direct us toward improve quality. Physicians play a critical role in caring for us seniors and people with disabilities, and paying them appropriately is an important part of I think any delivery system such as Medicare.

When I last chaired this Subcommittee, we created the Physician Fee Schedule to replace the cost-based reimbursement for physicians, and I was pleased at that time to work closely with the physician community to find a bipartisan consensus on that approach. The system was successful. Many private payers have adopted it since. But despite the success of the fee schedule, the solution to growth and volume and intensity still eludes us.

Analysis by GAO, MedPAC and others have shown us that the growth in volume and intensity of physician services varies dramatically across regions, providers and specialties. Even worse, we find that regional variations in volume and intensity of physician services don't relate to higher quality care or better outcomes. To the contrary, beneficiaries may be put at greater risk when they're subjected to more and more complicated procedures.

These trends should be a cause of serious concern for beneficiaries and taxpayers alike. Unfortunately, as MedPAC testified before our Committee in March, the solutions today won't solve all the problems for tomorrow. In 2007, tomorrow is here. There are several strategies to revise Medicare physician payment to more efficiently reward appropriate medical care, and that's what we're here to discuss today.

We're pleased to be joined by experts who have spent years studying ways to improve physician spending in Medicare as well as by practicing physicians who have many years of experience caring for Medicare beneficiaries. Our witnesses will review some tangible steps we can take to improve the current situation. Specifically, we'll hear testimony about whether Medicare should implement a system to feedback to physicians on how their practice patterns compare with their peers. Witnesses will also discuss whether Medicare should develop bundled payments for services in the physician fee schedule, both for coordinated management of chronic illness, such as a medical home, or as well as for episodes of highly specialized care. I look forward to working with my colleagues, the physician community and other health professionals, the administration and patients in the coming weeks.

I'd like to make one personal comment. We'll hear this morning from my friend and constituent, Dr. Mahal. He's here from Freemont, California to testify before us on behalf of the California Medical Association, and I want to take this moment to welcome Dr. Mahal and thank him for all the work that he's undertaken, along with his colleagues in the California Medical Association to help us come to a reasonable solution. Mr. Camp, would you like to comment?

Mr. CAMP. Thank you very much, Mr. Chairman, and thank you for holding this hearing. The Medicare payment formula known as a sustainable growth rate or SGR, is scheduled to reduce payments to physicians by 10 percent in 2008. It will also cause physician payments to be reduced by approximately 5 percent for each of the next 9 years. The SGR formula is obviously unsustainable. The SGR does not reward physicians for high quality or cost effective care. Under the SGR, physicians are paid more for the number of services they provide. This rewards physicians for the quantity but not the quality of their services.

We know that under the current system that the total number of procedures performed and images taken have increased, but it cannot tell us if patients are receiving better care. We need a better system that creates incentives for individual physicians to provide comprehensive, efficient and high-quality care.

In this hearing, we will look into two potential ideas to reform the physician payment system. One is the idea to provide resource use data to physicians and to compare their practice data with their peers. Private plans are already using this data in setting payments for physicians.

The second idea involves the bundling of payments. CMS did a demonstration in 1991 on bundling payments for cardiac bypass surgery. The demonstration was found to save money, but it was discontinued after 5 years. This hearing will hopefully examine these and other ideas for reform. I appreciate the witnesses being with us today, and I'm interested to know their views on these and other possible payment systems. While I'm eager to discuss long-term changes to the SGR, I recognize that we must still solve the immediate problem of the impending cuts.

From past experience, we've learned that short-term fixes don't always work. Sometimes they only exacerbate the problem. That being said, I look forward to working with the Chairman on an attempt to reform Medicare so that physicians are paid appropriately for their services and seniors get access to high-quality, affordable care.

Thank you, Mr. Chairman, and I yield back the balance of my time.

Chairman STARK. Thank you. Any other Members have an urgent statement to make? If not, I'd like to recognize our first panel and welcome back A. Bruce Steinwald, the Director of Health Care for the government Accountability Office, fondly known as GAO; Mr. Herb Kuhn, the Acting Deputy Administrator of the Centers for Medicare and Medicaid Services, CMS, and Mr. Glenn Hackbarth, Chairman of the Medicare Payment Advisory Commission, again, fondly known as MedPAC.

I want to first of all thank all of these gentleman for the help you've given the Subcommittee and the Members. In addition to these hearings, I think spending countless hours counseling and advising and educating us on the problems of the matter before us and other problems in the Medicare arena. We deeply appreciate it. There's a lot of work ahead of us, and the extra time that you take has been invaluable to the Members.

Why don't we start with Mr. Steinwald and run down the line, and you may proceed to inform us. If you care to summarize, we

have your written testimony, which without objection will appear in the record. If you care to summarize your testimony, we will then be able to inquire for more information. Mr. Steinwald.

STATEMENT OF A. BRUCE STEINWALD, DIRECTOR, HEALTH CARE, GOVERNMENT ACCOUNTABILITY OFFICE (GAO)

Mr. STEINWALD. Thank you, Chairman Stark and Mr. Camp and Members of the Subcommittee. Thank you for inviting me here today as you consider ways to encourage Medicare's physician payment system to be more efficient.

The Medicare Modernization Act required us conduct a study of the SGR system that's used to update physician fees from year to year, and to also conduct a study of physician compensation more generally.

Our SGR study concluded that the annual growth over the past several years and the volume and complexity of services delivered to Medicare beneficiaries has been the underlying reason that the SGR system has been, to put it mildly, problematic. This trend generates spending increases that are excessive under the SGR formula, which requires offsetting reductions in physicians fees and an annual headache for the Congress.

The SGR is a blunt instrument that treats every Medicare doctor the same, regardless of whether the doctor is conserving of resources or profligate. When we were planning our second MMA-mandated study, we wanted to investigate approaches that could look at individual doctor behavior, and this led us to profiling. Under profiling, the health care resources provided or ordered by a physician and consumed by that physician's patients can be compared to the average for similar doctors and patients. The doctors who appear to be practicing an efficient style of medicine can be identified individually.

We conducted an analysis of Medicare claims data pertaining to services provided to Medicare beneficiaries in 12 metropolitan areas to determine whether we could identify doctors who appeared to be practicing medicine inefficiently. I won't go into the details of the study at this time. But it will come as no surprise to you that we found evidence of inefficiency in all 12 areas.

We also concluded that if inefficient doctors' practices were brought into the normal range with their peer groups, Medicare could realize substantial savings. We also looked at outside of Medicare for other payers who are profiling doctors to see if there might be lessons for Medicare in what other organizations are doing to improve the efficiency of health care delivery.

We reported on 10 organizations ranging from traditional insurers to government payers who collect data on patient's health care expenditures at the physician or physician group level, and compared those expenditures to an average for comparable physicians. Among other things, we found that nearly all of these organizations established standards for quality as well as efficiency. They examined total health expenditures, not just physician service expenditures. The educate doctors about their profiling programs and how their performance compares to standards for efficiency and quality, and they created financial and other incentives for doctors to

change their behavior or for patients to seek care from the more efficient doctors.

Medicare currently has the tools necessary to conduct physician profiling on a large scale. It has a comprehensive claims database that can be used to calculate individual doctor's patients expenditures. It has enough physicians participating in Medicare in most geographic areas to ensure statistically valid comparisons, and it has experience in using methods to account for differences in patient health status, which is a central ingredient for profiling to be meaningful.

Medicare also faces some limitations which will need to be addressed. For example, in its comments on our draft report, CMS noted that profiling on a broad scale would be resource-intensive. We agree that any effort likely to improve efficiency program-wide would have to be adequately funded.

Second, CMS lacks the authority to use profiling results in some of the ways that the 10 payers that we studied to, such as varying patient copayments or physicians' fees, depending on whether quality and efficiency standards are met. Thus, to achieve the full potential that profiling offers to improve program efficiency will almost certainly require Congressional action.

CMS does have the authority to provide feedback to doctors who care for Medicare patients on how their care compares to peer groups. Provided that such an effort could get underway soon, showing doctors evidence that their practice styles may be inefficient compared to a peer group is a promising step to encourage them to conserve Medicare's resources. Such feedback may, if implemented program-wide, achieve some program savings in its own right.

However, to realize the full potential for profiling to affect physician behavior and to moderate the spending trend, financial incentives will almost certainly have to be imposed.

Mr. Chairman, this concludes my remarks, and I would be happy to answer your questions.

[The prepared statement of Mr. Steinwald follows:]

United States Government Accountability Office

GAO

Testimony

Before the Subcommittee on Health, Committee on Ways and Means, House of Representatives

For Release on Delivery
Expected at 10:00 a.m. EDT
Thursday, May 10, 2007

MEDICARE

Providing Systematic Feedback to Physicians on their Practice Patterns Is a Promising Step Toward Encouraging Program Efficiency

Statement of A. Bruce Steinwald
Director, Health Care

GAO-07-862T

May 10, 2007

GAO
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Highlights

Highlights of GAO-07-862T, a testimony before the Subcommittee on Health, Committee on Ways and Means, House of Representatives

MEDICARE

Providing Systematic Feedback to Physicians on their Practice Patterns Is a Promising Step Toward Encouraging Program Efficiency

Why GAO Did This Study

GAO was asked to discuss—based on *Medicare: Focus on Physician Practice Patterns Can Lead to Greater Program Efficiency*, GAO-07-307 (Apr. 30, 2007)—the importance in Medicare of providing feedback to physicians on how their use of health care resources compares with that of their peers. GAO's report discusses an approach to analyzing physicians' practice patterns in Medicare and ways the Centers for Medicare & Medicaid Services (CMS) could use the results. In a related matter, Medicare's sustainable growth rate system of spending targets used to moderate physician spending growth and annually update physician fees has been problematic, acting as a blunt instrument and lacking in incentives for physicians individually to be attentive to the efficient use of resources in their practices. GAO's statement focuses on (1) the results of its analysis estimating the prevalence of inefficient physicians in Medicare and (2) the potential for CMS to profile physicians in traditional fee-for-service Medicare for efficiency and use the results in ways that are similar to other purchasers' efforts to encourage efficiency.

What GAO Recommends

In its report, GAO recommended that CMS develop a system that identifies individual physicians with inefficient practice patterns and, seeking legislative authority as necessary, uses the results to improve program efficiency.

www.gao.gov/cgi-bin/getrpt?GAO-07-862T.

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

What GAO Found

Having considered efforts of 10 private and public health care purchasers that routinely evaluate physicians for efficiency and other factors, GAO conducted its own analysis of physician practices in Medicare. GAO focused the analysis on generalists—physicians who described their specialty as general practice, internal medicine, or family practice—and selected metropolitan areas that were diverse geographically and in terms of Medicare spending per beneficiary. Although GAO did not include specialists in its analysis, its method does not preclude profiling specialists, as long as enough data are available to make meaningful comparisons across physicians. Based on 2003 Medicare claims data, GAO's analysis found outlier generalist physicians—physicians who treat a disproportionate share of overly expensive patients—in all 12 metropolitan areas studied. Outlier generalists and other generalists saw similar numbers of Medicare patients and their respective patients averaged the same number of office visits. However, after taking health status and location into account, GAO found that Medicare patients who saw an outlier generalist—compared with those who saw other generalists—were more likely to have been hospitalized, more likely to have been hospitalized multiple times, and more likely to have used home health services. By contrast, they were less likely to have been admitted to a skilled nursing facility. GAO concluded that outlier generalists were likely to practice medicine inefficiently.

CMS has tools available to evaluate physicians' practices for efficiency, including a comprehensive repository of Medicare claims data to compute reliable efficiency measures and substantial experience adjusting for differences in patients' health status. The agency also has wide experience in conducting educational outreach to physicians with respect to improper billing practices and potential fraud—providing individual physicians, in some cases, comparative information on how the physician varies from other physicians in the same specialty or in other ways. A physician education effort based on efficiency profiling would therefore not be a foreign concept in Medicare. For example, CMS could provide physicians a report that compares their practice's efficiency with that of their peers, enabling physicians to see whether their practice style is outside the norm. As for implementing other strategies to encourage efficiency, such as the use of certain financial incentives, CMS would likely need additional legislative authority.

CMS agreed with the need to measure physician resource use in Medicare but raised concerns about the costs involved in reporting the results and was silent on other strategies discussed beyond physician education. GAO concurs that resource use measurement and reporting activities would require adequate funding; however, GAO is concerned that efforts to achieve efficiency that rely solely on physician education without financial or other incentives for physicians to curb inefficiencies will be suboptimal.

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today as you discuss the importance of physician-focused strategies to improve efficiency in Medicare. One such strategy entails providing feedback to physicians on how their use of health care resources compares with that of their peers. We recently issued a report, entitled *Medicare: Focus on Physician Practice Patterns Can Lead to Greater Program Efficiency*,[1] which discusses an approach to analyzing physicians' practice patterns in Medicare and ways the Centers for Medicare & Medicaid Services (CMS)[2] could use the results of such an analysis to modify inefficient physician behavior. In the report, we used the term efficiency to mean providing and ordering a level of services that is sufficient to meet a patient's health care needs but not excessive, given a patient's health status.

The report fulfilled a 2003 mandate that we examine aspects of physician compensation in Medicare, pertaining only to physicians serving beneficiaries in traditional fee-for-service (FFS) Medicare.[3] This topic has been of significant interest to the Congress, as Medicare's current system of spending targets used to moderate physician spending growth and annually update physician fees has been problematic. This spending target system—called the sustainable growth rate (SGR) system—adjusts Medicare's physician fees based on the extent to which actual spending aligns with specified targets. If the growth in the number of services provided per beneficiary—referred to as volume—and in the average complexity and costliness of services—referred to as intensity—is high enough, spending will exceed the SGR target. In recent years, the SGR system has called for cuts in physician fees to offset volume and intensity increases that have exceeded spending targets. Although these cuts have been overridden by legislative or administrative action, a sustained period of declining fees under the SGR system is projected. Policymakers are therefore concerned about the appropriateness of the SGR system for updating physician fees and about physicians' continued participation in the Medicare program. The problem, in part, is that the SGR system acts as a blunt instrument in that all physicians are subject to the consequences of

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[1]GAO-07-307 (Washington, D.C.: Apr. 30, 2007).

[2]CMS is the agency that administers Medicare.

[3]See Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Pub. L. No. 108-173, § 953, 117 Stat. 2066, 2428.

excess spending—namely, downward fee adjustments—that may stem from the excessive use of resources by only some physicians. In addition, under the SGR system, individual physicians have no incentive to be attentive to the efficient use of resources in their own practices.

Policymakers are also concerned that some of the increase in volume and intensity that drives spending growth may not be medically necessary. Experts agree that physicians play a central role in the generation of health care expenditures in total.[4] For example, physicians refer patients to other physicians; they admit patients to hospitals, skilled nursing facilities, and hospices; and they order services delivered by other health care providers, such as imaging studies, laboratory tests, and home health services. However, some of the spending for services provided and ordered by physicians may not be warranted. For example, the wide geographic variation in Medicare spending per beneficiary—unrelated to beneficiary health status or outcomes—provides evidence that health needs alone do not determine spending.[5] Medicare physician payment policy does little to change this situation; payments under the Medicare program are not designed to foster individual physician responsibility for the most effective medical practices. In contrast, some public and private health care purchasers have initiated programs to identify efficient physicians and encourage patients to obtain care from them.

Against this backdrop, my remarks today will focus on (1) the results of our analysis estimating the prevalence of inefficient physicians in Medicare and (2) the potential for CMS to profile physicians in traditional FFS Medicare for efficiency and use the results in ways that are similar to other purchasers' efforts to encourage efficiency. My remarks are based on findings in our report: *Medicare: Focus on Physician Practice Patterns Can Lead to Greater Program Efficiency*.[6] Having considered the efforts of 10 private and public health care purchasers that routinely evaluate physicians for efficiency and other factors, we conducted our own analysis

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[4]GAO, *Comptroller General's Forum on Health Care: Unsustainable Trends Necessitate Comprehensive and Fundamental Reforms to Control Spending and Improve Value*, GAO-04-793SP (Washington D.C.: May 1, 2004); Laura A. Dummit, *Medicare Physician Payments and Spending*, National Health Policy Forum, Issue Brief Number 815 (Washington D.C.: Oct. 9, 2006).

[5]Elliot S. Fisher, et al., "The Implications of Regional Variations in Medicare Spending. Part 1: The Content, Quality, and Accessibility of Care," *Annals of Internal Medicine*, vol. 138, no. 4 (2003): 273-287.

[6]GAO-07-307.

of physician practices in Medicare. We focused the analysis on generalists—physicians who described their specialty as general practice, internal medicine, or family practice—and selected metropolitan areas that were diverse geographically and in terms of Medicare spending per beneficiary. Although we did not include specialists in the analysis, our method does not preclude profiling specialists, as long as enough data are available to make meaningful comparisons across physicians. We based our analysis on 2003 Medicare claims data. We conducted our work from September 2005 through May 2007 in accordance with generally accepted government auditing standards.

In summary, we found outlier generalist physicians—physicians who treat a disproportionate share of overly expensive patients—in all 12 metropolitan areas studied. Outlier generalists and other generalists saw similar numbers of Medicare patients and their respective patients averaged the same number of office visits. However, after taking health status and location into account, we found that Medicare patients who saw an outlier generalist—compared with those who saw other generalists—were more likely to have been hospitalized, more likely to have been hospitalized multiple times, and more likely to have used home health services. By contrast, they were less likely to have been admitted to a skilled nursing facility. We concluded that outlier generalists were likely to practice medicine inefficiently.

CMS has tools available to evaluate physicians' practices for efficiency, including a comprehensive repository of Medicare claims data to compute reliable efficiency measures and substantial experience adjusting for differences in patients' health status. The agency also has wide experience in conducting educational outreach to physicians with respect to improper billing practices and potential fraud—providing individual physicians, in some cases, comparative information on how the physician varies from other physicians in the same specialty or in other ways. A physician education effort based on efficiency profiling results would therefore not be a foreign concept in Medicare. For example, CMS could provide physicians a report that compares their practice's efficiency with that of their peers, enabling physicians to see whether their practice style is outside the norm. As for implementing other strategies to encourage efficiency, such as the use of certain financial incentives, CMS would likely need additional legislative authority.

In our April 2007 report, we recommended that CMS develop a system that identifies individual physicians with inefficient practice patterns and, seeking legislative changes as necessary, uses the results to improve program efficiency. CMS agreed with the need to measure physician resource use in Medicare but raised concerns about the costs involved in reporting the results and was silent on other strategies discussed beyond physician education. We concur that resource use measurement and reporting activities would require adequate funding; however, we are concerned that efforts to achieve efficiency that rely solely on physician education without financial or other incentives for physicians to curb inefficiencies will be suboptimal.

Background

Linking efficiency to physician payment policy has been a subject of interest among policymakers and health policy analysts. For example, the Institute of Medicine has recently recommended that Medicare payment policies should be reformed to include a system for paying health care providers differentially based on how well they meet performance standards for quality or efficiency or both.[7] In April 2005, CMS initiated a demonstration mandated by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) to test this approach.[8] Under the Physician Group Practice demonstration, 10 large physician group practices, each comprising at least 200 physicians, are eligible for bonus payments if they meet quality targets and succeed in keeping the total expenditures of their Medicare population below annual targets.[9]

Several studies have found that Medicare and other purchasers could realize substantial savings if a portion of patients switched from less efficient to more efficient physicians. The estimates vary according to assumptions about the proportion of beneficiaries changing physicians.[10] In 2003, the Consumer-Purchaser Disclosure Project, a partnership of consumer, labor, and purchaser organizations, asked actuaries and health

[7]Institute of Medicine, *Rewarding Provider Performance: Aligning Incentives in Medicare (Pathways to Quality Health Care Series) – Summary* (Washington, D.C.: 2007).

[8]Pub. L. No. 106-554, app. F, § 412(a), 114 Stat. 2763, 2763A–509-515.

[9]We are currently conducting a study of the demonstration, as required by BIPA (Pub. L. No. 106-554, app. F, § 412(b), 114 Stat. 2763, 2763A–515).

[10]See Consumer-Purchaser Disclosure Project, *More Efficient Physicians: A Path to Significant Savings in Health Care* (Washington, D.C.: July 2003).

researchers to estimate the potential savings to Medicare if a small proportion of beneficiaries started using more efficient physicians. The Project reported that Medicare could save between 2 and 4 percent of total costs if 1 out of 10 beneficiaries moved to more efficient physicians. This conclusion is based on information received from one actuarial firm and two academic researchers. One researcher concluded, based on his simulations, that if 5 to 10 percent of Medicare enrollees switched to the most efficient physicians, savings would be 1 to 3 percent of program costs—which would amount to about $5 billion to $14 billion in 2007.

The Congress has also recently expressed interest in approaches to constrain the growth of physician spending. The Deficit Reduction Act of 2005 required the Medicare Payment Advisory Commission (MedPAC) to study options for controlling the volume of physicians' services under Medicare.[11] One approach for applying volume controls that the Congress directed MedPAC to consider is a payment system that takes into account physician outliers.

In our report on which this statement is based, we sought information about other purchasers' profiling efforts designed to encourage physicians to practice efficiently. We selected 10 health care purchasers that profiled physicians in their networks—that is, compared physicians' performance to an efficiency standard to identify those who practiced inefficiently.[12] To measure efficiency, the purchasers we spoke with generally compared actual spending for physicians' patients to the expected spending for those same patients, given their clinical and demographic characteristics.[13] Most purchasers said they also evaluated physicians on quality. The purchasers linked their efficiency profiling results and other measures to a range of physician-focused strategies to encourage the efficient provision of care. Some of the purchasers said their profiling efforts produced savings.

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[11]MedPAC is an independent federal body established by the Balanced Budget Act of 1997 to advise the Congress on payment, access, and quality issues affecting the Medicare program.

[12]In our report we used the term purchaser to mean health plans as well as agencies that manage care purchased from health plans; one of the entities we interviewed is a provider network that contracts with several insurance companies to provide care to their enrollees.

[13]Generally, estimates of an individual's expected spending are based on factors such as patient diagnoses and demographic traits.

Through Profiling, We Found That Physicians Likely to Practice Inefficiently in Medicare Were Present in All Areas Selected for Study

Having considered the efforts of other health care purchasers in profiling physicians for efficiency, we conducted our own profiling analysis of physician practices in Medicare and found individual physicians who were likely to practice medicine inefficiently in each of 12 metropolitan areas studied. We selected areas that were diverse geographically and in terms of Medicare spending per beneficiary.[14] We focused our analysis on generalists—physicians who described their specialty as general practice, internal medicine, or family practice. Although we did not include specialists in our analysis, our method does not preclude profiling specialists, as long as enough data are available to make meaningful comparisons across physicians.

Under our methodology, we computed the percentage of overly expensive patients in each physician's Medicare practice. To identify overly expensive patients, we grouped the Medicare beneficiaries in the 12 areas according to their health status, using diagnostic and demographic information. We classified beneficiaries as overly expensive if their total Medicare expenditures—for services provided by all health providers, not just physicians—ranked in the top fifth of their health status cohort for 2003 claims.[15]

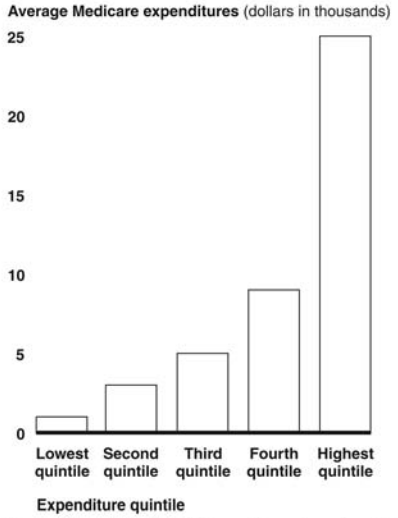
Within each health status cohort, we observed large differences in total Medicare spending across beneficiaries. For example, in one cohort of beneficiaries whose health status was about average, overly expensive beneficiaries—the top fifth ranked by expenditures—had average total expenditures of $24,574, as compared with the cohort's bottom fifth, averaging $1,155.[16] (See fig. 1.)

[14]The 12 metropolitan areas were Albuquerque, N.M.; Baton Rouge, La.; Des Moines, Iowa; Phoenix, Ariz.; Miami, Fla.; Springfield, Mass.; Cape Coral, Fla.; Riverside, Calif.; Pittsburgh, Pa.; Columbus, Ohio; Sacramento, Calif.; and Portland, Maine.

[15]Expenditures identified were for services from inpatient hospital, outpatient, skilled nursing facility, physician, hospice, durable medical equipment, and home health providers.

[16]See GAO-07-307, appendix I, for a depiction of beneficiary expenditures at the 20th, 50th, and 80th percentile for each health status cohort.

Figure 1: Average Medicare Expenditures, by Quintile, for Beneficiaries of Nearly Average Health Status



Source: GAO analysis of 2003 Medicare claims and enrollment data.

Note: Beneficiaries who died during 2003 are excluded.

This variation may reflect differences in the number and type of services provided and ordered by these patients' physicians as well as factors not under the physicians' direct control, such as a patient's response to and compliance with treatment protocols. Holding health status constant, overly expensive beneficiaries accounted for nearly one-half of total Medicare expenditures even though they represented only 20 percent of beneficiaries in our sample.

Once these patients were identified and linked to the physicians who treated them, we were able to determine which physicians treated a disproportionate share of these patients compared with their generalist peers in the same location. We classified these physicians as outliers—that is, physicians whose proportions of overly expensive patients would occur by chance less than 1 time in 100. Notably, all physicians had some overly expensive patients in their Medicare practice, but outlier physicians had a

much higher percentage of such patients. We concluded that these outlier physicians were likely to be practicing medicine inefficiently.[17]

Based on 2003 Medicare claims data, our analysis found outlier generalist physicians in all 12 metropolitan areas we studied. The Miami area had the highest percentage—almost 21 percent—of outlier generalists, followed by the Baton Rouge area at about 11 percent. (See table 1.) Across the other areas, the percentage of outliers ranged from 2 percent to about 6 percent.

Table 1: Percentage of Outlier Physicians in 12 Metropolitan Areas, 2003

Metropolitan area	Percentage of outlier physicians
Miami, Fla.	20.9
Baton Rouge, La.	11.2
Cape Coral, Fla.	6.3
Portland, Maine	5.8
Riverside, Calif.	5.8
Phoenix, Ariz.	5.2
Sacramento, Calif.	5.2
Des Moines, Iowa	4.8
Columbus, Ohio	4.6
Pittsburgh, Pa.	3.8
Springfield, Mass.	2.9
Albuquerque, N. Mex.	2.0

Source: GAO analysis of 2003 CMS claims and enrollment data.

Note: Outlier percentages greater than 1 percent indicate that an area has an excessive number of outlier physicians.

In 2003, outlier generalists' Medicare practices were similar to those of other generalists, but the beneficiaries they treated tended to experience higher utilization of certain services. Outlier generalists and other generalists saw similar average numbers of Medicare patients (219 compared with 235) and their patients averaged the same number of office visits (3.7 compared with 3.5). However, after taking into account beneficiary health status and geographic location, we found that beneficiaries who saw an outlier generalist, compared with those who saw

[17]Our approach to estimating outlier physicians was conservative in that it captured only the most extreme practice patterns; therefore, our analysis does not mean that all nonoutlier physicians were practicing efficiently.

other generalists, were 15 percent more likely to have been hospitalized, 57 percent more likely to have been hospitalized multiple times, and 51 percent more likely to have used home health services. By contrast, they were 10 percent less likely to have been admitted to a skilled nursing facility.[18]

CMS Has Tools Available to Profile Physicians for Efficiency

Medicare's data-rich environment is conducive to identifying physicians who are likely to practice medicine inefficiently. Fundamental to this effort is the ability to make statistical comparisons that enable health care purchasers to identify physicians practicing outside of established standards. CMS has the tools to make statistically valid comparisons, including comprehensive medical claims information, sufficient numbers of physicians in most areas to construct adequate sample sizes, and methods to adjust for differences in patient health status.

Among the resources available to CMS are the following:

- *Comprehensive source of medical claims information.* CMS maintains a centralized repository, or database, of all Medicare claims that provides a comprehensive source of information on patients' Medicare-covered medical encounters. Using claims from the central database, each of which includes the beneficiary's unique identification number, CMS can identify and link patients to the various types of services they received and to the physicians who treated them.

- *Data samples large enough to ensure meaningful comparisons across physicians.* The feasibility of using efficiency measures to compare physicians' performance depends, in part, on two factors: the availability of enough data on each physician to compute an efficiency measure and numbers of physicians large enough to provide meaningful comparisons. In 2005, Medicare's 33.6 million FFS enrollees were served by about 618,800 physicians. These figures suggest that CMS has enough clinical and expenditure data to compute efficiency measures for most physicians billing Medicare.

[18]These findings were derived from logistic regressions in which health status, geographic area, and beneficiary contact with an outlier generalist were the explanatory variables used to predict whether a beneficiary was hospitalized, used home health services, or was admitted to a skilled nursing facility.

Methods to account for differences in patient health status. Because sicker patients are expected to use more health care resources than healthier patients, the health status of patients must be taken into account to make meaningful comparisons among physicians. Medicare has significant experience with risk adjustment, a methodological tool that assigns individuals a health status score based on their diagnoses and demographic characteristics. For example, CMS has used increasingly sophisticated risk adjustment methodologies over the past decade to set payment rates for beneficiaries enrolled in managed care plans. On the related topic of measuring resource use, CMS noted in comments on a draft of our report that emerging "episode grouper" technology was a promising approach to measuring resource use associated with a given episode of care. We agree, but we also consider our measurement of resource use on a per capita basis, capturing total health care expenditures for a given period of time, equally promising.

To conduct profiling analyses, CMS would likely make methodological decisions similar to those made by the health care purchasers we interviewed. For example, the health care purchasers we spoke with made choices about whether to profile individual physicians or group practices; which risk adjustment tool was best suited for a purchaser's physician and enrollee population; whether to measure costs associated with episodes of care or the costs, within a specific time period, associated with the patients in a physician's practice; and what criteria to use to define inefficient practice patterns.

As for ways CMS could use profiling results, actions taken by other health care purchasers we interviewed may be instructive in suggesting future directions for Medicare. For example, all purchasers in our study used physician education as part of their strategy to change behavior. Educational outreach to physicians has been a long-standing and widespread activity in Medicare as a means to change physician behavior based on profiling efforts to identify improper billing practices and potential fraud. Outreach includes letters sent to physicians alerting them to billing practices that are inappropriate.[19] In some cases, physicians are given comparative information on how the physician varies from other physicians in the same specialty or locality with respect to use of a certain service.

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[19]Other forms of physician education include face-to-face meetings, telephone conferences, seminars, and workshops.

A physician education effort based on efficiency profiling would therefore not be a foreign concept in Medicare. For example, CMS could provide physicians a report that compares their practice's efficiency with that of their peers. This would enable physicians to see whether their practice style is outside the norm. In its March 2005 report to the Congress,[20] MedPAC recommended that CMS measure resource use by physicians and share the results with them on a confidential basis. MedPAC suggested that such an approach would enable CMS to gain experience in examining resource use measures and identifying ways to refine them while affording physicians the opportunity to change inefficient practices.[21] In commenting on a draft of our report, CMS noted that the agency would incur significant recurring costs in developing reports on physician resource use and disseminating them nationwide. We agree that any such undertaking would need to be adequately funded.

Another application of profiling results used by the purchasers we spoke with entailed sharing comparative information with enrollees. CMS has considerable experience comparing certain providers on quality measures and posting the results to a Web site. Currently, Medicare Web sites with comparative information exist for hospitals, nursing homes, home health care agencies, dialysis facilities, and managed care plans. In its March 2005 report to the Congress, MedPAC noted that CMS could share results of physician performance measurement with beneficiaries once the agency gained sufficient experience with its physician measurement tools.

Several structural features of the Medicare program would appear to pose challenges to the use of other strategies designed to encourage efficiency. These features include a beneficiary's freedom to choose any licensed physician permitted to be paid by Medicare; the lack of authority to exclude physicians from participating in Medicare unless they engage in unlawful, abusive, or unprofessional practices; and a physician payment system that does not take into account the efficiency of the care provided. Under these provisions, CMS would not likely be able—in the absence of additional legislative authority—to assign physicians to tiers associated

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[20]MedPAC, *Report to the Congress: Medicare Payment Policy* (Washington, D.C.: March 2005).

[21]In several testimonies before the Congress in the last half of 2005, CMS officials said that they were taking steps to implement this recommendation. See Value-Based Purchasing for Physicians Under Medicare: Hearing Before the House Subcommittee on Health, Committee on Ways and Means, 109th Cong. (2005) (statement of Mark B. McClellan, MD, Ph.D., Administrator of CMS).

with varying beneficiary copayments, tie fee updates of individual physicians to meeting performance standards, or exclude physicians who do not meet practice efficiency and quality criteria. In commenting on our draft report, CMS was silent with regard to the need for legislative authority. The agency noted that it is studying and implementing initiatives that link assessment of physician performance to financial and other incentives, such as public reporting.

Regardless of the use made of physician profiling results, the involvement of, and acceptance by, the physician community and other stakeholders of any actions taken is critical. Several purchasers described how they had worked to get physician buy-in. They explained their methods to physicians and shared data with them to increase physicians' familiarity with and confidence in the purchasers' profiling. CMS has several avenues for obtaining the input of the physician community. Among them is the federal rule-making process, which generally provides a comment period for all parties affected by prospective policy changes. In addition, CMS forms federal advisory committees—including ones composed of physicians and other health care practitioners—that regularly provide it with advice and recommendations concerning regulatory and other policy decisions.

Having considered the tools CMS has available and the structural challenges the agency would likely face in seeking to implement certain incentives used by other purchasers, we recommended in our April 2007 report that the Administrator of CMS develop a profiling system—seeking legislative authority, as necessary—that includes the following elements:

total Medicare expenditures as the basis for measuring efficiency,

adjustments for differences in patients' health status,

empirically based standards that set the parameters of efficiency,

a physician education program that explains to physicians how the profiling system works and how their efficiency measures compare with those of their peers,

financial or other incentives for individual physicians to improve the efficiency of the care they provide, and

methods for measuring the impact of physician profiling on program spending and physician behavior.

Concluding Observations

Policymakers have expressed interest in linking physician performance to Medicare payment so that incentives under FFS for physicians to practice inefficiently can be reversed. In our view, Medicare should adopt an approach that relies not only on physician education but also financial or other incentives—such as discouraging patients from obtaining care from physicians who are determined to be inefficient. A primary virtue of profiling is that, coupled with incentives to encourage efficiency, it can create a system that operates at the individual physician level. In this way, profiling can address a principal criticism of the SGR system, which only operates at the aggregate physician level. Although any savings from physician profiling alone would clearly not be sufficient to correct Medicare's long-term fiscal imbalance, it could be an important part of a package of reforms aimed at future program sustainability.

Mr. Chairman, this concludes my prepared remarks. I will be pleased to answer any questions you or the Subcommittee Members may have.

GAO Contacts and Acknowledgments

For future contacts regarding this testimony, please contact A. Bruce Steinwald at (202) 512-7101 or at steinwalda@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. Other individuals who made key contributions include Phyllis Thorburn, Assistant Director; Todd Anderson; Hannah Fein; Richard Lipinski; and Eric Wedum.

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Chairman STARK. Thank you.
Mr. Kuhn.

STATEMENT OF HERBERT B. KUHN, ACTING DEPUTY ADMINISTRATOR, CENTERS FOR MEDICARE & MEDICAID SERVICES

Mr. KUHN. Chairman Stark, Mr. Camp, Members of the Subcommittee, thank you for inviting me here today to discuss quality and efficiency in Medicare physician payment. The fee-for-service Medicare Program has largely been a passive payer of health-care services. Given the size and impact of Medicare, it is a top priority at the Centers for Medicare & Medicaid Services to transform Medicare from a passive payer to an active purchaser of high quality, efficient care.

Medicare payment systems should encourage reliable, high quality and efficient care, rather than payment based simply on the quantity of services provided and resources consumed. CMS has taken a leadership role in a multi-pronged approach to addressing value-based purchasing for physician services. Strategies to measure and encourage quality services, to understand appropriate resource use, and to examine current value-based purchasing models are all at the heart of CMS efforts to help modernize the physician payment system.

One such method would be to refine the payment system, including the additional use of bundled payments for physician services. As with other payment systems, Medicare supports efforts to identify opportunities for paying physicians and providers a single or bundled amount to take care of the patient for the range of services that are necessary to manage the patient through an episode of care. This contrasts to the current fee schedule and physician payment system where we typically pay for the individual services.

We have limited experience in this area for physician services. Accordingly, it would take additional research and analytical work before we could make substantive changes in this area. However, we have had experience with bundling, and our results are mixed. I'd like to share with you some of those results.

For example, one, we have established national definitions for global surgical packages so that the payment is made consistently for all pre-and post-operative visits. We believe this has promoted efficiency in the delivery of surgical services and fostered continuity of care by the surgeon. It has also led to greater payment predictability for the surgeon and for the Medicare beneficiary in terms of their copayments. However, there are issues about how accurate we are at estimating the number and the level of services in the bundle.

We also would pay physicians a monthly capitated payment for managing the care of ESRD patients receiving dialysis services. At one time this was a single payment for the visits and services the physician performed during the month of care. However, based on concerns that physicians were not performing the visits during the month, we split the Codes, and payment now varies depending on the number of visits provided.

In general, bundling works very well, but it's more problematic in the physician payment setting. Bundled payment approaches rely upon a system of averages. This can work very well for pro-

viders, such as hospitals or large physician groups or clinics, that provide a wide range of services for a diverse mix of patients. But bundling can be problematic for small physician groups that tend to specialize or treat a more limited set of patients.

While there are certainly limitations to bundling for physician services, there are areas where additional research on bundling options could be considered in the physician payment area. One are might be to develop a more comprehensive office visit package. Another payment option might allow for bundling to eliminate incentives for physicians to furnish services on different days in order to avoid the current Medicare payment discounts for multiple services furnished on the same day.

It is important, however, as we move in this area of payment reform, that we make sure that we provide the safeguards against any misalignments of payment incentives could diminish the level of care of Medicare beneficiaries, and this is important to all of us.

A second area of payment reform deals with the extensive variation of physician use of resources to treat a given condition, particularly geographic variation. Studies show that greater volume of services does not appear to correlate with high-quality care or improved outcomes.

Measuring physician resource use in Medicare is an ambitious undertaking. Nearly 700,000 physicians receive Medicare payments, and those physicians submit about 800 million claims per year. As with the development of the Medicare payment systems, which typically are multi-year, multi-step processes, so too will the measurement of physician resource use take some time.

A tool used in assessing resource use for an episode of care is the episode grouper, which organizes the different services furnished to the beneficiary into clinical meaningful episodes using the diagnosis and other information that are present on the physician claim. When services are grouped, the total cost of all services involved with treating the condition or illness can be compiled and then compared.

CMS is currently evaluating two commercial and proprietary episode grouper software products currently on the market and used by other payers. Episode groupers have a great promise as a way to organize Medicare data to make meaningful resource use comparisons among physicians. However, there are multiple issues that we need to sort through as we look at this to make sure that we accurately measure physician resource use. This includes attribution. This includes patient characteristics, such as severity adjustments. Finally, it really is to make sure that we have appropriate comparison groups.

We have also begun the effort to engage physicians on the use of these tools, including asking physician groups to share with us clinical scenarios that then we can pass through the groupers to see if we come out with the same outcome as they do when they do it manually; again, a validation process. Also we'd be taking some of the reports we've gotten from these groupers and sharing them with physicians and focus groups to make sure that they're meaningful, that they're accurate, and that they can be actionable for physicians as they move forward.

We hope to have more information for all of you later this year in terms of our evaluation.

Mr. Chairman, thank you again for this opportunity to testify on quality and efficiency in Medicare physician payment. We look forward to working with Congress, the physician community, MedPAC and other stakeholders as we continue to analyze the various appropriate to physician payment.

We look forward to answering any questions the Committee might have.

[The prepared statement of Mr. Kuhn follows:]

Testimony of
Herb Kuhn
Acting Deputy Administrator
Centers for Medicare & Medicaid Services
Before the
House Ways and Means Subcommittee on Health
Hearing on
Physician Quality and Efficiency
May 10, 2007

Chairman Stark, Mr. Camp, distinguished members of the Committee, thank you for inviting me here today to discuss quality and efficiency in Medicare physician payment. The fee-for-service Medicare program has largely been a passive payer of health care services. Given the size and impact of Medicare, it is a top priority at the Centers for Medicare & Medicaid Services (CMS) to transform Medicare from a passive payer to an active purchaser of high quality, efficient health care.

To maximize the value of the Medicare dollar, we are studying and implementing value based purchasing initiatives for Medicare payment systems, including physicians' services. Value-based purchasing links assessment of performance, through the use of measures, to financial and other incentives, such as public reporting. A comprehensive set of performance measures includes not only measures of clinical effectiveness and patient-centeredness, but also measures of resource use. Thus, value based purchasing recognizes the importance of measuring and encouraging both the provision of high quality care and the avoidance of unnecessary resource use in the provision of care.

Medicare's overarching goal in pursuing a more active purchasing strategy is to encourage continued improvement in the efficiency and quality of health care delivered to Medicare beneficiaries. Achieving that goal depends, of course, on the active participation of physicians in the program. While this hearing is not about the Sustainable Growth Rate (SGR), improving the quality and efficiency of physicians' services and other services is important in and of itself while exploring efforts to address the SGR issue.

Medicare payment systems should encourage reliable, high quality and efficient care, rather than payment based simply on the quantity of services provided and resources consumed. Medicare payment systems should encourage physicians to provide the right care at the right time and in the right setting; encourage prevention and ongoing care for the chronically ill; encourage greater transparency so physicians and their patients have the information they need to choose high quality care; and help avoid unnecessary services.

CMS has taken a leadership role in a multi-pronged approach to addressing physician payment issues. We are committed to working collaboratively with medical professionals, the Congress and MedPAC to develop an overall approach to improving physician payment with the ultimate goal of achieving better health outcomes for beneficiaries in the most efficient manner that does not increase cost to taxpayers or Medicare and its beneficiaries. Strategies to measure and encourage quality services, to understand appropriate resource use, and to examine current value-based purchasing models are all at the heart of CMS efforts to help modernize the physician payment system.

Assessing and Encouraging Quality

Quality measures are the basic foundation and pre-requisite for a payment system that encourages physicians to provide the most clinically appropriate care, rather than the highest volume. The physician community, supported by CMS, has been engaged in efforts to develop meaningful measures of quality care.

CMS implemented the Physician Voluntary Reporting Program (PVRP) in 2006. Under PVRP, for services furnished to Medicare beneficiaries during 2006, physicians were able to voluntarily report to CMS a starter set of 16 evidence-based performance measures that captured quality of care data. In December 2006, CMS provided confidential feedback reports containing reporting and performance rates to the physicians who had submitted performance data for the second calendar quarter of 2006. That experience provided a basis for the 2007 Physician Quality Reporting Initiative

(PQRI) in the Tax Relief and Health Care Act of 2006 (TRHCA). The PQRI establishes financial incentives for eligible professionals to report quality measures. Specifically, eligible professionals who successfully report a specified set of quality measures on claims for dates of service from July 1 to December 31, 2007, may earn a bonus payment, subject to a cap, of 1.5 percent of total allowed charges for covered services. To ensure smooth and timely implementation of the program, CMS posted the 2007 PQRI measures to our website well in advance of the April 1, 2007 statutory deadline. We currently are on target to post the refined measure specifications in a few weeks, again well in advance of the statutory deadline (July 1, 2007) for this step.

TRHCA also requires CMS to use notice and comment rulemaking to propose a set of measures that could be used for 2008. By statute, the 2008 measures shall be measures that have been adopted or endorsed by a consensus organization (such as the National Quality Forum or AQA), that include measures that have been submitted by a physician specialty; and that the Secretary identifies as having used a consensus-based process for developing such measures. In addition, such measures shall include structural measures such as the use of electronic health records or electronic prescribing technology. TRHCA also requires that, as part of rulemaking for 2008 measures, CMS address a mechanism for providing data on quality measures through an appropriate medical registry (such as the Society of Thoracic Surgeons National Database).

Numerous clinical databases and registries are maintained not only by medical professional societies, but also by medical boards, disease groups, patient safety groups, medical group management organizations and therapist groups. In fulfillment of the TRHCA requirement, CMS is exploring the possibilities of drawing on these databases and registries for reporting of quality measures. Such use could decrease the burden of quality reporting for professionals and CMS while increasing the quality and usefulness of the data. As we implement the statutory requirement to develop measures for 2008, we also are sorting through options for structural measures.

Beyond our efforts to implement PQRI and other quality provisions in TRHCA, CMS continues to collaborate directly with the medical community on the development of quality measures. The Physician Consortium of the American Medical Association (AMA) has played an important role in the development of physician quality measures, and CMS has supported their efforts. We also are supporting consensus processes of the AQA and NQF to adopt and endorse measures. These significant efforts have provided the basis for both the 2006 PVRP and the 2007 PQRI programs and are continuing for quality measures for 2008.

Measuring and Addressing Resource Use

As noted earlier, there is extensive variation in physician use of resources to treat a given condition, particularly geographic variation. Greater volume of services does not appear to correlate with higher quality care or improved outcomes; in fact physician "practice style" often is suggested as at least partly responsible for resource use variation.

We are investigating ways to measure individual physician resource use that links quality in the provision of care to Medicare beneficiaries and encourages physicians to focus on efficiency. A goal of resource use measurement is to provide information that is meaningful, actionable, and fair to physicians in order to reduce inefficient practice patterns. We have tested approaches for reporting resource use with physician focus groups and the results suggest that physicians may understand their practices from a patient-by-patient perspective, not from an aggregate statistics perspective. Reports on aggregate annual Medicare expenditures could be more meaningful and actionable to physicians if accompanied by appropriate detail. We have also learned that detailed data for a specific procedure or service out of context may limit the meaningfulness of the report and the ability of physicians to act on the information. The physician focus groups have also emphasized that adequate risk adjustment is essential to creating a fair measurement tool.

Measuring physician resource use in Medicare will be an ambitious undertaking. Nearly 700,000 physicians receive Medicare payments, and those physicians submit about 800

million claims per year. As with the development of Medicare payment systems which typically are multi-year, multi-step processes, so too will be the measurement of physician resource use. Given the benefits that could result from appropriately measuring physician resource use and sharing that information with physicians, the task has much potential. We are working with MedPAC, the AQA Alliance, the National Committee for Quality Assurance (NCQA), NQF, the Agency for Healthcare Research and Quality (AHRQ) and the Government Accountability Office (GAO) on physician resource issues.

In measuring resource use among physicians, it is important to include not just the services furnished by a physician, but also the services a physician orders -- laboratory and diagnostic tests, as well as hospital and other services. Given large resource use variations, resource use measurement has the potential to support physicians in the best exercise of their clinical judgment, and to ultimately provide incentives for high-quality, efficient care.

A tool used in assessing resource use for an episode of care is an "episode grouper," which organizes the different services furnished to a beneficiary into clinically meaningful episodes using the diagnoses and other information on claims. When services are grouped, the total costs of all services involved with treating a condition or illness can be compiled. The resources used by different physicians in furnishing similar episodes to similar patients can be compared. CMS is evaluating two commercial and proprietary episode grouper software products currently on the market and used by other payors. Episode groupers have great promise as a way to organize Medicare data to make meaningful resource use comparisons among physicians.

There are multiple issues to sort through with respect to accurately measuring resource use, including the development of rules for attributions of services to physicians, adjustments for patient characteristics, specification of the physician unit for episodes of care, identification of appropriate comparison groups, etc. Appropriate adjustments

would need to be made to ensure that physicians are being compared for comparable episodes.

We currently are in the early stages of a long-term effort to properly measure physician resource use. As with any long-term policy development, there are many steps and iterations along the way. Initially Medicare data would need to be assembled to present as comprehensive a picture of physician resource use as possible, covering as many specialties as possible, and as many services of physicians as is practical to measure. As the possibilities and limitations of our data are better understood and measurement issues are sorted through, an assessment can be made about specialties, services or physicians for which resource use is most promising.

After initial resource use evaluations are made, it is important to engage individual physicians in discussions about their data. Sharing the resource use information with physicians confidentially would allow them to see how they compare to peers, and provide us with their input to inform and help refine the next iteration of resource use comparisons.

Ongoing Demonstrations Linking Payment to Quality and Efficiency

Through several demonstrations, CMS is testing new physician payment methodologies that link payment to quality and efficiency. These demonstrations -- the Medicare Physician Group Practice (PGP) Demonstration; the Medicare Care Management Performance Demonstration (MCMP); the Medicare Health Care Quality Demonstration; and the Medical Home Demonstration -- are focused on physicians succeeding in improving patient outcomes and lowering overall health care costs.

The PGP Demonstration, authorized under Section 412 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, is a value-based purchasing initiative that rewards large physician groups for improving the quality and efficiency of health care delivered to Medicare fee-for-service beneficiaries. The MCMP demonstration, authorized under Section 649 of the Medicare Prescription Drug

Improvement and Modernization Act of 2003 (MMA), is a value-based purchasing initiative with small to medium sized physician groups. The demonstration promotes the adoption and use of evidence-based care and health information technology to promote continuity of care, stabilize medical conditions, prevent or minimize acute exacerbations of chronic conditions, and reduce adverse health outcomes.

Physician groups have volunteered to participate in these value-based purchasing demonstrations. As part of the demonstrations, physician groups are making investments in infrastructure and redesigning care processes to improve quality of care and report a comprehensive set of quality measures focusing on high volume and high cost Medicare conditions. In addition, participants are implementing innovative care management programs designed to reduce avoidable inpatient admissions and emergency room visits to generate savings for the Medicare Trust Funds. Physician groups are making these investments to improve quality and patient care management with no guarantee that they will receive an incentive payment since such payments are tied to their ability to generate savings and/or achieve performance thresholds for improving patient care processes and outcomes.

Section 646 of the MMA requires a Medicare Health Care Quality Demonstration. CMS is currently implementing this demonstration to identify, develop, test, and disseminate major and multi-faceted improvements to the health care system. Projects approved under this demonstration are expected to achieve significant improvements in safety, effectiveness, efficiency, patient-centeredness, timeliness and equity: the six aims for improvement in quality identified by the Institute of Medicine in its *Crossing the Quality Chasm*.

Physician groups, integrated health care delivery systems, and regional health care consortia are eligible to apply for the demonstration. These projects may involve the use of alternative payment systems for items and services provided to beneficiaries, and they may involve modifications to the traditional Medicare benefit package. In addition, the Agency for Healthcare Research & Quality (AHRQ) may use this program as a

laboratory for the study of quality improvement strategies, and CMS will provide the data necessary to analyze and evaluate the projects conducted under this program. The program will identify best practices in terms of system designs that encourage greater quality, efficiency and effectiveness, and focus on ways to make payment more consistent with these practices.

Most recently, TRHCA directed the Secretary to conduct a 3-year demonstration project of the Medical Home. This demonstration will occur in rural, urban and underserved areas in up to 8 states. The demonstration will target high-need Medicare beneficiaries who have been diagnosed with multiple chronic illnesses and require regular medical monitoring, advising or treatment.

The Medical Home can be large or small medical practices where a board-certified physician provides comprehensive and coordinated patient centered medical care and acts as the "personal physician" to the patient. This care would include using evidence-based medicine and decision support tools, health assessments and the use of health information technology (HIT), such as patient registries or remote patient monitoring. A care management fee for the coordination of services will be paid to the patient's personal physician, in addition to whatever Medicare covered services they may provide.

We are encouraged that these opportunities will yield information helpful to CMS and the Congress as we consider options for revising the Medicare physician payment system. However, it is important to note that all of these approaches are in their infancy and need further refinement and analysis before they could be appropriate for widespread adoption in the physician payment system. They also pose significant technical and operational challenges that need to be considered. We will continue to work with physicians in an open and transparent way to further develop these innovative ideas that support the best approaches to provide high quality health care services without creating additional costs for taxpayers and Medicare beneficiaries.

Conclusion

Mr. Chairman, thank you again for this opportunity to testify on quality and efficiency in Medicare physician payment. It is a top priority at CMS to transform Medicare from a passive payor to an active purchaser of high quality, efficient health care services. We are studying and implementing value based purchasing initiatives for Medicare payment systems, including physicians' services.

As a growing number of stakeholders now agree, well-designed and comprehensive quality and efficiency measurement should play a key role in Medicare physician payments. This approach has been supported not only by MedPAC, but also the Institute of Medicine (IOM), Congressional legislation, and many in the health care community. In addition, the Fiscal Year 2008 President's Budget supports budget-neutral physician payment reform and states that "an important component of improving quality is encouraging more efficient and high-quality physicians' services."

We look forward to working with Congress, the physician community, MedPAC, and other interested parties as we continue to analyze appropriate alternatives to the current system that could ensure appropriate payments while promoting high quality care, without increasing Medicare costs.

Thank you and I would be happy to answer any questions.

Chairman STARK. Thank you.

Glenn, would you like to enlighten us?

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

Mr. HACKBARTH. Thank you, Mr. Chairman, Mr. Camp, other Members of the Subcommittee. It's good to see you again. The medical care provided to Medicare patients, indeed, all Americans, is often amazing. It saves lives, reduces pain and disability, yet as has been alluded to already, there's growing evidence of uneven quality in the care provided. The care is often too fragmented and often more expensive than perhaps it needs to be. However, hard experience has taught us that the momentum toward more sophisticated, costly and fragmented care is very, very powerful and it will not be easily reversed.

Today we're discussing a number of polices that hold some promise, we believe, for redirecting the system's momentum, thus increasing the value that Medicare beneficiaries and taxpayers receive for their substantial investment in the Medicare Program.

In this opening statement, I want to highlight four policies of particular interest to MedPAC. First is profiling physicians, already discussed at some length by Bruce, we refer to it as a measuring resource use.

In 2005, MedPAC recommended that CMS provide physicians with confidential feedback on their practice patterns and how those patterns compare with their peers. With additional study over the last couple of years, we're even more convinced that this is a doable and worthwhile effort. I might add it's one that's enthusiastically endorsed by all of the physician members of MedPAC. Like GAO, we believe confidential feedback is the first step. Ultimately, the information should be used to adjust payments for physicians based on their cost and quality.

A second policy direction that I want to highlight is improving pricing accuracy for physician services meaning doing everything we can to get the price right for individual services. Last year MedPAC made a series of recommendations about how the current process for updating physician relative values might be improved. If payments, the prices we pay are too high, a service may be provided too often. On the other hand, if they're too low, the service may be underprovided. If errors persist over long periods of time, they may even begin to affect decisions about choice of specialty among medical students.

Getting prices exactly right is impossible, and indeed there are some important conceptual issues about how you define what the right price is. Nevertheless, MedPAC sees evidence of some fairly large errors in the physician payment system that are skewing the system toward the production of costly services at the expense of basic services of very high value.

A third policy direction is care management and coordination. Medicare patients, especially those with multiple chronic conditions, may see eight, ten, a dozen or more physicians in a given year. Without a concerted effort to coordinate and integrate that care, there's a great risk of patient confusion, unnecessary duplication and waste, important matters falling through the cracks, or

even dangerous interactions among treatments. Yet Medicare does not properly reward physicians for taking the time and effort to manage the care of these complex patients. Indeed, Medicare's payment system is contributing, we fear, to the steady, even accelerating erosion of the nation's primary care workforce. In our June 2006 report, we discussed potential models for improving care coordination in Medicare.

The final policy direction I wanted to mention is comparative effectiveness. As you know all too well, the U.S. spends a very large share of its national wealth on health care, yet we often know very little about how alternative treatments compare in their effectiveness. There's too little incentive for private parties to invest in such research, and when they do, the results may be compromised by proprietary interests. MedPAC believes that knowledge about what works in medicine is a public good that will always be underproduced by the private marketplace. Therefore, we believe a significant increase in public investment is required.

In our June 2007 report, we recommended that Congress charge an entity with expanding our knowledge base while taking steps to assure the entity's independence as well as adequate and secure funding.

In conclusion, let me state the obvious. None of these steps is a panacea for the problems facing the Medicare program. Some of the proposals are technically complex, and all of them are probably politically complex. There is, however, no silver bullet for Medicare's cost and quality problems. There's much work to be done on many fronts.

CMS has many important projects underway, including several important demonstrations and pilots that Congress has specifically requested. The problem is that it currently takes too long to develop, implement and refine new payment policies, despite heroic efforts by CMS staff. Because there's so much to be done, and because we feel growing urgency about getting it done, we urge Congress to give serious consideration to a substantial increase in its investment in CMS's capacity for innovation.

Thank you, Mr. Chairman.

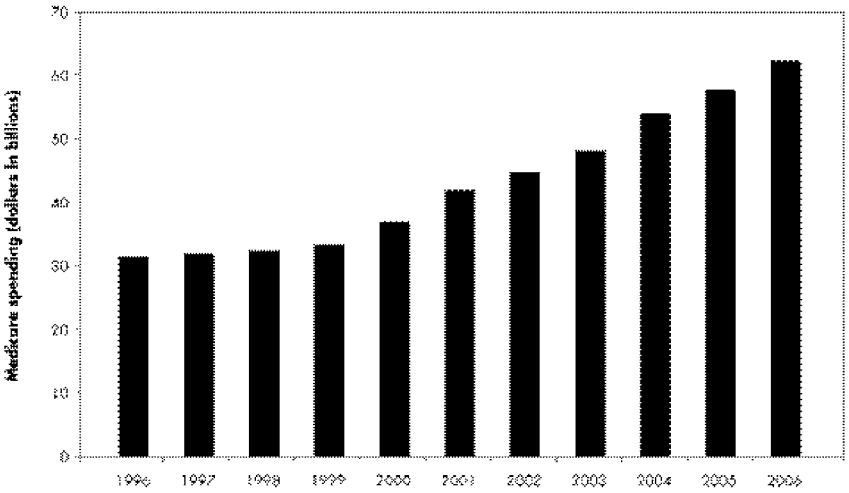
[The prepared statement of Mr. Hackbarth follows:]

Statement of Glenn M. Hackbarth, Chairman, Medicare Payment Advisory Commission

Chairman Stark, Ranking Member Camp, distinguished Subcommittee members, I am Glenn Hackbarth, Chairman of the Medicare Payment Advisory Commission (MedPAC). I appreciate the opportunity to be here with you this morning to discuss ways that Medicare can improve its physician payment system.

Since 2000, total Medicare spending for physician services has climbed more than 9 percent per year (Figure 1). Slowing the increase in Medicare outlays is important; indeed, it is becoming urgent. Medicare's rising costs, particularly when coupled with the projected growth in the number of beneficiaries, threaten the sustainability of the program. The Medicare Trustees' warn that even their unrealistically constrained estimate of Part B spending growth (due to multiple years of fee reductions mandated under current law) will still significantly outpace growth in the U.S. economy. Part B and total Medicare spending growth will continue to put pressure on the federal budget. That pressure puts other national priorities, such as homeland security and education, at risk.

FIGURE 1. FFS MEDICARE SPENDING FOR PHYSICIAN SERVICES, 1996—2006

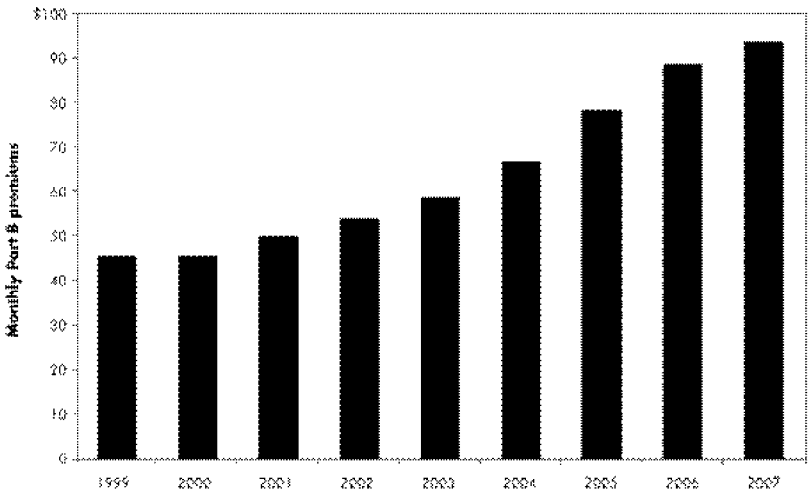


Note: FFS (fee-for-service). Dollars are Medicare spending only and do not include beneficiary coinsurance.

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

Rapid growth in expenditures also threatens to make the program unaffordable for beneficiaries. It contributes, directly and indirectly, to higher out-of-pocket costs through increased copayments, premiums for Medicare Part B, and premiums for supplemental coverage. As beneficiaries receive more services, they are required to make more copayments. Growth in copayments, in turn, pushes up the cost of supplemental insurance. In addition, because the monthly Part B premium is determined by average Part B spending for aged beneficiaries, an increase in expenditures affects the premium directly. From 1999 to 2002, the premium grew by an average of 5.8 percent per year, but the cost-of-living increases for Social Security benefits averaged only 2.5 percent per year. Since 2002, the Part B premium has increased even faster—by 13.5 percent in 2004, 17.3 percent in 2005, and 13.2 percent in 2006 (Figure 2).

FIGURE 2. MONTHLY PART B PREMIUMS, 1999—2007



Note: Beginning in 2007, monthly Part B premiums are income-adjusted. The standard premium for 2007 is $93.50.

Source: Congressional Research Service. 2004. *Medicare: Part B premiums*. Washington, DC: CRS; CMS press release, dated September 12, 2006, *Medicare premiums and deductibles for 2007*; and CMS press release, dated September 16, 2005, *Medicare premiums and deductibles for 2006*.

Spending for physician services has grown largely because of increased volume—the number of services furnished and the complexity, or intensity, of those services. Some observers have hypothesized that new technology, demographic changes, and shifts in site of service spur growth in the volume of physician services. Changes in medical protocols and a rise in the prevalence of certain conditions may also play a role. But analyses by MedPAC and others suggest that much of the rise in volume is unexplained. A RAND study found that technological advances and changes in medical protocols that are specific to particular illnesses do not fully account for volume growth. Other studies suggest that, after controlling for input prices and health status, differences in the volume of physician services are driven in large part by practice patterns and physician supply and specialization. As Elliott Fisher and others described in a series of articles, in geographic areas with more health care providers and more physician specialists, beneficiaries receive more services but do not experience better quality of care or better outcomes, nor do they report greater satisfaction with their care. John Wennberg identified some discretionary services that can be overprovided as preference-sensitive care because they involve significant trade-offs and should be selected only by patients capable of making an informed decision. This suggests that some services may be unnecessary, exposing some beneficiaries to needless risk and generating unwarranted costs for beneficiaries and the program. At the same time, evidence shows that beneficiaries do not always receive the care they need, and too often the care they do receive is not high quality.

To help address Medicare's growing financial crisis, MedPAC focuses much of its work on improving efficiency—getting more in terms of quality and outcomes for each Medicare dollar spent. Increasing the value of the program to both beneficiaries and taxpayers will require efforts to improve the incentives inherent in Medicare's fee-for-service (FFS) physician payment system.

Ideally, payment systems will give providers incentives to furnish better quality of care, to coordinate care (across settings, for chronic conditions), and to use resources judiciously. However, Medicare pays its providers the same regardless of the quality of their care, which perpetuates poor care for some beneficiaries, misspends program resources, and is unfair to providers who furnish high-quality care and use resources judiciously. Medicare's payment system does not reward physicians for coordinating patients' care across health care settings and providers, and it does little

to encourage the provision of primary care services, even though such actions may improve the quality of care and reduce costs. Further, inaccurate prices may inappropriately affect physician decisions about whether and what services to furnish. And Medicare's FFS method of paying for physician services contributes to volume growth by giving physicians a financial incentive to increase volume.

As discussed in our March 2007 report on Assessing Alternatives to the Sustainable Growth Rate System, Medicare needs to change the incentives of the payment system by ensuring that its prices are accurate, furnishing information to providers about how their practice styles compare with their peers' practice styles, encouraging coordination of care and provision of primary care, and bundling and packaging services where appropriate to reduce overuse. In addition, Medicare should promote quality by instituting pay for performance, encouraging the use of comparative-effectiveness information, and, where appropriate, imposing standards for providers as a condition of payment. If Medicare's FFS program is to function more efficiently, the Congress needs to provide CMS with the necessary time, financial resources, and administrative flexibility. CMS will need to invest in information systems; develop, update, and improve payment systems and measures of quality and resource use; and contract for specialized services.

Ensuring accurate prices

Misvalued services can distort the price signals for physician services as well as for other health care services that physicians order, such as hospital services. Some overvalued services may be overprovided because they are more profitable than other services. Conversely, some providers may opt not to furnish undervalued services, which can threaten access to care, or they may opt to furnish other, more profitable services instead, which can be costly to Medicare and to beneficiaries.

A service can become overvalued for a number of reasons. For example, when a new service is added to the physician fee schedule, it may be assigned a relatively high value because of the time, technical skill, and psychological stress that are required to perform it. Over time, the time, skill, and stress involved may decline as physicians become more familiar with the service and more efficient at providing it. The amount of physician work needed to furnish an existing service may decrease when new technologies are incorporated. Services can also become overvalued when practice expenses decline. This can happen when the costs of equipment and supplies fall, or when equipment is used more frequently, reducing its cost per use. Likewise, services can become undervalued when physician work increases or practice expenses rise. CMS—with the assistance of the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC)—reviews the relative values assigned to some physician services every five years. But many services likely continue to be misvalued.

In recent years, per capita volume for different types of services has grown at widely disparate rates, with volume growth in imaging and non-major procedures (e.g., endoscopies) outpacing that for office visits and major procedures. Volume growth differs across services for several reasons, including variability in the extent to which demand for services is discretionary and subject to the judgment of a physician or beneficiary, as well as advances in technology that expand access and can improve patient outcomes. The Commission and others have voiced concerns, however, that differential growth in volume is due in part to differences in the profitability of furnishing services. One reason that different services have varying opportunities for profit is their prices. In some instances, prices for services have been set too high relative to costs. For example, MedPAC and CMS have raised issues about the equipment use rate assumptions for imaging services. This rate may be set too low for some imaging services, meaning that Medicare's payment rate is set too high for these services.

To the extent that the Medicare's sustainable growth rate (SGR) system limits growth in aggregate physician spending, differences in the rate of volume increases across services mean that certain types of services—such as imaging—are capturing a growing portion of Medicare physician spending at the expense of other services. As discussed below, the Commission has expressed particular concern about the tendency of primary care services to become undervalued relative to procedural services over time. This creates disincentives to furnish primary care services and over time can affect the willingness of physicians to enter the primary care specialties. (For more discussion of this issue, see p. 13.) Based on the

RUC's recommendation, CMS recently increased the work relative values of many evaluation and management services. Because the fee schedule changes are implemented in a budget-neutral manner, their impact is partially limited.

Given the importance of accurate payment, the Commission concluded in the March 2006 report to the Congress that CMS must improve its process for reviewing

the work relative values of physician services. CMS looks to the RUC to make recommendations about which services should be revalued. But the RUC's three reviews—completed in 1996, 2001, and 2006—recommended substantially more increases than decreases in the relative values of services, even though one might expect many services to become overvalued over time. We have noted that physician specialty societies have a financial stake in the process and therefore have little incentive to identify overvalued services. Although we recognize the valuable contribution the RUC makes, we concluded in our 2006 report that CMS relies too heavily on physician specialty societies, which tend to identify undervalued services without identifying overvalued ones. We found that CMS also relies too heavily on the societies for supporting evidence.

To maintain the integrity of the physician fee schedule, we recommended that CMS play a lead role in identifying overvalued services so that they are not overlooked in the process of revising the fee schedule's relative weights; we also recommended that CMS establish a group of experts, separate from the RUC, to help the agency conduct these and other activities. This recommendation was intended not to supplant the RUC but to augment it. To that end, the new group should include members who do not directly benefit from changes to Medicare's payment rates, such as physicians who are salaried, retired, or serve as carrier medical directors and experts in medical economics and technology diffusion. The Commission has also urged CMS to update the data and some of the assumptions it uses to estimate the practice expenses associated with physician services.

In addition, we recommended that the Secretary, in consultation with the expert panel, initiate reviews of services that have experienced substantial changes in volume, length of stay, site of service, and other factors that may indicate changes in physician work. For example, when a service becomes easier, quicker, or less costly to perform, physicians may be able to provide more of it. Rapid growth in volume for a specific service may therefore signal that Medicare's payment for that service is too high relative to the time and effort needed to furnish it. The Secretary could examine services that show rapid volume increases per physician over a given period. Volume calculations would need to consider changes in the number of physicians furnishing the service to Medicare beneficiaries and in the hours those physicians work. CMS could use the results from these analyses to flag services for closer examination (by CMS or by the RUC) of their relative work values. The RUC could also conduct such volume analyses when making its work value recommendations to CMS, but its current process (every five years) may not be timely enough to capture services with rapid increases in volume.

Alternatively, the Secretary could automatically correct such misvalued services, and the RUC would review the changes during its regular five-year review. In this scenario, CMS would identify specific service codes with volume increases exceeding a standard, such as average historical growth. The Secretary of Health and Human Services would then automatically adjust work values for these codes down. The RUC would consider the changes as part of their next five-year review.

Corrections to the practice expense values may also be in order. MedPAC is currently studying the impact of CMS's recent changes to the fee schedule practice expense calculation, including the use of newer practice cost data from some, but not all, specialties. We are also analyzing equipment pricing assumptions that are used to derive the practice expense values, particularly for imaging services. Ensuring that practice expense values are accurately priced reduces market distortions that make some services considerably more profitable than others, thus creating financial incentives to provide some services more than others.

Finally, revisiting the conceptual basis of the resource-based Relative Value Scale system may be in order. Some observers suggest that the pricing of individual services should account not just for time, complexity, and other resources but also for the value of the service and the price needed to ensure an adequate supply.

Measuring resource use and providing feedback

Elliott Fisher and others have found that Medicare beneficiaries in regions of the country where physicians and hospitals deliver many more health care services do not experience better quality of care or outcomes, nor do they report greater satisfaction with their care. Thus, the nation could spend less on health care, without sacrificing quality, if physicians whose practice styles are more resource intensive reduced the intensity of their practice.

In the March 2005 report to the Congress, the Commission recommended that CMS measure physicians' resource use over time and share the results with physicians. Physicians would then be able to assess their practice styles, evaluate whether they tend to use more resources than their peers or what evidence-based research (when available) recommends, and revise their practice styles as appropriate. More-

over, when physicians are able to use this information in tandem with information on their quality of care, they will have a foundation for improving the value of care beneficiaries receive.

Private insurers increasingly measure physicians' resource use to contain costs and improve quality. Evidence on whether measuring resource use contains private sector costs is mixed and varies depending on how the results are used. Providing feedback on use patterns to physicians alone has been shown to have a statistically significant, but small, downward effect on resource use. However, John Eisenberg found that, when feedback is paired with additional incentives, the effect on physician behavior can be considerably larger.

Medicare's feedback on resource use has the potential to be more successful than previous experience in the private sector. As Medicare is the single largest purchaser of health care, its reports should command greater attention. In addition, because Medicare's reports would be based on more patients than private plan reports, they might have greater statistical validity and acceptance from physicians. Confidential feedback of the results to physicians might induce some change. Many physicians are highly motivated individuals who strive for excellence and peer approval. If identified by CMS as having an unusually resource-intensive style of practice, some physicians may respond by reducing the intensity of their practice. However, confidential information alone may not have a sustained, large-scale impact on physician behavior.

Using results for physician education would provide CMS with experience using the measurement tool and allow the agency to explore the need for refinements. Similarly, physicians could review the results, make changes to their practice as they deem appropriate, and help shape the measurement tool. Once greater experience and confidence were gained, Medicare could use the results for payment—for example, as a component of a pay-for-performance program (which rewards both quality and efficiency). Alternatively, Medicare could use the results to create other financial incentives for greater efficiency or could make the results public to enable beneficiaries to identify physicians with high-quality care and more conservative practice styles. Eventually, collaboration between the program and private plans could result in the development of a standard report card.

MedPAC has been conducting research using episode grouping tools for the past two years and has found that they may be a promising tool for measuring resource use among physicians. We have found that the vast majority of Medicare claims can be assigned to an episode, and that most episodes can be attributed to a responsible physician. Once episodes are assigned to a responsible physician, each physician's spending for a given episode can be compared to that of his or her peers and the results aggregated into an overall "score." Episode groupers also permit analysis of the reasons for higher or lower resource use: Each episode can be subdivided into its component costs (e.g., hospital inpatient admissions, diagnostic testing, physician visits, post-acute care).

Additional research remains, however, to ensure that resource use measurement consistently groups claims into episodes and attributes episodes to physicians in a manner that correctly classifies physicians as high, average, or low users of resources. We also want to integrate quality measures into our comparisons of resource use. Adequate risk adjustment is crucial to ensure that episode grouping tools are measuring actual variation in resource use rather than variation in the health status of the beneficiaries being treated. Further, we and others have found significant variations in practice patterns for some conditions across the nation. As a first step it may be prudent to hold physicians to a local standard (e.g., metropolitan statistical area or state) rather than a national one and to compare physicians only to others in the same specialty. For example, in our March 1 report to the Congress on the SGR, we compare a selected cardiologist in Boston to his local peers for his treatment of a specific condition (Table 1). In this way, we control for some of the differences in practice patterns and patient health status that can drive resource use.

TABLE 1. HYPERTENSION EPISODE RESOURCE USE AND SCORES BY TYPE OF SERVICE

	Total	E&M	Procedures	Imaging	Tests	Other
Stage 1 hypertension						
Selected Boston cardiologist	$623	$359	$4	$50	$118	$92
All Boston cardiologists	357	206	6	32	83	28
Selected Boston cardiologist's resource use score	1.74	1.74	0.67	1.56	1.39	3.29

Note: E&M (evaluation and management). Stage indicates the progression of the disease, with 1 being the mildest form. Resource use score is the ratio of the cardiologist's resource use to the average for cardiologists in Boston.

Source: MedPAC analysis of 100 percent sample of 2001—2003 Medicare claims using the Medstat Episode Group grouper from Thomson Medstat.

Encouraging coordination of care and the use of care management processes

The Commission has explored multiple strategies to provide incentives for high-quality, low-cost care and thus improve value in the Medicare program. However, even if individual providers are efficient, a beneficiary may still receive less-than-optimal care if providers do not communicate well with each other or if they do not monitor patient progress over time. To address this problem, we have considered ways to promote care coordination and care management by creating incentives for providers to share clinical information with other providers, monitor patient status between visits, and fully communicate with patients about how they should care for themselves between physician visits.

While many patients could benefit from better coordination of care and care management, the patients most in need are those with multiple chronic conditions and other complex needs. Gerard Anderson found that, in 2001, 23 percent of Medicare beneficiaries had five or more chronic conditions and accounted for 68 percent of program spending. But according to researchers at RAND, beneficiaries with chronic conditions do not receive recommended care and may have hospitalizations that could have been avoided with better primary care. Studies attribute this problem to poor monitoring of treatment—especially between visits—for all beneficiaries and to a general lack of communication among providers. Physician offices, on their own, struggle to find time to provide this type of care, and few practices have invested in the necessary tools—namely, clinical information technology (IT) systems and care manager staff. At the same time, beneficiaries may not be educated about steps they can take to monitor and improve their conditions. Coordinated care may improve patients' understanding of their conditions and compliance with medical advice and, in turn, reduce the use of high-cost settings such as emergency rooms and inpatient care. Ideally, better care coordination and care management will improve communication among providers, eliminating redundancy and improving quality.

Research suggests that, without the support of IT and nonphysician staff, physicians can only do so much to improve care coordination. Individual physicians may not have the time or be well suited to provide the necessary evaluation, education, and coordination to help beneficiaries, especially those with multiple chronic conditions. One study found that older patients with select conditions that require time-consuming processes, such as history taking and counseling, are at risk for worse quality of care. Further, physicians may lack training or resources that would allow them to educate patients about self-care or to set up systems for monitoring between visits. Physicians' use of basic care management tools is low, even in group practices where building the infrastructure for care coordination, including the use of clinical IT, may be more feasible.

Care coordination is difficult to accomplish in the FFS program because it requires managing patients across settings and over time, neither of which is supported by current payment methods or organizational structures. Further, because patients have the freedom to go to any willing physician or other provider, it is difficult to identify the practitioner most responsible for the patient's care, especially if the patient chooses to see multiple providers. The challenge is to find ways to create incentives in the FFS system to better coordinate and manage care.

In our June 2006 report to the Congress, the Commission outlined two illustrative care coordination models for complex patients in the FFS program: (1) Medicare could contract with providers in large or small groups that are capable of inte-

grating the IT and care manager infrastructure into patient clinical care, and (2) CMS could contract with stand-alone care management organizations that would work with individual physicians. In the second model, the care management organization would have the IT and care manager capacity.

In either model, payment for services to coordinate care would depend on negotiated levels of performance in cost savings and quality improvements. Given that Medicare faces long-term sustainability problems and needs to learn more about the most cost-effective interventions, the entities furnishing the care managers and information systems should initially be required to produce some savings as a condition of payment. However, demonstrating continued savings may not be necessary or feasible once strategies for coordinating care are broadly used.

To encourage individual physicians to work with care coordination programs, Medicare might pay a small monthly fee to a beneficiary's personal physician or medical group for time spent coordinating with the program. As with other fee schedule services, these expenditures would be accommodated by reallocating dollars among all services in the fee schedule.

In either model, patients would volunteer to see a specific physician or care provider (e.g., a medical group or other entity) for their care. CMS could help beneficiaries identify the physician or physicians who provide most of their care. Beneficiaries could then designate the practitioner they wanted to oversee most aspects of their care to be the contact with the care management program. The physician and the beneficiary would agree that the beneficiary would consult first with that physician but would not be restricted to seeing only that physician. The physician, or the medical group on behalf of the practitioner in the case of a provider-based program, would receive the monthly fee when the beneficiary enrolls in the care management program. This designated physician (which need not be a primary care physician, because a specialist might be the appropriate person for patients with certain conditions) would serve as a sort of medical home.

These models do not represent the only ways care coordination might work in Medicare. The American College of Physicians recently advocated using advanced medical homes. In addition, other strategies, such as pay for performance, complement care coordination models by focusing on improving care. In addition, adjusting Medicare's compensation to physicians to reflect the longer time spent caring for patients with complex issues may be warranted if the current fees do not compensate for this extra time. (For example, CMS could apply a multiplier to the relative value of certain services for identified patients with multiple chronic conditions.) Medicare could also establish billing codes to enhance payments for chronic care patients for services such as case management. The Medicare Health Care Quality Demonstration, which tests the ability of innovative payment arrangements for providers in integrated delivery systems to improve quality, may provide further models for improving coordination of care.

Evidence shows that care coordination programs improve quality, particularly as measured by the provision of necessary care. Evidence on cost savings is less clear and may depend on how well the target population is chosen. When cost savings are shown, they are often limited to a specific type of patient, the intervention used, or the time frame for the intervention. Indeed, researchers at Mathematical have suggested that cost and quality improvements are more likely to be achieved if programs are specifically targeted and the interventions are carefully chosen to benefit the targeted patient group. If care coordination programs work, annual spending may decrease, but beneficiaries may live longer with a better quality of life—a positive outcome for Medicare beneficiaries, but the Medicare program may not spend less than it otherwise would have. This possibility argues for assessing programs on the basis of whether they provide the interventions known to be effective or achieve certain quality improvements rather than on the basis of cost savings.

Promoting the use of primary care

Research shows that geographic areas with more specialist-oriented patterns of care are not associated with improved access to care, higher quality, better outcomes, or greater patient satisfaction. Cross-national comparisons of primary care infrastructures and health status have demonstrated that nations with greater reliance on primary care have lower rates of premature deaths and deaths from treatable conditions, even after accounting for differences in demographics and gross domestic product. Increasing the use of primary care in the United States, therefore, and reducing reliance on specialty care, could improve the efficiency of health care delivery without compromising quality.

But many observers worry that the United States is not training enough primary care physicians. Indeed, the growth in the supply of physicians in recent decades has occurred almost solely due to growth in the supply of specialists, while the sup-

ply of generalists—family physicians, general practitioners, general internists, and pediatricians—has remained relatively constant. A study by Perry Pugno and others found that the share of U.S. medical graduates choosing family medicine fell from 14 percent in 2000 to 8 percent in 2005. A 2006 study by Colin West and others found that 75 percent of internal medicine residents become subspecialists or hospitalists. There are many reasons why an increasing number of physicians choose to specialize, but one factor may be differences in the profitability of services.

Historically, Medicare's payment system has valued primary care services less highly than other types of services. For example, according to a recent *Annals of Internal Medicine* article by Thomas Bodenheimer and others, the 2005 fee for a typical 30-minute physician office visit in Chicago was $90 while the fee for an outpatient colonoscopy, also about 30 minutes, was $227. In addition, primary care services also may be more likely than other services to become undervalued over time. While other types of services become more productive with the development of new techniques and technology, primary care services do not lend themselves as easily to these gains. Primary care is largely composed of cognitive services that require that the physician spend time with the beneficiary. In addition, many beneficiaries have multiple chronic conditions and a compromised ability to communicate with and understand their physician, both of which increase the time required for visits. It is difficult to reduce the length of these visits without reducing quality. (For that reason, physicians also find it difficult to increase the volume of primary care services furnished in a work day.) Over time, the specialties that perform those services may become less financially attractive.

Some Commissioners have argued that the relative value units of the physician fee schedule should be at least partly based on a service's value to Medicare. Such an approach would focus on primary care services as well as other valuable services. For example, if analysis of clinical effectiveness for a given condition were to show that one service were superior to an alternative service for a given condition, then Medicare's process of setting relative values might reflect that. This process would be a significant departure from the established method of setting relative values based only on the time, mental effort, technical skill and effort, psychological stress, and risk of performing the service.

In the longer term, the Commission is concerned that the nation's medical schools and residency programs are not adequately training physicians to be leaders in shaping and implementing needed changes in the health care system. Physician training programs must emphasize a new set of skills and knowledge. For example, programs need to train residents to measure their performance against quality benchmarks, use patient registries and evidence-based care guidelines, work in multidisciplinary teams, manage the hand-off of patients, and initiate improvements in the process of caring for patients to reduce medication and other costly errors. Policymakers may want to consider tying a portion of the medical education subsidy to specific programs or curriculum characteristics that promote such educational improvements. In addition, policymakers may want to consider policies that promote the education of primary care providers and geriatricians. Bear in mind that physicians' motivations to enter certain specialties go beyond income, including lifestyle concerns and professional interests.

Medicare's cost-sharing requirements provide no encouragement for beneficiaries to seek services, when appropriate, from primary care practitioners instead of specialists, unlike most cost sharing in the under-65 market, where primary care copayments are often lower than those for specialists. Medicare's payment policies and cost-sharing structure need to be aligned to encourage the use of primary care. The Commission's pay-for-performance and care coordination recommendations could also encourage the use of primary care.

Bundling to reduce overuse

A larger unit of payment puts physicians at greater financial risk for the services provided and thus gives them an incentive to furnish and order services judiciously. Medicare already bundles preoperative and follow-up physician visits into global payments for surgical services. Candidates for further bundling include services typically provided during the same episode of care, particularly those episodes for conditions with clear guidelines but large variations in actual use of services, such as diabetes treatment.

Bundled payments could lead to fewer unnecessary services, but they could also lead to stinting or unbundling (e.g., referring patients to other providers for services that should be included in a bundle). Medicare should explore options for increasing the size of the unit of payment to include bundles of services that physicians often furnish together or during the same episode of care, similar to the approach used in the hospital inpatient prospective payment system.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) changed the way Medicare pays for dialysis treatments and dialysis drugs. However, the MMA did not change the two-part structure of the outpatient dialysis payment system. One part is a prospective payment called the composite rate that covers the bundle of services routinely required for dialysis treatment; the other part includes separate payments for certain dialysis drugs, such as erythropoietin, iron, and vitamin D analogs that were not available when Medicare implemented the composite rate. Providers receive the composite rate for each dialysis treatment provided in dialysis facilities (in-center) or in patients' homes.

The Commission has recommended that the Congress broaden the payment bundle to modernize this payment system. Medicare could provide incentives for controlling costs and promoting quality care by broadening the payment bundle to include drugs, laboratory services, and other commonly furnished items that providers currently bill separately and by linking payment to quality.

A bundled rate would create incentives for providers to furnish services more efficiently. For example, a bundled rate would remove the financial incentive for facilities to overuse separately billable drugs under the current payment method. In addition to an expanded bundle, changing the unit of payment to a week or a month might give providers more flexibility in furnishing care and better enable Medicare to include services that patients do not receive during each dialysis treatment.

MedPAC is examining bundling the hospital and physician payments for a selected set of diagnosis related groups (DRGs), which could increase efficiency and improve coordination of care. This approach to bundling could be expanded in the future to capture periods of time (e.g., one or two weeks) after the admission but likely to include care (e.g., post-acute care, physician services) strongly related to the admission, further boosting efficiency and coordination across sites of care. Bundled payments could be adjusted to provide incentives for hospitals and physicians to avoid unnecessary readmissions. Bundling services could be structured so that savings go to the providers, the program, or both. The Commission is also examining bundling physician payments with payments for other providers, such as hospital outpatient departments and clinical laboratories. In addition, MedPAC plans to examine the physician services furnished to patients before, during, and after inpatient hospitalizations for medical DRGs to assess whether a global fee should be applied to these services, as it is for surgical DRGs.

Hospital readmissions are sometimes indicators of poor care or missed opportunities to better coordinate care. Research shows that specific hospital-based initiatives to improve communication with beneficiaries and their other caregivers, coordinate care after discharge, and improve the quality of care during the initial admission can avert many readmissions. Medicare does not reward these efforts. In fact, the program generally pays for readmissions, creating a disincentive to avoid them. To encourage hospitals to adopt strategies to reduce readmissions, policymakers could consider requiring public reporting of hospital-specific readmission rates for a subset of conditions and adjusting the underlying payment method to financially encourage lower readmission rates.

Episode grouper software, which is used to measure physician resource use and was discussed earlier, could also serve as a platform for bundling services for selected conditions.

Linking payment to quality

Medicare, the single largest payer in the U.S. health care system, pays all health care providers without differentiating on the basis of quality. Those providers who improve quality are not rewarded for their efforts. In fact, Medicare often pays more when poor care results in complications that require additional treatment.

To rectify this situation, MedPAC has recommended that Medicare change the incentives of the system by basing a portion of provider payment on performance. We recommended that CMS start by collecting information on structural measures associated with use of IT, such as whether a physician's office tracks whether patients receive appropriate follow-up care, and claims-based process measures for a broad set of conditions important to Medicare beneficiaries. At the outset, CMS should base rewards only on the IT structural measures, with claims-based process measures being added to the pay-for-performance program within two to three years. Two other structural measures—certification and education—could become part of a measure set, but the link with improved care would need to be clear. The program should be funded initially by setting aside a small portion of budgeted payments—for example, 1 percent to 2 percent. The program should be budget neutral; all monies set aside would be redistributed to those providers who perform as required.

The Institute of Medicine (IOM) and MedPAC have stated that, ideally, pay-for-performance measures should be developed and used for all physician service pro-

viders to create incentives to provide better quality care. However, currently we do not have well-established measures for all providers of physician services. Thus, initially, policymakers might consider prioritizing the implementation of some pay-for-performance measures over others. Focusing measures on high-cost, widespread, chronic conditions (e.g., congestive heart failure) might be a good short-term strategy that will maximize benefits to the Medicare program and to beneficiaries. Further, measures that reflect coordination between health sectors will encourage and reward communication between providers, which may improve patient outcomes and reduce Medicare costs. The Commission considers that pay-for-performance initiatives would be implemented in a budget-neutral manner.

IOM and MedPAC assessments of the current state of quality measurement are similar. The indicators that are available now could form a starter quality measurement set. However, the measures that are currently available are fragmented across different users for different purposes and cannot be tied explicitly to the overarching, national goals laid out by IOM. Composite scores that could bring together multiple measures of different aspects of quality into a meaningful summary are needed, but judging the relative value of competing goals that would underpin such a summary is a challenge.

Both IOM and MedPAC have recommended that a national entity is needed to:

- set and prioritize the goals of the health care system;
- monitor the nation's progress toward these goals;
- ensure the implementation of data collection, validation, and aggregation;
- coordinate public and private efforts at local, state, and national levels;
- establish public reporting methods;
- identify and fund development of the measures; and
- evaluate the impact of quality improvement initiatives.

Encouraging the use of comparative-effectiveness information

Increasing the value of the Medicare program to beneficiaries and taxpayers requires knowledge about the costs and health outcomes of services. Comparative-effectiveness information, which compares the outcomes associated with different therapies for the same condition, could help Medicare use its resources more efficiently. Comparative effectiveness has the potential to identify medical services that are more likely to improve patient outcomes and discourage the use of services with fewer benefits. CMS already assesses the clinical effectiveness of services when making decisions about national coverage and paying for certain services. But to date FFS Medicare has not routinely used comparative information on the costs of services, although Medicare Part D plans and other payers and providers, such as the Veterans Health Administration, do use comparative information (e.g., in drug formulary decision-making processes).

Medicare could use comparative-effectiveness information in a number of ways to improve the quality of care beneficiaries receive. Medicare could use such information to inform providers and patients about the value of services, since there is some evidence that both might consider comparative-effectiveness information when weighing treatment options. Medicare might also use the information to prioritize pay-for-performance measures, target screening programs, or prioritize disease management initiatives. In addition, Medicare could use comparative-effectiveness information in its rate-setting process or in coverage decisions.

Given the potential utility of comparative-effectiveness information to the Medicare program, an increased role of the Federal Government in sponsoring the research is warranted. In our forthcoming June report, MedPAC will recommend that the Congress should establish an independent entity whose sole mission is to produce and provide information about the comparative effectiveness of health care services. The entity should set priorities and standards for new clinical- and cost-effectiveness research, examine comparative effectiveness of interventions over time and disseminate information to providers, patients, and federal and private health plans. The entity could be funded jointly by the Federal Government and the private sector, with an independent board of experts overseeing the development of research agendas and ensuring that research is objective and methodologically rigorous.

Using standards to ensure quality

CMS has set standards to ensure minimum qualifications for various types of providers (e.g., hospitals and skilled nursing facilities), but there are few examples of federal standards that apply to physician offices. The Commission has recommended that such standards be implemented for physicians who perform and interpret imaging studies. This recommendation was motivated by rapid growth in the volume of imaging. This growth was driven in part by imaging being increasingly provided in physician offices rather than in facility settings. (The growth is not fully offset with

a corresponding decrease in imaging use in facilities.) The lack of quality standards for imaging conducted in physician offices raises a number of quality concerns. Therefore, the Commission recommended standards for physicians, facilities, and technicians that perform imaging studies. In the future, other types of services may be candidates for such standards.

Chairman STARK. Thank you all. If I can divide this discussion into two parts. We have the question of the payment per procedure and then volume. Glenn, you suggested that if we had the wrong payment for a procedure we can influence volume up or down, depending on where it is. Mr. Steinwald talks about whether we have enough information to really identify individual physician's behavior relative to volume. Is that what you told us?

Mr. STEINWALD. Yes, sir. Primarily through the 800 million claims that Herb Kuhn referred to earlier.

Chairman STARK. Now, Mr. Kuhn, are those 800 million claims—that's a year?

Mr. KUHN. That is correct. Every year.

Chairman STARK. Are they all digitized? I mean, can you slice and dice those on your laptop so you could give me all kinds of information in specifics, down to specific physicians in specific neighborhoods? Is it a pretty comprehensive database?

Mr. KUHN. It is that comprehensive, and we hope to be able to do exactly what you said, be able to get it down by physician and area.

Chairman STARK. Then let me make a suggestion and see whether you agree or disagree. I think we're a lot closer to identifying or being able to accept both by the providers and us and CMS and the taxpayers the individual procedure payments, recognizing that we may get it wrong. But there's been a lot more agreement—what disagreement comes, and we can let physicians fight that out among themselves. Certainly we're not capable of deciding that. That the bigger problem that has occurred me is how do we control what's referred to as volume?

So, I guess I'd start with Mr. Steinwald. Do we have enough information and do we have the mechanical or computer ability to actually adjust volume on a basis of individual practitioners? Can we get down that fine?

Mr. STEINWALD. My first response is yes, I think we have sufficient information certainly to begin a process of providing feedback to physicians. And——

Chairman STARK. I didn't say the feedback. How about money?

Mr. STEINWALD. Well, the first question is, will the feedback in itself create a behavioral response that will achieve program savings? I'd like to think that if the program were rolled out in large scope and conducted properly that it would. But I think the other shoe that has to drop is that if you want to get the full benefit, there need to be incentives that go with the profiling.

Chairman STARK. Okay. Let me just say it a little bit different way. We could probably go back to the old volume performance, and let's assume that we're about close enough for government work to the procedural payment, per procedure. So, that if volume is our big—and particularly in things like diagnostic imaging, things like that, which seem to go off the charts, we could take

groups, physicians in a state—let's take radiologists, across the country. We could narrow it, I suppose, to statistical areas. Or we could drill down to the individual radiologist. My guess is that we're not quite ready to do that in the next few months for us to legislate.

But would it make sense to—are we at a place where we could start that? Get out immediately the information to groups of physicians such as peers are doing in terms of volume, and then begin to refine that to see whether we could get a more sophisticated method than just every radiologist in the country, if they go above a certain amount, cutting the fees by a certain amount, perhaps adjusting that so that those who are—become outliers get a large reduction than those who perhaps are judicious in their utilization? Is that—do we have the data and the technical ability to approach that?

Mr. STEINWALD. I believe we do. There are those who will argue that our system for adjusting for patient health status is imperfect and needs to be improved. But our position is that there is sufficient data and tools there to begin the process.

Chairman STARK. Mr. Kuhn, can—are you ready to do that for us next week?

Mr. KUHN. We've been doing a lot of work in this area and on evaluation, and I would like to think that, with the proper authority and resources, we could be in a position sometime mid-'08 to begin putting that kind of information——

Chairman STARK. You're kidding?

Mr. KUHN. Yeah. I don't want to have a sense of bravado here that, you know, we can perform miracles, but I think——

Chairman STARK. What kind of resources would you need from us——

Mr. KUHN. I'm not sure——

Chairman Stark [continuing]. Or legislation even?

Mr. KUHN. I'm not sure of the resources. I think that's something we'd like to talk to the Committee, about but to give you a sense here, I mean, to churn the data is probably the smallest part. Really, we've got to clean the data and make sure it's good. It's the old issue of ″garbage in, garbage out. So, we've got to make sure″ it's good, clean data and it works.

The fact that we've got 700,000 physicians, depending on how fast and how frequently we want to give reports—is it monthly, is it quarterly? That cost to get the resources out to them, and then, ultimately, get it in the hands of physicians. You just don't want to drop it at their doorstep. There's got to be some kind of educational program around that.

It's what Bruce—and I think, Glenn—have both talked about—How do they compare to their peers, and what kind of program. Are there educational tools we can provide? Are there educational tools that will help facilitate data exchange and physician specialists can provide? Do we engage the QIOs, for example, to come in and work with physicians so they can understand it so that it's actionable once they are able to receive it?

So, I think we're talking a package like that, and that's something we'd like to talk further with you and the Committee about.

Chairman STARK. Glenn, I know you're not in as much—in terms of volume containment, but how does this strike you?

Mr. HACKBARTH. Well, we did recommend a couple of years ago now that Medicare move down this path of using tools that are widely used in the private sector to assess physician practice patterns. We think they can be an effective tool for altering those patterns, both initial information feedback, but ultimately through changes in payment. So I largely agree with what Bruce and Herb have said on that.

The other point that I would like to raise, Mr. Chairman is that looking at price adjustments can be an important tool in addressing the volume issue. Let me take the area of imaging. As you well know, as the Committee well knows, a lot of the growth in imaging is great stuff. It's improving care for patients, and for sure we don't want to stop that. On the other hand, there is some reason for concern that some of the growth is not very high value care.

There are ways that we might approach the pricing of imaging services that would automatically result in some price reductions on rapidly growing services and create a rebuttal presumption, if you will, that the costs of providing those services are falling with the rapid growth. That's what happens in most parts of the economy. What happens now in Medicare is prices are set at a given level for new stuff, and they often stay at a high level and they're never adjusted downward.

So, building some mechanisms into the program that would facilitate price adjustment, and there is a rapid growth and rapid dispersion of new technology, we think would be the fairer system in relative prices and help address volume.

Chairman STARK. Do you have the resources at MedPAC to monitor this as—enough to create a system. I know you can study it from time to time, but do you have the resources to continuously monitor that and adjust for what I would call productivity gains in areas where we should be getting a lower price because it takes less time or it's done?

Mr. HACKBARTH. Well, ultimately, we think that the responsibility for ongoing monitoring needs to reside in CMS.

Chairman STARK. Yes.

Mr. Hackbarth. We've made some proposals, in fact, on how to augment their resources and their process, bring in some experts to help them do that.

Chairman STARK. I thank you. I thank all of you. Mr. Camp?

Mr. CAMP. Well, thank you, Mr. Chairman. Again, thank you all for coming. Obviously, Mr. Steinwald, you've said that health needs alone haven't been determining spending, and clearly with Medicare spending on physicians increasing at 9 percent per year and certain distortions based upon the value of services occurring in the market, you're suggesting that an analyzation of claims data will help address this issue.

I guess my question for all of you is if you look at claims data alone, that can tell us the volume of services provided certainly, but how do we address the issue of medical necessity? If you each want to answer that.

Mr. STEINWALD. It's essential in a profiling system to recognize variations in patient needs. But the point that we made in our re-

port and the testimony to you is that there are tools that enable one to do that. In a study that we conducted, for example, we divided patients into 30 cohorts based on their health status. Their health status was measured in terms of their diagnoses, their chronic diseases and some demographic characteristics.

So, when we examine—we identified physicians who appear to be practicing medicine inefficiently, we were attempting to hold health status constant. Health status is our measure of the degree of patient need. So, we think that the tools are there and sufficient to at least go forward with a feedback program, and then during the time that the feedback program is in effect, these tools can be refined.

Mr. CAMP. All right. Mr. Kuhn.

Mr. Kuhn. I agree with Bruce. I think the necessity issue is there in terms of the Codes that we use, the Codes that we have, and the way we have to go back and look at the claims that come through the system.

Obviously, we have opportunities with both the QIOs and with our contractors to go back and follow up with providers to make sure that the care that is given appropriate and necessary. But I agree with him. The fact that once you begin to put together these episodes and begin to look at them, I think that it gets to the core function of—Are we having a lot of overuse of services here, and do we have people who are operating outside the norm? I think that would give us additional tools to be able to look at that.

Mr. CAMP. You're really thinking of practice patterns here, I think, is what I hear you saying?

Mr. KUHN. I think, it's kind of a two-part. One would be on evidence-based guidelines and certainly practice patterns based on good evidence. But at the same time, you don't want to be so restrictive that you eliminate the art of medicine and don't allow physicians to deal with different patients who have different characteristics. So, finding that fine line is going to be key for us here, but I think we could do that.

Mr. CAMP. All right. Mr. Hackbarth.

Mr. HACKBARTH. Yeah. I have a couple of points, Mr. Camp. One is that what MedPAC envisions, recommends is that the system look not just at the cost of the care provided, but also integrate into the system quality measures. So, what we want to do ultimately is to award physicians who are truly efficient; namely, providing high quality care at a lower cost. So, we need to have both cost and quality in the analysis.

Second, as an initial step, what we envision is that the comparison could be to peers by specialty within their geographic area to increase the comfort level among physicians that they're being compared to a reasonable target. So, it would be a cardiologist in Boston compared to other cardiologists in Boston. Here's how you fare. We've actually provided some examples of how those data look in some of our reports.

The third point I make is that we do need to, for the long run, find research on what works so we can better evaluate practice patterns so we know what's good and what's bad. That's a long-term project, and that's why we think it's important to increase funding for that effort as soon as possible.

Mr. CAMP. All right. Thank you. Mr. Kuhn, where is the CMS physician quality reporting initiative implementation going? How is that going?

Mr. KUHN. We're moving along very well on that. As I think people know, it begins in July and will allow physicians to report quality measures. We have 74 measures that we've posted on the website already, with good descriptors on each, and we're ahead of the timeline on that. Physicians will be reporting in July for the 6 months till the end of the year, and then with a payment differential of up to 1.5 percent in the next year.

So far, I think development of the measures, the good collaboration of the physicians has gone well. Where we're spending most of our time right now is in developing good educational information and outreach to the physician community. We don't want anybody to be left behind or to not understand how to participate in this program. So we think with our ten regional offices, good support from the AMA and the other physician specialty groups out there, we've done some extensive outreach. So I feel pretty good about where we are at this stage. As the issues come up, we try to address them. I think the real test will probably be in September or October when we start to get the initial reports back and see how many physicians are reporting and whether we have any glitches in system. But for right now, we feel very secure about where we are in the development and implementation.

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

Chairman STARK. Ms. Tubbs Jones, would you like to inquire?

Ms. TUBBS JONES. Mr. Chairman, yes I would. Thank you very much. Good morning, gentlemen. This is my first service on the Subcommittee on Health, and I'm reading through one of the reports. It, for some reason, some of this stuff seems to make it out like it's rocket scientist. We all understand that primary care to a senior is what will make them hopefully live longer and the coordination of their benefits will hopefully make the dollar go through—stretch out or have greater value. Is this rocket scientist you're putting forth in this report or is it something that we've always known but we've not been able to reach it in the Medicare Program?

Mr. Hackbarth, I think this is your report I'm referring to.

Mr. HACKBARTH. Yeah. Well, I suppose sometimes we do try to make things complicated, but we try to be precise and analytic. There is a lot of evidence that good primary care improves results to patients and perhaps even saves money. I think the real challenge is how to operationalize that.

Ms. TUBBS JONES. Would you say, then, that in the United States where we have the greatest health care in the world, is it the delivery of the health care that we're not able to put our arms around to provide the kind of health care that people need in the United States?

Mr. HACKBARTH. Yeah. American health care is wonderful in its sophistication, the technology that's used to provide it. But there are large-scale problems in the delivery of services, problems in getting the right services to the right patients at the right time, large problems with equity and access and the like. So, yeah, our

problems are delivery problems. The financing system often shapes delivery.

Ms. TUBBS JONES. Obviously. My next question is, there is a discussion of a lot of friends that are physicians, a lot of friends that are dentists, and on and on and on, who are saying that the undervaluation of their services is driving them away from rendering care to Medicare beneficiaries. What are we doing to address that particular area? Anybody can answer that question. Mr. Kuhn, I didn't mean that leave you all out.

Mr. KUHN. No, not a problem. You're right. The undervaluation of services also creates a real severe problem in terms of making sure physicians get the correct resources they need and beneficiaries have access to those services.

What happened was——

Ms. TUBBS JONES. Say that again?

Mr. KUHN.One of the things we did last year is that every 5 years by statute, we're supposed to go back and look at the physician payment system to make sure that the relative values are set appropriately. It's called the 5-year review. It's managed by the AMA's Relative Value Update Committee, also known as the RUC.

The good thing and the exciting thing that happened last year is they came back with a set of recommendations that we had never seen before to actually reward what we call E&M codes or evaluation and management codes—basically, those used predominately by primary care physicians, people who are doing family medicine and others. We increased those substantially, basically saying ″let's pay physicians more for spending time with the patients, talking with the patients, meeting with them.″ And we accepted 100 percent of those recommendations as we went forward.

So, I hope that we'll see this year and next year—we'll move forward the results of that charge because it was probably one of the most significant changes out there in terms of payment in the last decade. It represented real realignment. So, we're making those changes. They're probably not as aggressive as some probably thought they were or should be. But that was a good, significant move and one we were happy to adopt and implement last year.

Ms. TUBBS JONES. Mr. Steinwald, I don't want to leave you. I have one little other area I want to go real quick so we've got probably seconds. So, go ahead.

Mr. STEINWALD. Yes ma'am. In general, the number of services performed for Medicare beneficiaries is up in almost every specialty area and in every part of the country. The trend over this decade has been for more beneficiaries to receive services and each beneficiary getting more services in a period of time.

I won't dispute what Glenn said about the relative valuation of primary care versus specialty care. But the data generally shows that Medicare beneficiaries are receiving services and there are very few places where you can identify what you would regard as an access problem.

Ms. TUBBS JONES. But the real problem, however, may well be the coordination of the services. You've got seniors and doctors who are not talking to one another, and delivery of service is a real problem. I'm probably out of time, but I think—my biggest concern is that we do all this research and all these studies, which are real

important to me, and my seniors are not getting the services that they need. So, somehow I'm asking you to do both. Study but deliver.

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

Mr. RAMSTAD. Thank you, Mr. Chairman. Chairman Hackbarth, both in your written testimony and in your colloquy today with Mr. Camp, you mentioned—discussed what I think is the obvious, that Medicare does not pay providers based on quality or efficiency of care.

I'd like to ask you to elaborate or the other two distinguished panelists, this is nowhere better exemplified than in my home state of Minnesota where physicians provide some of the highest quality and lowest priced, lowest cost care in the country, and instead of being rewarded for providing high quality and low cost care, they're penalized consistently through inequitable payments pursuant to the archaic, arcane, outrageous and unfair AAPCC formula for managed care, and also the geographic adjustments in traditional fee-for-service Medicare.

In my judgment, this—well, both payment systems are perverse, because they perversely reward high cost and inefficiency. Isn't it time—and, again, I welcome your input, Chairman Hackbarth, and you, Mr. Kuhn, and you, Mr. Steinwald—isn't it time to scrap this arcane payment system? Isn't it time for Congress, working with experts like you, to develop a system where we finally are able to reward providers for high quality and lower cost care?

Mr. HACKBARTH. Absolutely. We've over the years proposed a lot of different ways that you might go about doing that. We talked about several of them this morning.

I would say, Mr. Ramstad, though, that given Medicare's long-term financing issues, what we need to do is not bring the low cost, high quality areas up in terms of their expenditure, but rather bring the high cost areas down to where they are. It's an understandable reaction for people to say, well, we're being efficient with the low cost and high quality and those other guys are getting all the money, and we should be getting that money. But a terrible long-term financing problem requires that we move down and not go up.

Mr. RAMSTAD. Recognizing that—pardon my interruption. Recognizing that fact, on that point, there isn't enough money—God doesn't have enough money to do it that way. Certainly Medicare doesn't. So, my fundamental question, the only way we're going to resolve this, isn't it true to say, isn't it fair to say, is by scrapping the present system? We can't do it pursuant to the current system.

Mr. HACKBARTH. Which system?

Mr. RAMSTAD. The AAPCC formula for managed care and the geographic adjustments in traditional fee-for-care.

Mr. HACKBARTH. Well, the Medicare Advantage issue is a separate topic that we've discussed a lot. Again, the basic point that MedPAC made, for example, in our report on the SGR in March, is that if we've got geographic disparities in aggregate expenditures, what we need to do is squeeze the high-cost states down, not bring the low-cost states up. That's what the long-term financing does.

Mr. RAMSTAD. But how do we do that short of scrapping the present formula? How do we do that? That's what I've heard for 12 years here, and then I've heard we can't scrap the present formula because there are more Members, more votes from Florida and New York and California than there are from Minnesota and Iowa and North Dakota and Wyoming, the states that are penalized. So, how we do that short of scrapping the formula?

Mr. HACKBARTH. Well, it would involve scrapping the formula and making significant changes, yes, absolutely.

Mr. RAMSTAD. That's the answer I was looking for, and I appreciate your candor and your recognition of that fact. Do either of you have anything to add?

Mr. KUHN. Just one thing I'd add to that, Mr. Ramstad, is you're absolutely right. The judicious use of resources is absolutely essential to the Medicare Program and how we can put together payment systems that drive us in that direction is key. The issue of the wage index that you raised, one of the things for this Committee to look forward to which will be arriving soon, is that part of the tax relief bill was passed last year was a mandate for a report to Congress on how we develop other alternatives to the wage index.

MedPAC has taken the lead on that. They're going to produce a report I think in June that will be handed off to us, and then we will take that work that they've done and subsequently give a report to Congress. So, the opportunity for further dialog on that issue with some options coming forward is near.

Mr. RAMSTAD. Thank you. Briefly.

Mr. STEINWALD. Back to fee-for-service Medicare. The blunt instrument I referred to earlier that the SGR system poses. If we were able to replace that with programs that recognize individual doctor's adherence to the practice standards, those doctors who do adhere to practice standards will be better off than those that are costing us these big payment increases.

Mr. RAMSTAD. Well, thank you for your expertise, and thank you for your candor. Thank you, Mr. Chairman.

Chairman STARK. Mr. Becerra, I think we'll have time for two more Members to inquire before we have to go vote. Would you like to inquire?

Mr. BECERRA. Yes, Mr. Chairman. Thank you. Gentlemen, thank you for your testimony. Let me step back a second ask you to help me compare what we do in this country with other countries that offer their seniors a universal system of health care.

Tell me what you see as the differences between our system from its initial starting point versus another system that's perhaps comparable. I'm not sure what country would have a system comparable in terms of its population profiles and it's way of administering services and its level of sophistication in services.

So, let's say whether it's Great Britain or Canada, are there any countries that you can use as a base model to compare both our population and our system for providing health care to our seniors? I'd ask you to be as brief as possible so I can then follow up.

Mr. HACKBARTH. Yeah. I'd hesitate to choose any one particular country. I can make some general statements. As is well known, we tend to spend significantly more per capita than even

other wealthy countries. The growth in expenditures, though, tend to be about the same. So, it's not like we're growing dramatically faster than others. They're pretty similar.

There has been some research that shows the major reason for the difference in cost in the U.S. versus other countries is the prices paid for services, prices paid for physician services and hospitals and drugs and the like, tend to be significantly higher, and those translate into a higher income for physicians and all health care professionals in the U.S. than in foreign countries.

Mr. BECERRA. Utilization rates, are they similar?

Mr. HACKBARTH. You know, they vary somewhat. The research I was just referring to about price differences says that, you know, on most important issues of utilization, access to the care and the like, lower-cost countries compare favorably to the U.S. They get access to new technology, et cetera. The big difference is price differentials.

Mr. BECERRA. Mr. Hackbarth, my understanding is, it's sort of what you've just said, is that we typically start our baseline at a higher level than other advanced countries do when it comes to what they're paying for a service. We seem to have a higher utilization rate in some cases of some of the more expensive services that are provided than do other countries. So, we start off already, before the first dollar is out the door, paying more than other advanced countries do for health care for seniors, and we seem to find that the more expensive services are used more often in this country.

Mr. HACKBARTH. Yeah. Perhaps——

Mr. BECERRA. Perhaps our seniors are no better off, in some cases worse off, than the population of seniors in those other countries.

Mr. HACKBARTH. Yeah. We're really generalizing here, and there's always risks in doing that. But often, the U.S., there will be faster access to the new technology, lower thresholds on who qualifies for an expensive new technology, and in many cases, that's a difference and it increases costs in the Medicare system.

Mr. BECERRA. I thank you for that. I hope we explore more what other countries are doing, because other countries have had long-term experience in the ways we have to some degree, in providing universal health care to our seniors. But they certainly seem to do it for a lot less and in many cases, they're outcomes seem to be as good if not better than ours. So, they're getting far more bang for the buck for our seniors.

The other question is, this whole description of the primary physician, gatekeeper, or what's the other term, home?

Mr. HACKBARTH. Medical home.

Mr. BECERRA. The medical home. I know when you talk to some physicians, especially the specialists and they hear the word ″gatekeeper," they get somewhat concerned about what—or how we describe that primary care physician, and they tend to think more in terms of a gatekeeper versus a medical home.

Can you give us a sense of how you get the physician community to feel comfortable that we may move more toward a system of a medical home or gatekeeper?

Mr. KUHN. I'm not sure. You know, this is going to be a maturation process for all of us as we go forward here. We are trying to put together a demonstration on a medical home model right now, and we've been meeting with a lot of the physician groups to help them help us describe what a medical home is. I'll tell you, every physician group you talk to has a different idea. As some people describe it, it almost sounds like a medical lean-to. On the other side of the spectrum, it's almost a medical mansion. But what is a ″medical home″? It's somewhere in the middle. How can you get a good description of that so that you have the coordination of care that you're after?

Mr. BECERRA. Let me ask one last question. My time has expired. Do any of you believe that we can move forward in a productive way with Medicare without coming up with some definition of a ″medical home″ or a gatekeeper system?

Mr. KUHN. I think the ″medical home″ as Glenn laid out through, in his opening remarks, about four different initiatives. It's going to be one of many things we're going to need to explore. I don't think there's a silver bullet here anywhere. But it's one of many things that I think will be helpful to us.

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

Chairman STARK. Ron, do you want to ask a question?

Mr. KIND. Yes. Thank you, Mr. Chairman. We just have a few minutes before we have to run to vote, but we appreciate your testimony today. I personally kind of went through medical home type of process myself, having walked through with my older sister, breast cancer treatment in my hometown in La Crosse. They called it the integrated team approach, but it sounds very comparable where the patient is taken and then instead of just being handed off to physician to physician, there was that team that was formed around her so there was no slipping through the cracks. Let me tell you, for her confidence and reassurance and the whole family, it worked marvelously. Of course the quality of care standards have improved dramatically as well. It's been a real model that they're trying to help other providers throughout the country.

But I just echo and ditto what my friend from Minnesota said earlier in regards to the high quality, low reimbursed areas and the frustration many of our providers have over that. I assume you're all looking at states to see what type of innovative practices they're making to improve quality and reporting requirements. In Wisconsin, for instance, we have since 2004, hospital quality reporting program called Checkpoint. It's a voluntary consortium of providers throughout the state and 128 hospitals are participating. This reflects 99 percent of the hospital admissions, and it's getting information out to the public, and they're holding themselves to some very high standards of care.

Then a year earlier in 2003, Wisconsin formed for the Collaborative for Health Care Quality, which again is another voluntary consortium on establishing quality standards and then a self-reporting mechanism that's available to the public. It seems to be helping drive competition but increasing quality of care. So, I'm hoping that we're paying very close attention to what states are

doing innovatively and creatively to come up with some of the solutions themselves.

The question I have for you, however, and taking a step back from this conversation, something a little more fundamental, because, again, a lot of my providers back home are doing it, is they're instituting lean programs in their hospitals to increase efficiency. Because as I visited a lot of them, and as they tell me, there's a lot of low-lying fruit out there just to increase the way service is being provided and getting doctors to think more efficiently in how they're handling their own practice areas.

Are we looking at that? Or perhaps the better question is, what can we do to incentivize that so more providers are implementing or instituting programs like lean, which seems to be easier to do than Six Sigma, which requires a few more hurdles to do?

Mr. HACKBARTH. Yeah. Actually, we had panel on that very topic I guess a year or so ago and heard from some people actively involved in trying to streamline their system, and heard a couple of things. They think is a potential for both improving quality and patient satisfaction while reducing cost is very large. A significant barrier that they run into, however, is the payment system, not just the one used by Medicare, payment systems used by private payers as well.

Often if you change, you make the system more efficient over here, you may increase costs somewhat over there, and the payment systems don't really properly adjust. So what you end up with is you don't reap rewards of your efforts to improve efficiency.

A generic approach, a generic way of thinking about how to create stronger incentives, is increase the size of the bundles. The larger the bundle the provider has responsibility for, the more flexibility they have to change the mix of inputs, change their processes and still benefit from improvements in efficiencies. If you have narrow bundles, then there's a lot of leakage, and they're not rewarded for their efforts.

Mr. KIND. Well, I'd like to—given the time, we've got to run and go to vote—just follow up with you on that. I'm very interested in trying to pursue it. So, the problem with the reimbursement system that creates disincentives for them to increase their own efficiency, we've got to address that as well. Because the feedback we're getting from our providers who do institute these programs is they are efficient, more efficient. It frees up physician time. They're able to spend more time with their patients, see more patients. The quality of care is being increased, because medical errors are also being reduced at the same time.

So, I think there's a lot of win-win-win as to why we should be doing this. But if there is a disincentive in the reimbursement system, we need to be taking a look at that, too. So, I'd like to just follow up with you at some point, probing this conversation.

Thank you again for being here. Thank you, Mr. Chairman.

Chairman STARK. I want to thank the panel. I'm sorry to rush off. I wish we could—well, I know we'll be back talking with each of you and all of you some more as we try to resolve this. We will recess, subject to the call of the chair, it will be another 20 minutes I guess, and then we'll, for the benefit of the second panel, we'll reconvene.

Thank you very much, gentlemen. We're in recess

[Recess until 12:20 p.m.]

AFTERNOON SESSION

Chairman STARK. Thank the panel for their patience as we proceed to salvage small business from bankruptcy. We'll proceed. We're pleased to have you here. Bob Berenson, Dr. Bob Berenson from the Urban Institute. Dr. Rick Kellerman from the American Association of Family Physicians. Dr. John—you got out of order there, didn't you? Dr. John Mayer, and Dr. Anmol Mahal, my constituent and neighbor in Freemont, California, who is President of the California Medical Association and the Society of Thoracic Surgeons represented by Dr. John Mayer.

If you gentleman would like to proceed to, starting with Dr. Berenson, summarize your printed testimony, I'd ask unanimous consent that your entire testimony will appear in the record. If you'd summarize it in any way you care, and my colleagues will try and weasel more information out of you in the questioning period.

Bob.

STATEMENT OF ROBERT A. BERENSON, M.D., SENIOR FELLOW, THE URBAN INSTITUTE

Dr. BERENSON. Thank you, Mr. Stark, Mr. Camp and Members—well, no other Members of the Committee.

[Laughter.]

Dr. BERENSON. I appreciate the opportunity to provide testimony to the Subcommittee on Health on a subject I have been deeply involved with through most of my professional career as a practicing internist, medical director of a PPO, a senior official at TMS, and now as a researcher and policy analyst.

I believe that this is an important hearing because the focus of the hearing is not on how to use marginal dollars, 1 to 2 percent, to try to influence physician performance, or on paying third-party disease management organizations that are separate from the physicians actually providing the medical care to beneficiaries with chronic conditions, but rather explores how the program might better spend 100 percent base of physician spending to include quality and efficiency.

Many policymakers still use the—or commonly use the term ″fee-for-service Medicare" to designate the original Medicare Program and to distinguish it from the various kinds of Medicare Advantage products. However, this convenient shorthand actually mischaracterizes how the traditional Medicare Program pays providers. In fact, the physician fee schedule is one of the last payment approaches in Medicare that remains truly fee-for-service. Accumulated evidence documents that prospective payments based on episodes of care have moderated cost increases in the traditional Medicare Program.

In contrast, the physician payment system remains fee-for-service, although even the fee schedule, there are significant examples of bundled or packaged payments, as Herb Kuhn discussed in his testimony earlier. These longstanding approaches to bundling can be looked to for guidance on how to expand episode-based payments to physicians.

The program is now experiencing an explosion of volume and intensity growth in some clinical areas. For the first decade or so of the Medicare fee schedule, the evolving expenditure target approach has actually worked reasonably well to constrain spending growth. The situation has clearly changed in the last 6 years, and Congress, with the exception of 2002, has acted to override the across-the-board fee reductions called for under the SGR mechanism.

Because of the volume growth of services that are inherently discretionary in nature and increasingly where physicians have a financial interest, in my opinion there is little question that bundling payments for episodes of care needs to be a primary objective of physician payment reform, just as it has been successful when applied to other providers in Medicare.

I will provide one important example of why moving to bundled payments for physicians, in contrast to fee-for-service, makes good policy sense. The work of Dr. Edward Wagner at the MacColl Institute in Seattle makes this clear. He describes a chronic care model in which the proper management of patients with one or more severe chronic conditions, such as diabetes and congestive heart failure, involves lots of communication with patients outside of standard office visits by phone, and possibly e-mail, care by multidisciplinary professional teams, active use of patient registries and enhanced coordination among professionals and providers practicing in many locations.

In my view, for reasons that are in my written statement, it would be foolhardy to try to pay for most of these additional services on an a la carte basis as fee-for-service does. Episode-based payment not only for primary care physicians but specialists caring for a variety of acute and chronic health care medical problems has an inherent appeal. There will be important in implementation issues that will need be worked through.

I think it is time to recognize that a one-size-fits-all physician payment system may no longer work properly to support the increasing diversity of physician activity that has resulted from subspecialization. Medicare should develop and maintain different payment approaches for real and virtual multi-specialty groups able and willing to believe accountable for cost and quality, rather than pay them on the lowest common denominator approach that would apply to a solo practitioner.

At the same time, fee-for-service will be with us a long time, for those physicians unable or unwilling to accept bundled places that places them at significant financial risk and for physicians outside of large groups who provide specialized, one-time services.

Therefore, I would like to make a couple of comments about Medicare physician fee schedule. The Resource-Based Relative Value Scale approach first implemented in 1992 and still a work in progress, is a marked improvement over the charge-based use schedule that preceded it in Medicare. For all of RBRVS's complexity, the right institutions are in place to make important and overdue improvements to the fee schedule refinement process. To use a sports metaphor, attempting to get the prices right is the blocking and tackling of a fee schedule. Yet in recent years, fee schedule prices have become distorted, but without much notice.

These pricing distortions have occurred in Medicare but even more so in most commercial health plan fee schedules which are based on Medicare's. Prices have been allowed increasingly to deviate from the underlying costs of production, producing unfortunate behavioral responses by physicians, contributing to the explosion in volume of services in areas such as imaging.

In my view, it would be relatively straightforward technically to correct many of these distorted prices, if there were the political will and support to do so. Correcting distorted prices would help control the utilization of services that are leading to the expenditure problems and the need for an SGR fix.

With that, I will pass it on to the next witness. Thank you.

[The prepared statement of Dr. Berenson follows:]

Statement of Robert A. Berenson, M.D., Senior Fellow, the Urban Institute

Chairman Stark, Mr. Camp, and members of the Committee:

I appreciate the opportunity to provide testimony to the Health Subcommittee on a subject I have been deeply involved with through most of my professional career. I practiced internal medicine for over twenty years, twelve of which were in a group practice just a few blocks from here. I was the first representative of the American College of Physicians to the American Medical Association's Resource-Based Relative Value Scale (RBRVS) Update Committee (RUC). In the last part of the Clinton Administration, I had operational responsibility for the Medicare Physician Fee Schedule at the Centers for Medicare and Medicaid Services (CMS). Finally, in recent years as a Senior Fellow at the Urban Institute, I have had a chance to study how well the Medicare Physician Fee Schedule has worked and what might be done to improve it.

I believe that this is an important hearing—because the focus of the hearing is not on how to use marginal dollars—1–2 percent—to try to influence physician performance or on paying third-party disease management organizations that are separated from the physicians actually providing the medical care to beneficiaries with chronic conditions—but rather explores how the program might better spend the 100 percent base of physician spending, which is now approaching $60 billion. It is important to explore the likely effects of these newer approaches to improving quality and efficiency on beneficiaries, physicians, and the Medicare program overall.

The hearing is also important because it signifies that the budgetary pressure of finding a solution to the shortfall created by the cumulative deficit produced by the sustainable growth rate (SGR) formula should not occupy all of the time and attention of health policy makers. Indeed, as I will try to make clear, I believe that greater attention to how we spend the base of $60 billion can provide both short-term and long-term improvement to the financial bottom-line and ease off some of the SGR pressure that currently exists. In recent months, very constructive ideas, including some presented at today's hearing, have been raised. I hope to contribute to that discussion in my remarks today.

Many policy makers use the term "fee-for-service Medicare" to designate the original Medicare program and to distinguish it from the various kinds of Medicare Advantage products. However, this convenient short-hand actually mischaracterizes how the traditional Medicare program pays providers. Indeed, in a book on Medicare prospective payment that I co-authored with Rick Mayes last year, I emphasize that the Medicare Fee Schedule (MFS) is one the last payment approaches in Medicare that remains truly fee-for-service (FFS).[1] Initially, with the Hospital Inpatient Prospective Payment System and then subsequently with a series of prospective payment systems created in the Balanced Budget Act of 1997 and later legislation, providers typically receive bundled payments for an episode of care, appropriately case-mix adjusted to take into account patient severity. Under these bundled payment approaches, providers have an incentive to provide services more efficiently, for less than the average costs on which payment amounts are based. Accumulated evidence documents that prospective payments based on episodes of care have moderated cost increases in the traditional Medicare program.

In contrast, the physician payment system remains FFS, although even in the fee schedule there are significant examples of bundled or packaged payments, most no-

[1] Rick Mayes and Robert A. Berenson, *Prospective Payment and the Shaping of U.S. Health Care*, (Baltimore: Johns Hopkins University Press, 2006)

tably the 90-day global fees for surgical procedures under which routine pre- and post-operative services are included into the global payment amount, and the monthly payment to renal physicians overseeing renal dialysis for patients with End Stage Renal Disease. These long-standing approaches to bundling can be looked to for guidance on how to expand episode-based payments to physicians.

Because the physician payment system is almost purely FFS, it was understandable that Congress, in OBRA 1989, placed a volume expenditure target—then called the Volume Performance Standard—as an admittedly crude approach to containing spending growth under the MFS that began in 1992. It is interesting to note that the 1989 Physician Payment Review Commission Report thought that the expenditure target mechanism could work only for a few years and that organized medicine needed to actively develop clinical practice guidelines, with accompanying physician education efforts, as a needed long-term solution to constrain volume growth. Unfortunately, efforts to find alternatives to the top-down expenditure target approach were not sustained. And the program is now experiencing an explosion of volume and intensity growth in some clinical areas.

Yet, for the first decade or so of the MFS, the evolving expenditure target approaches actually worked reasonably well to constrain spending growth. The situation has clearly changed in the past 6 years, and Congress, with the exception of 2002, has acted to override the across-the-board fee reductions called for under the SGR mechanism. In the absence of broad-based clinical practice guidelines and because of the volume growth of services that are inherently discretionary in nature and, increasingly, under physicians direct control, in my opinion there is little question that bundling payments for episodes of care needs to be a primary objective of physician payment reform, just as it has been successful when applied to other providers in Medicare.

Examples of Bundled Services

I will provide one important example of why moving to bundled payments for physicians, in contrast to fee-for-service, makes good policy sense. The work of Dr. Edward Wagner, at the MacColl Institute for Healthcare Innovation in Seattle, Washington, on what he calls the Chronic Care Model makes clear that the proper management of patients with one or more severe chronic conditions, such as diabetes and congestive heart failure, involves lots of communication with patients outside of standard office visits by phone and, possibly, email; care by multi-disciplinary professional teams; active use of patient registries; and enhanced coordination among professionals and providers practicing in many locations. In my view, it would be foolhardy to try to pay for most of these additional services on an a la carte basis, as FFS does.

Consider, as an example, phone calls. The transaction costs of billing and collecting would be more than the reimbursement for most of the individual services; program integrity concerns would abound; and the inevitable explosion of volume on easily provided and well-appreciated phone calls would become financially prohibitive. The alternative that MedPAC and others have discussed is a chronic care management fee for primary and principal care physicians who would agree to be accountable for providing the array of services in the Chronic Care Model, much as the American Academy of Family Practice, the American College of Physicians and others have envisioned in the patient-centered medical home. My own preference would be to provide a "per beneficiary per month" fee not only for care coordination but also for some or all of the actual medical services provided by the same practice.[2] The right approach, which should be tested in multi-payer demonstrations, might actually be a mixture of reduced fee-for-services combined with monthly fees for specified bundles of services.

The medical home concept presents a number of specific operational challenges, which I am prepared to discuss, but the main point to make is that it is the conceptually right thing to do. The approach not only should improve the care provided to beneficiaries with chronic health problems, but importantly, would provided involved practices with improved incentives to avoid unnecessary downstream utilization by other providers. In this context, pay-for-performance to reward efficiency and to protect against under-provision of important primary and secondary preventive services might play a useful, supportive role.

Episode-based payment not only for primary care physicians but also for specialists caring for a variety of acute and chronic health care medical problems has inherent appeal. There, are, however, important implementation issues regarding spe-

[2] Goroll, HA, Berenson RA, Schoenbaum SC, Gardner, LB. Fundamental Reform of Payment for Adult Primary Care: Comprehensive Payment for Comprehensive Care. *Journal of General Internal Medicine,* 22(3):410–415, 2007.

cialist bundling as well. In particular, given the documented problem of inappropriate procedures producing unjustifiable and costly practice variations, any episode-based payment system should not incorporate an inherent bias for performance of procedures, as already exists in the RBRVS-based fee schedule. Although the costs of an episode need to recognize that there are direct physician expenses associated with the procedure provision itself, the valuation of condition-specific episodes should minimize payment differentials that reward clinical decisions to provide the procedural intervention.

Further, as with all episode or period of time based payment approaches, clinically sophisticated case-mix adjustment is needed to prevent perverse effects, such as physicians giving preference to less severe patients within a cohort with a particular condition or over-diagnosing relatively minor complaints to generate compensable episodes. All payment systems offer "gaming" opportunities. The work on developing payment bundles and episodes needs to protect against such behavior. Fortuitously, in recent years, we now have much more sophisticated approaches to case-mix adjustment such that payment approaches, such as capitation, that often foundered when used by private health plans in the past, now might be much more successful.

One size no longer fits all

It is time to recognize that a "one size fits all" physician payment system may no longer work properly to support the increasing diversity of physician activity that has resulted from sub-specialization. Primary care physicians and particular subspecialists typically care for patients over many years, and much of their value derives from continuity and consistency. As already noted, an immediate Medicare challenge is to develop a payment approach to support robust chronic care coordination and management. At the other end of the physician spectrum, some physicians, including radiologists, pathologists, anesthesiologists, and emergency room physicians, mostly provide one-time, discrete services and typically do not have ongoing responsibilities regarding individual patients. For these physicians, FFS would seem to be an appropriate reimbursement mechanism for a third-party payer, such as Medicare, which does not employ physicians and thus are unable to pay a salary. In the middle of the spectrum, many physicians provide both discrete, one-time services and have ongoing care responsibilities.

Ideally, all specialties would work together, either in real multi-specialty group practices or in virtual multi-specialty collaborations, with payment made to the organization on a per beneficiary per month basis for "medical home" services, with payment adjustments for episodes of illness that require highly specialized services. The current physician group practice demonstration is a very important one in recognizing the opportunity to compensate large real and virtual groups differently from the payment approaches that apply to individual physicians or single specialty groups. Further, physician pay-for-performance, generally should attempt to measure group-level, rather than individual, physician performance.

In sum, Medicare should develop and maintain different payment approaches for multi-specialty groups and collaboratives able and willing to be accountable for costs and quality, rather than pay them on the lowest common denominator approach that would apply to a solo practitioner. At the same time, FFS will be with us for a long time—for those physicians unable or unwilling to accept bundled payments that places them at significant financial risk and for physicians outside of large groups who provide specialized, one-time services.

Improving the RBRVS System to Promote Efficiency

I have recently co-authored medical journal articles critiquing recent implementation of the MFS, especially the RBRVS component.[3] But I do not want these published comments and concerns to be misunderstood. The RBRVS approach, first implemented in 1992 and still a work in progress, was a marked improvement over the charge-based fee schedule that preceded it in Medicare. And for all of RBRVS's complexity, the right institutions are in place to make important and overdue improvements to the fee schedule refinement process. Unfortunately, the MFS, I believe, has suffered from a relative lack of attention in recent years by Federal policy makers—at CMS, at MedPAC, and in Congress, as policy interest has focused elsewhere. As a result, the program has spent unnecessarily because of a failure to anticipate and guard against highly inflationary increases in the volume and intensity of many physician services.

[3] Bodenheimer T, Berenson RA, and Rudolf P. The Primary Care-Specialty Income Gap: Why It Matters, *Annals of Internal Medicine* 146(4):301–306, 2007; Ginsburg PB and Berenson RA. Revising Medicare's Physician Fess Schedule—Much Activity, Little Change. *New England Journal of Medicine* 356(12):1201–1203, 2007; Maxwell S, Zuckerman, S, and Berenson RA. Use of Physicians' Services Under Medicare's Resource-Based Payments, *New England Journal of Medicine* 356(18):1853–1861, 2007.

To use a sports metaphor, attempting to get the prices right is the blocking and tackling of a fee schedule. Yet, in recent years, fee schedule prices have become distorted, but without much notice. These pricing distortions have occurred in Medicare but even more so in most commercial health plan fee schedules, which are based on Medicare's. Prices have been allowed, increasingly, to deviate from the underlying costs of production, producing unfortunate behavior responses by physician, which I will detail in a moment. Yet, in my view, it would be relatively straightforward technically to correct the distorted prices, if there were the political will and support to do so.

In the recent articles, colleagues and I have attempted to explain some of the technical reasons why the prices became distorted. I will emphasize two issues here. Keeping the relative values accurate requires an effective process that reflects changes in medical practice and trends in physician productivity. But, for the most part, relative values have defied gravity—going up or staying the same but rarely coming down.[4] Because physician time spent is a crucial element in estimating both the work and practice expense components that make up the RBRVS approach, it is time to base time elements for high frequency services on objective time data, rather than on surveys of self-interested specialty groups. In that way, time estimates can be kept more current and accurate than under the five-year review process that is now used.

Second, problems with accurate estimation of relative values for practice expenses have worsened as physicians in some specialties have billed for more ancillary services associated with high equipment expenses. CMS has used unrealistically low assumptions about rates of use if equipment and unrealistically high assumptions about amortization rates for large equipment purchases. Furthermore, the payment of average costs for services whose variable costs are low encourages physicians to order more services and to view the services as profit centers. These services include imaging and clinical tests, which are among the fastest growing services in Medicare. In short, because of the failure to consider that the cost of providing a service such as an MRI scan is reduced with every scan performed, Medicare's reimbursements overpay and create an incentive for ordering and providing too many such scans.

During site visits to twelve nationally representative metropolitan areas through work conducted by the Center for Studying Health System Change, my colleagues and I have observed increasing numbers of physicians building capacity to compete with hospital outpatient departments by offering these lucrative services.[5] Indeed, such market-based developments provide a direct signal to policy-makers of distorted payment levels, pointing to priority targets for price error corrections.

It is not by simple chance that CMS and MedPAC find the volume and intensity of imaging, tests, and minor procedures—all discretionary services which ostensibly produce little or no patient harm—are growing much faster than the categories of major surgical procedures and evaluation and management services. The latter services provide much less opportunity for physician-induced demand.

We now see that single specialty groups are merging to have the size and scope to purchase or lease imaging equipment, such as MRI and PET scans. This behavior suggests that the prices for advanced imaging services, such as MRI and PET scans are too high and can be safely reduced without compromising patient access to these important services. (Conversely, other imaging services, such as screening mammograms and DEXA scans for osteoporosis, where access problems appear to exist are likely under-priced.)

There are many technical reasons for why the RBRVS system has gotten off track. The Congress can play an important role in assuring that the technical experts within organized medicine, at MedPAC, and at CMS make the needed corrections to currently distorted prices. And while work proceeds to adopt bundled-based payments for physician services, in my opinion there remains a strong policy rationale for expenditure targets, but specifically targeted to discretionary services that are growing rapidly. In sum, in the long-term we need fundamental reform of how physicians are paid in traditional Medicare. In the short-term, greater attention to correcting incorrect prices and more carefully targeting expenditure targets can produce savings and produce the climate needed to accomplish the needed fundamental reforms that the witnesses have discussed at this hearing.

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[4] Ginsburg and Berenson

[5] Berenson RA, Bodenheimer T and Pham, HH. Specialty-Service Lines: Salvos in the New Medical Arms Race, *Health Affairs* 25:w337-w343, 2006.

Chairman STARK. Thank you.
Dr. Kellerman.

STATEMENT OF RICK KELLERMAN, M.D., PRESIDENT, AMERICAN ACADEMY OF FAMILY PHYSICIANS

Dr. KELLERMAN. Chairman Stark and Mr. Camp, I'm Dr. Rick Kellerman of Wichita, Kansas, and I am president of the American Academy of Family Physicians representing 93,800 members nationwide. On behalf of the Academy, thank you for this opportunity to discuss proposals that we believe are important elements of physician payment reform under Medicare.

The Academy appreciates the work that the Subcommittee has undertaken to examine how Medicare pays for the services physicians deliver to Medicare beneficiaries, and we share the Subcommittee's concerns that the current system is inefficient, inaccurate and outdated. For those reasons, the Academy supports the restructuring of Medicare payments to reward coordination of health care and quality improvement.

Medicare should focus attention on how a coordinated physician can integrate the health care patients receive from different providers in different settings with the goal of preventing duplication of tests and procedures and assuring comprehensive patient care, not unlike a network administrator keeps a computer system functioning efficiently.

More than 20 years of evidence shows that having a health care system based on primary care reduces costs and benefits the patient's health. By using a system of health care that is not predicated on primary care physicians coordinating patients' care, the U.S. health care system pays a steep economic price, and our Medicare beneficiaries pay a steeper price in terms of their quality of care.

Currently, 82 percent of the Medicare population has at least one chronic condition, and two-thirds have more than one chronic condition. Moreover, 20 percent of beneficiaries have five or more chronic conditions and account for two-thirds of all Medicare spending.

There is strong evidence that adopting the chronic care model that Dr. Berenson referred to would improve health care quality and cost effectiveness, integrate patient care and increase patient satisfaction. This well known model is based on the fact that most health care for the chronically ill takes place in primary care settings such as the offices of family physicians.

The chronic care model focuses on several essential components:

Enhanced self-management by patients of their disease;
An organized and sophisticated delivery system;
Evidence-based support for clinical decisions;
Information systems; and
Links to community support organizations.

This model with its emphasis on care coordination, has been tested in dozens of studies and has repeatedly shown its value. Because of the prevalence of chronic disease among the elderly, applying the chronic care model to Medicare is appropriate. Thus the

Academy proposes a new Medicare physician payment system that includes:

Application of the chronic care model through adoption of the patient-centered medical home;

Provision of a monthly care management stipend for recognized physician practices designated by beneficiaries as their medical home;

Continued use of the resource-based relative value scale using a conversion factor updated annually by the MEI; and

Creation of an oversight entity to make recommendations to the Secretary about the appropriate value of services.

Medicare should compensate physicians for coordinating care, a concept supported by both the Institute of Medicine and MedPAC. In addition, this concept is supported by ample literature and is being advanced jointly by the AAFP, the American Academy of Pediatrics; the American College of Physicians; and the American Osteopathic Association.

In order to be recognized as a medical home, practices would submit to a voluntary recognition process by an appropriate nongovernmental entity to demonstrate that they have the capability to provide patient-centered services consistent with the model. Currently, the Academy and other primary care specialty societies are in discussion with the National Committee for Quality Assurance on creating such a recognition program for the patient-centered medical home.

Herb Kuhn characterized in his testimony, testimony that the medical home has been defined. I want the Subcommittee to know that the four medical societies that I mentioned have agreed on the principles of a patient-centered medical home. Payment of a monthly stipend to the medical home for care coordination and other designated activities would reflect the value of work that falls outside of face-to-face visits, such as ongoing coordination of care within a given practice, as well as with consultants, ancillary providers and community resources.

In conclusion, the Academy believes it is time to stabilize and modernize Medicare by recognizing the importance of appropriately valuing primary care, and by embracing the patient-centered medical home model as an integral part of the Medicare program.

[The prepared statement of Dr. Kellerman follows:]

Statement of Rick Kellerman, M.D., President, American Academy of Family Physicians, Shawnee Mission, KS

Chairman Stark, and members of the subcommittee, I am Dr. Rick Kellerman of Wichita, Kansas, and I am president of the American Academy of Family Physicians representing 93,800 members nationwide. On behalf of the Academy, thank you for this opportunity to share with the subcommittee the proposals that AAFP believes to be important elements of physician payment reform under Medicare.

The AAFP appreciates the work this subcommittee has undertaken to examine how Medicare pays for services physicians deliver to Medicare beneficiaries and we share the subcommittee's concerns that the current system is inefficient, inaccurate and outdated. Finding a more efficient and effective method of reimbursing physicians for services delivered to Medicare beneficiaries with a large variety of health conditions is a necessary but difficult endeavor, and one that has tremendous implications for millions of patients and for the Medicare program itself.

We particularly appreciate your asking us to discuss what we are calling the Patient-Centered Medical Home as a component of a Medicare program that offers better health care more efficiently. Family physicians believe that the restructuring of Medicare payment 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 physicians integrate the health care these patients receive from different providers and settings, with the goal of preventing duplicative tests and procedures and assuring the availability to each provider of the most accurate and complete information regarding each patient. We do not believe that the Patient Centered Medical Home is business as usual, but rather a significant step toward added value for the patient, for the complex array of health care providers and for the Medicare program.

Current Payment Environment

The environment in which U.S. physicians practice and are paid is challenging at best. Medicare has a history of making disproportionately low payments to family physicians, largely because its payment formula is based on a reimbursement scheme that rewards procedural volume and fails to foster comprehensive, coordinated management of patients. This formula has produced payment rates that have declined, except for Congressional intervention, by 5–7 percent annually for the last five years. As a result, the Medicare payment rate for physicians has fallen to the 2001 level. These steep annual cuts resulting from the flawed payment formula serve to undermine confidence in the Medicare program. In this current environment, physicians know that, without annual Congressional action, they will face a 10-percent cut in the Medicare payment rate for 2008 and cuts in the 5-percent range annually thereafter. Clearly, the Sustainable Growth Rate (SGR) formula belies its name and simply is not sustainable.

Primary Care Physicians in the U.S.

This persistent payment imbalance has led to a decline in the numbers of graduates from U.S. medical schools choosing primary care medicine. As a result, while other developed countries have a better balance of primary care doctors and subspecialists, primary care physicians make up less than one-third of the U.S. physician workforce. Compared to those in other developed countries, Americans spend the highest amount per capita on healthcare but have some of the worst healthcare outcomes.

However, more than 20 years of evidence shows that having a health care system based on primary care benefits the economy and the patients' health. Three years ago, a study comparing the health and economic outcomes of the physician workforce in the U.S. reached this conclusion (*Health Affairs*, April 2004). By using a system of health care that is not predicated on primary care physicians coordinating patients' care, we the U.S. health care system pays a steep economic price and our Medicare beneficiaries pay a steeper one in terms of their quality of life.

The businesses that purchase health insurance for their employees are recognizing the value of a health care system based on primary care. For example, Martin-Jose Sep veda, MD, who is the Vice President for Global Well-being Services and Health Benefits for IMB, Corp., recently wrote "Why should major companies support patient-centered primary care? Because research shows that patient-centered primary care results in better health care, lower costs, greater satisfaction with the health-care system and more equal access to health care for all citizens."

A Chronic Care Model in Medicare

If we do not change the Medicare payment system, the aging population and the rising incidence of chronic disease will overwhelm Medicare's ability to provide health care. Currently, 82 percent of the Medicare population has at least one chronic condition and two-thirds have more than one illness. However, the 20 percent of beneficiaries with five or more chronic conditions account for two-thirds of all Medicare spending.

There is strong evidence the *Chronic Care Model* (Ed Wagner, Robert Wood Johnson Foundation) would improve health care quality and cost-effectiveness, integrate patient care, and increase patient satisfaction. This well-known model is based on the fact that most health care for the chronically ill takes place in primary care settings, such as the offices of family physicians. The model focuses on six components:

- self-management by patients of their disease
- an organized and sophisticated delivery system
- strong support by the sponsoring organization
- evidence-based support for clinical decisions

- information systems; and
- links to community organizations.

This model, with its emphasis on care-coordination, has been tested in some 39 studies and has repeatedly shown its value. While we believe reimbursement should be provided to any physician who agrees to coordinate a patient's care (and serve as a medical home), generally this will be provided by a primary care doctor, such as a family physician. According to the Institute of Medicine, primary care is "the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community." Family physicians are trained specifically to provide exactly this sort of coordinated health care to their patients.

The AAFP advocates for a new Medicare physician payment system that embraces the following:

- Adoption of the "Medical Home" model which would provide a per month care management fee for physicians whom beneficiaries designate as their "Patient-centered Medical Home;"
- Continued use of the resource-based relative value scale (RBRVS) using a conversion factor updated annually by the Medicare Economic Index (MEI);
- No geographic adjustment in Medicare allowances except as it relates to identified shortage areas;
- A phased-in voluntary pay-for-reporting, then pay-for-performance system consistent with the IOM recommendations.

Care Coordination and a Patient-Centered Medical From the outset, the Medicare program has based physician payment on a fee-for-service system. As a result, Medicare currently is a system of misaligned incentives which rewards individual physicians for ordering more tests and performing more procedures. The system provides no incentive for physicians to coordinate the tests, procedures, or patient health care generally and it puts very little emphasis on preventive services and health maintenance. This payment method has produced an expensive, fragmented Medicare program.

To correct these inverted incentives, the AAFP recommends that beginning in 2008, Medicare compensate physicians for care coordination services The **Institute of Medicine** (IOM) has repeatedly praised the value of, and cited the need for, care coordination as has the Medicare Payment Advisory Commission (MedPAC). And while there are a number of possible methods to build this into the Medicare program, AAFP recommends a blended model that combines fee-for-service with a per-beneficiary, per-month stipend for care coordination in addition to meaningful incentives for delivery of high-quality and effective services in the Patient-Centered Medical Home.

The patient-centered, physician-guided medical home is being advanced jointly by the AAAFP, the American Academy of Pediatrics (AAP), the American College of Physicians (ACP) and the American Osteopathic Association (AOA). This model would include the following elements:

- **Personal physician**—each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.
- **Physician directed medical practice** the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.
- **Whole person orientation**—the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.
- Care is coordinated and/or integrated across all providers and settings of the health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services) facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.
- **Quality and safety** are hallmarks of the patient-centered medical home.

Evidence-based medicine and clinical decision-support tools guide decision making. Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improve-

ment. Patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met.

Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication.

Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient-centered services consistent with the medical home model. To this end, the AAFP, AAFP, ACP and AOA are in discussions with the National Committee for Quality Assurance (NCQA) on creating such a recognition program for the Patient-Centered Medical Home.

- **Enhanced access** to care through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and office staff.

A reimbursement system with appropriate incentives for the patient and the physician recognizes the time and effort involved in ongoing care management.

The AAFP commends the Congress for incorporating the medical home demonstration into the Medicare physician payment provisions of the *Tax Reform and Health Act*. However, the statutory composition of the provision including the requirement of the development of a procedural code and establishing a value for same, will unduly delay the implementation of the medical home. Code development and valuation alone can take two plus years. Thus the results from a three-year demonstration will not be available until well beyond 2011. Because of the strength of the existing literature describing the effectiveness (both health and economic) of the medical home, AAFP would urge the committee to authorize the Centers for Medicare and Medicaid Services (CMS) to adopt the Patient-centered Medical Home as an interim component of physician payment while awaiting the implementation of and results from the demonstration project.

Payment of the care management fee for the medical home would reflect the value of physician and non-physician staff work that falls outside of the face-to-face visit associated with patient-centered care management, and it would pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources.

Patient-Centered Medical Home: A Gateway, not a "Gatekeepter"

It is important to note that the patient-centered Medical Home differs from the so-called ″gatekeeper" model employed in the ?80s and ?90s. The PC–MH model expands access rather than decreases it as a capitated gatekeeper model could. The PC–MH model does not interfere with patient choice or patient self-referral but it offers appropriate incentives for physicians and patients to use resources more appropriately. The Academy believes this is what patients want and need and the mechanism that can improve quality of care and quality of life for beneficiaries and increase cost-effectiveness for the Medicare program.

In fact, patients and payers alike want a medical "network administrator" for their employees, beneficiaries and patients. AAFP, AAP, ACP and AOA have also conferred with major employers, like IBM, in determining what these employers envision as an appropriate medical home for their employees. The primary care physician organizations have been working with IBM in Austin, Texas, to create a demonstration project for their employees that will examine the characteristics of a successful patient-centered medical home. And AAFP, ACP, AOA and the National Association of Community Health Centers have joined with the ERISA Industry Committee, the National Business Group on Health and several major employers to form the Patient Centered Primary Care Collaborative to advance the medical home as a way to improve the health care system generally.

The Cost-Effectiveness of the Medical Home

We understand the very difficult budget constraints that Congress faces as you try to determine how to improve Medicare. The restructuring of payment that we are suggesting will include an additional investment in the short term. But there is ample evidence already that the potential savings are large and near-term. Community Care of North Carolina (CCNC) is a state-wide health care delivery program developed by Allan Dobson, MD, Assistant Secretary for the North Carolina Department of Health and Human Services. The program provides a primary care medical home for all the Medicaid recipients in the state. It joins health care providers, like hospitals and nursing homes, and necessary social service providers, like substance abuse and mental health services, with the local physicians. The system pays the physician practice an additional per-patient, per-month fee to coordinate the care of the Medicaid patients, while also paying a regional network administrator, who

makes sure the necessary technical and ancillary services (like transportation, health education counselors and trained translators) are available within the region.

The state legislature has received a report from an independent audit by Mercer that showed from July 1, 2003 to June 30, 2004 the state spent $10.2 million on the CCNC program, but saved $124 million compared to the previous fiscal year and $225 million if the same population was served by the fee-for-service only system. The conclusion is that for every Medicaid dollar spent on the medical home in North Carolina, the state is saving $8. We realize that the Congressional Budget Office is reluctant to include savings in how it calculates the cost of a program, but a realistic view of what Medicare patients need shows that a medical home will provide them their health care at less cost to them and to the system. Somehow, CBO should take that into account.

Information Technology in the Medical Office Setting

An effective system emphasizing coordinated care is predicated on the presence of health information technology, i.e., the electronic health record (EHR) in the physician's office. 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 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 an HHS-supported EHR Pilot Project conducted by the AAFP, we learned that practices with a well-defined implementation plan and analysis of workflow and processes had greater success in implementing an EHR. CHiT used this information to develop a practice assessment tool on its Web site, allowing physicians to assess their readiness for EHRs.

In any discussion of increasing utilization of an EHR system, there are a number of barriers, and cost is a top concern for family physicians. 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 care coordination, the AAFP joins the IOM in encouraging federal funding for health care providers to purchase HIT systems. According to the U.S. Department of Health & Human Services, billions of dollars will be saved each year with the wide-spread adoption of HIT systems. While the Federal Government has already made a financial commitment to this technology, only a few dollars trickle down to where the funding, unfortunately, 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 you to include funding in the form of grants, low interest loans or tax credits for those physicians committed to integrating an HIT system in their practice.

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.

Aligning Incentives

In replacing the outdated and dysfunctional SGR formula, Congress should look to a method of determining physician reimbursement that is sensitive to the costs

of providing care, creates a stable and predictable economic environment, and aligns 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. Just as importantly, the reformed system should 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 IOM in its 2001 publication *Crossing the Quality Chasm*.

Another IOM report released in autumn of 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 through pay-for-performance is to create payment incentives that will: (1) encourage the most rapidly feasible performance improvement by all providers; (2) support innovation and constructive change throughout the health care system; and (3) promote better outcomes of care, especially through coordination of care across provider settings and time. The Academy concurs with the IOM recommendations that state:

- Measures should allow for shared accountability and more coordinated care across provider settings.
- P4P programs should reward care that is patient-centered and efficient. And they should reward providers who improve performance as well as those who achieve high performance.
- Providers should be offered (adequate) incentives to report performance measures.
- Because electronic health information technology will increase the probability of a successful pay-for-performance program, the Secretary should explore ways to assist providers in implementing electronic data collection and reporting to strengthen the use of consistent performance measures.

Aligning the incentives requires collecting and reporting data through the use of meaningful quality measures. AAFP is supportive of collecting and reporting quality measures and has demonstrated leadership in the physician community in the development of such measures. It is the Academy's belief that measures of quality and efficiency should include a mix of outcome, process and structural measures. Clinical care measures must be evidence-based and physicians should be directly involved in determining the measures used for assessing their performance.

Quality Reporting

AAFP is supportive of collecting and reporting quality measures and has led the physician community in the development of meaningful measures. Consistent with the philosophy of aligning incentives, the reward for collecting and reporting data must be commensurate with the effort and processes necessary to comply and must be sufficient to obtain the desired response from providers. The Academy is skeptical that the incentive of 1.5 percent of a physician's covered charges for collecting and reporting quality measurement data will be sufficient to cover the actual cost of operationalizing such a program. However, we are generally and conceptually supportive of the policy and will monitor its implementation closely.

A Framework for Pay-for-performance

The following is a proposed framework for phasing in a Medicare pay-for-performance program for physicians that is designed to improve the quality and safety of medical care for patients and to increase the efficiency of medical practice.

- Phase 1

  All physicians would receive a positive update in 2008, consistent with recommendations of MedPAC. Congress should establish a floor for such updates in subsequent years.

- Phase 2

  Following the implementation of the Physician Quality Reporting Initiative, Medicare would encourage structural and system changes in practice, such as electronic health records and registries, through a "pay for reporting" incentive system such that physicians could improve their capacity to deliver quality care. The update floor would apply to all physicians.

- Phase 3

Pay-for-reporting transitions to pay-for performance and particular effort is made to ensure that the quality bonus is sufficient to cover the costs of administration as well as providing sufficient incentive to participate. Medicare continues to encourage reporting of data on evidence-based performance measures that have been appropriately vetted through mechanisms such as the National Quality Forum and the Ambulatory Care Quality Alliance. The update floor would apply to all physicians.

- Phase 4

Contingent on repeal of the SGR formula and development of a long term solution allowing for annual payment updates linked to inflation, Medicare would encourage continuous improvement in the quality of care through incentive payments to physicians for demonstrated improvements in outcomes and processes, using evidence-based measures.

This type of phased-in approach is crucial for appropriate implementation. While there is general agreement that initial incentives should foster structural and system improvements in practice, decisions about such structural measures, their reporting, patient registries, threshold for rewards, etc., remain to be determined.

The program must provide incentives—not punishment—to encourage continuous quality improvement. For example, physicians are being asked to bear the costs of acquiring, using and maintaining health information technology in their offices, with benefits accruing across the health care system—to patients, payers and insurance plans. Appropriate incentives must be explicitly integrated into a Medicare pay-for-performance program if we are to achieve the level of infrastructure at the medical practice to support collection and reporting of data.

Conculsion

It is time to stabilize and 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 reimbursement 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 designated by the beneficiary as the patient-centered medical home shall receive a per-member, per-month stipend in addition to payment under the fee schedule for services delivered.
- Phase in value-based purchasing by starting with the Physician Quality Reporting Initiative. Analyze compensation for reporting and ensure that it is sufficient to cover costs associated with the program and provide a sufficient incentive to report the required data.
- 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.

Chairman STARK. Thank you.

Dr. Mahal.

STATEMENT OF ANMOL S. MAHAL, M.D., PRESIDENT, CALIFORNIA MEDICAL ASSOCIATION

Dr. MAHAL. Chairman Stark, Mr. Camp, I am Anmol Mahal, the president of the 150-year-old California Medical Association, representing 35,000 physicians dedicated to the health of Californians.

Thank you for this opportunity to testify on this most important issue, the issue of having a viable health care system for the most treasured part of our society, our elderly. The Chairman and his staff and I have had the privilege of engaging in discussions, as Mr. Stark is my congressman, and he has requested me to comment on a profiling system that is used in my community that I participate in in Northern California that compares my practice pattern to that of my peers in my community.

Providing for the purposes of comparative effectiveness is a program that I participate in in my community. This is a rather comprehensive program that has multi—or elements, and is a multipronged program. Very briefly, sir, there are six elements to the program.

There is a utilization profile that the program uses that not only looks at professional services, but I have to stress also importantly looks at ancillary services and pharmacy costs and also looks at facility costs and hospital services as an overall cost of care.

It looks at clinical profiles, mostly using HEDA's criteria. For example, breast cancer screening, diabetic and cholesterol screening.

It uses the participation profile criteria, which includes regular participation in educational sessions held by the group. It looks at prescribing, et cetera.

There is a satisfaction profile that is added on to the profiling criteria that looks at results from a patient survey that is very well crafted to meet some minimum thresholds.

It looks at patient risk adjustment, so that physicians are not averse to taking care of the sickest and the most elderly folks with the most chronic conditions.

Finally, a very important aspect of this program is a stop loss adjustment so that a physician who desires to take care of patients with HIV/AIDS, oncology patients, patients on dialysis and expensive procedures like colonoscopy are all bundled in and spread the risk in the entire group rather than the risk being adjusted to the individual physicians.

In summary, the physicians in my community, Mr. Chairman, I'm certain in California and indeed in the entire United States, do what they think is right in their hearts and in their experience and training as to what is required for their given patients.

Physicians are constantly enhancing their education, and I feel that education based on profiling and peer comparison provided in a confidential way would be received well by physicians. It would result, in my case, in my personal case, perhaps even increased utilization in some areas where I may not be doing appropriate studies compared to my peers, and in other areas, more modulation of utilization where I'm out of the bell curve when compared to my peers for similar patient mix.

But the key, sir, is to have risk adjustment and to have stop loss adjustment to have the total cost of care looked at. Because a majority of the cost of care, while it's ordered by physicians, it's really not in the physician's hands. It's on pharmaceutical, it's on hospitals, it's on devices, and all of that should be taken into consideration as we put a profiling educational program together.

Done in the way that I have mentioned, we have to be careful that we craft this program so that we do not incentivize physicians

to withhold care, but rather to do what's right for their patients. We do not want to take the art form of medicine, at least the way I practice medicine, Mr. Chairman, today, I think it's as much of art as delivery of technology and science to my patients. We need to maintain that element. Physicians in my community will look positively at peer data provided for educational purposes, provided in a confidential way, and we look forward to working with you on such a program.

Thank you.

[The prepared statement of Dr. Mahal follows:]

Statement of Anmol S. Mahal, M.D., President, California Medical Association, Freemont, CA

Mr. Chairman and Members of the Committee, on behalf of the California Medical Association, I want to thank you for inviting me to testify before the Committee on the important Medicare issues facing our nation. I hope to provide some insights about our California experiences to help the Committee in its deliberations.

I also want to extend a special greeting to my Congressman, Mr. Stark. Mr. Chairman, we sincerely appreciate your efforts to work with us to design a Medicare physician payment system that will appropriately reimburse physicians and ensure the highest quality medical care for our Medicare patients.

I. *Introduction*

Mr. Chairman and Members of the Committee, California physicians are keenly aware that Medicare is in precarious financial condition and we are extremely concerned about the program's ability to continue fulfilling its mission. We understand that Congress faces competing goals for the Medicare program. The government must rein-in Medicare spending at a time when the baby boomers will begin enrolling in the program—thereby increasing the volume of services. But Congress must also fix the physician payment system to ensure those same baby boomers have access to doctors in the future.

Physicians face similar challenges on an individual level. Eighty-three percent of Medicare patients have chronic conditions and the numbers are growing. In ten years, physicians will spend nearly half their time treating Medicare patients with multiple chronic conditions. Physicians are concerned about their capacity to appropriately treat these increasingly sick patients with diminishing resources and reimbursement.

As California physicians, we agree we must do our part to provide the highest quality care in the most efficient possible manner. We must join Congress in being responsible stewards of the Medicare program, just as we are stewards and advocates for our patients. We at the CMA are committed to working with Congress to improve the Medicare program by sharing our knowledge of evidence-based medicine and our experience with programs that attempt to manage costs and care—such as the physician peer comparison programs in California.

II. *California Medical Association SGR Overhaul Plan*

To that end, the California Medical Association recently unveiled a long-term plan to overhaul the SGR system. Included in the plan are recommendations for Congress to establish a series of demonstration projects that would test different systems for appropriately managing costs, incenting the efficient use of resources, and better coordinating patient care. Ultimately, the successful programs would replace the SGR as the volume control mechanism. We fully understand that the Committee is searching for better tools to control the growth in the volume of physician services, such as the physician peer comparison programs.

The Chairman has asked me to comment on a program in which I participate in Northern California, which compares my practice patterns to my peers. The program is educational in nature and physician performance on utilization, quality and patient satisfaction are rewarded through bonus payments. Many safeguards would be necessary before such a complex program could be considered in the Medicare fee-for-service system.

I also should make clear at this point that the California Medical Association has not yet taken a position regarding physician peer comparison programs. We are currently in the process of thoroughly evaluating the peer comparison programs operating in California. We certainly believe that peer comparison information provided to physicians on a confidential basis for educational purposes would be beneficial

to physicians and the Medicare program in general. However, peer comparison programs that tie reimbursement to utilization performance should be examined through Medicare demonstration projects because of their complexity and potential impact on patient care.

III. ***A California Physician Peer Comparison Program***

As a primary care physician, I participate in a physician peer comparison program through a large Independent Practice Association (IPA) in northern California. The IPA provides confidential comparative information to individual doctors on how their quality, utilization, and patient satisfaction compare to their peers. The IPA's program is called the Primary Care Management Program.

Many California medical groups and IPAs who run sophisticated managed care systems employ utilization profiling methods, but the vast majority of these groups use them only for educational purposes. The educational aspect of comparative information is vital to the success of these programs. Such information has helped physicians better understand their practice patterns compared to their peers and allowed many physicians to improve their practice.

Overall, the group in which I practice employs two tools to manage the care of its patients. The first tool is a physician peer comparison tool that fosters self-improvement. The second tool is a financial reward for meeting quality measures and utilizing services consistent with one's peers. Such financial incentives have proven crucial to maintaining access to primary care physicians in my community and in helping physicians begin to invest in health information technology.

Compensation—Primary care physicians (PCPs) affiliated with the group receive compensation in two distinct ways. They receive fees for the services they provide to patients (fee-for-service payments), and also receive a quarterly fee that rewards the effective management of their patient population. As for the fee-for-service payments, PCPs are paid for the services they actually provide, so there is no incentive to underutilize, and they also receive a per member payment that is based on their performance on specific metrics.

The quarterly fee for effective management is called the Primary Care Management Fee (PMF), and is based on many different metrics specific to the physician's practice. These metrics reside in one of four profiles: The Utilization Profile, the Clinical Profile, the Participation Profile, and the Satisfaction Profile. I will describe each of the four.

Utilization Profile—The Utilization Profile measures the cost of all health care services used by the group's physician members. Its components include physician professional services, pharmacy and facility costs. PCPs with fewer than 200 adjusted members are not considered statistically relevant and are excluded from the calculation.

The Pharmacy component of the Utilization Profile includes a synopsis of the PCP's prescribing patterns and resulting PMPM costs. The cost reported here represents 50 percent of the actual total pharmacy costs. By contrast, facility costs are reported at the group level due to statistical unreliability at the individual level. The facility costs assigned to each physician represent 50 percent of the total facility cost. Admission rates and lengths of stay are included in the calculation. The total cost figure is the sum of professional, pharmacy and facility costs, and the final calculation shows where the physician's utilization costs stand relative to the panel average.

Clinical Profile—The second profile—the Clinical Profile—measures the group's clinical initiatives. These metrics report individual performance against that of the physician's panel, region and system, and holds the physician to the system average. There are currently eight clinical measures included in the profile. They are designed to maintain a high standard of care and to improve patient outcomes. The eight measures include: Breast Cancer Screening, Cervical Cancer Screening, Diabetes HbA1c, Use of Appropriate Asthma Medication, Childhood Immunizations, Comvax and Pediatric Use, Cholesterol Screening, and Chlamydia Screening.

Participation Profile—With respect to the Participation Profile, physicians earn points for participating in the group's activities.

Satisfaction Profile—The fourth and final profile is the Satisfaction Profile. As its name suggests, the Satisfaction Profile is based on a Patient Assessment Survey in which physicians are rated by their patients. Patients are randomly selected to participate in the survey. In order for a physician's scores to be counted, at least 20 surveys must be returned. The most heavily weighted question asks the patient if he or she would recommend the doctor to family or friends.

Patient Calculations—Because the costs associated with treating patients in a given practice are calculated on a per-member basis, it is essential to acknowledge that not all members are the same. Accordingly, the program makes adjustments

based upon the demographics of the physician's patient population, including an adjustment based upon the number of Medicare patients the physician is treating. On this last point I think it is important to note that Medicare patients are weighted as four commercial private patients. Adjustments for age and sex are computed based on system wide data.

Stop Loss Adjustment—There are some costs that are shared among an entire region rather than assigning them at the physician level. Maternity, HIV/AIDS, wellness (i.e., screenings and immunizations) dialysis, oncology, colonoscopy, and ophthalmology costs are allocated to all PCPs equally. This Stop Loss Adjustment was created to prevent a few very costly patients from inappropriately overstating the total cost in a PCP's profile.

IV. *Recommendations for Physician Peer Comparison Programs*

Based on California physician experiences, I would like to offer the Committee a few recommendations to consider when implementing a Physician Peer Comparison Program.

I would also like to differentiate between a physician peer comparison program that provides confidential, educational feedback to physicians as a tool for self-improvement and a comparison program that ties reimbursement to efficiency. CMA physicians are interested in self-improvement and we believe that the educational aspects of peer comparison can be extremely helpful to physicians and effective in improving practice patterns. We would support such programs.

However, as you can see from the background we provided to the Committee, comparison programs are extremely complex if implemented appropriately. Therefore, we would prefer to see any comparison programs that are tied to performance payments to be examined in a Demonstration Project environment before being adopted by Medicare.

The CMA recommendations for Peer Comparison Programs are set forth below:

1. *Overall, Physician Peer Comparison Programs are not a panacea for Medicare's financial problems.* However, they could be an effective tool for identifying outliers and encouraging the efficient use of resources. These programs can also produce accountability at the individual physician level, which has been a source of criticism for the SGR. Some California programs have produced a savings and allowed physicians to further invest in meeting quality measures and adopting health information technology.

   The Medicare program should not focus myopically on whether physicians are doing too much. Instead, it should assess whether they are doing enough of the right things, such as providing evidence-based care and preventive care. If physicians are providing preventive care, hospitalizations will be reduced, patient outcomes will improve, and Medicare will gain significant savings.
2. *Physician education must be the focus of the program*. Comparative information is a strong tool to foster self-improvement. California peer comparison programs have been effective in educating physicians and helping them to improve.
3. *Programs that provide positive incentives are the most effective*. Medicare's goal should be to encourage all physicians to participate. In many communities, Medicare cannot afford to lose primary care physicians.
4. *Paramount to a successful program is reliable data that can be verified*.

   The data must also be statistically valid based on the number of patients per physicians.
5. *The program must couple utilization and clinical/quality criteria*.

   An extremely important and positive component of the California program is that it combines utilization criteria with clinical/quality measures. Physicians should not be inappropriately incented to withhold preventive care merely because it would drive up their utilization scores. Physicians providing more preventive services will have higher utilization, but their overall hospital costs will be less. This is a major point on which we disagree with the GAO. Utilization and efficiency *cannot* be viewed independent of clinical quality. It is important to note that in California, preventive quality measures are the general focus of all physician profiling programs and their associated bonus payments.
6. *The program must examine the total cost of care provided to a patient—facility costs, pharmacy costs and physician services—for both primary care and specialty care.*

   An important component of the California program in which I participate is that it calculates the total cost of care for each patient. Lower physician utilization is not necessarily better for the patient and—ultimately—may not save money. For instance, patients with asthma should see a doctor often to

manage their disease. As physician office visit utilization goes up, the total cost of care goes down by reducing unnecessary ER visits and hospitalizations.

On the other hand, many physicians have criticized the profiling program in which I participate because it is difficult to hold a primary care physician responsible for the services provided by a specialist to whom they referred a patient, or a hospitalist caring for a patient upon admission to the hospital or during home health visits. Primary care physicians cannot control patient care beyond their practice and, therefore, it is not appropriate to hold them accountable for such utilization.

The utilization to which a physician is held accountable requires precise and complex evaluation tools. Nonetheless, the educational aspects of such information is extremely beneficial.

7. *All data must be risk-adjusted for age, sex and health status.*

However, it is important to note that risk adjustment methods are still inadequate to fully capture differences in patient health status. Patient compliance issues must also be considered. Most sophisticated managed care groups in California only do risk adjustment for age and sex. It is important to note that my IPA attributes four commercial patients to one Medicare patient.

8. *There must be a "stop-loss" type of adjustment* for HIV/AIDS, oncology, maternity, screenings and immunizations, dialysis, colonoscopy so the costs are spread out across the entire system. It would be truly perverse to penalize individual physicians for treating seriously ill patients.
9. *Patient Satisfaction Surveys are an important component of any program.*
10. *Specialty Referral Issues Must Be Carefully Considered*

The Specialty Referral tracking system in my group is controversial. The group tracks referrals to specialists and accounts for those referrals in a physician's overall score. Some specialty referrals are more "costly" to the primary care physician than others. In some instances, referrals to specialists are appropriate and result in lower costs. In other instances, they may be unnecessary. But some physicians and patients have questioned whether the specialty referral incentive system has inappropriately denied patient access to specialists. One positive aspect of the program is that primary care physicians receive credit for referring patients to specialists to receive treatments included in the set of clinical/quality measures. This sort of primary care gatekeeper approach would be extremely difficult to replicate in the Medicare Fee-for-Service program, where patients can directly access specialists.

11. *Physician-Designed and Directed*

Programs that involve clinical utilization and quality information must be designed and directed by physicians to ensure that the highest quality care is provided.

12. *Demonstration Programs To Protect Patients*

For all of the reasons I have discussed, CMA would support programs that soley focus on confidential education. However, programs that financially reward certain practice patterns must include safeguards against incentives that would reward physicians for withholding care to the detriment of their patients. Therefore, efficiency programs tied to payment should be tried on a Demonstration basis first.

V. *Geographic Variation*

One further note, the CMA recommends that the Committee not only examine practice variations between individual physicians, but also variations in care between geographic regions. There are dramatic and costly variations in care across the country. We need to better understand why this occurs through careful demonstration programs, and work together to reduce inappropriate differences.

VI. *Conclusion*

Physician Peer Comparison Programs can work if the emphasis is on confidential physician education and self improvement. Such programs must couple both utilization and clinical/quality criteria. They must also examine the total costs of providing care to patients—physician, hospital and pharmacy—and should be risk-adjusted.

While the CMA has not officially endorsed peer comparison programs that tie payment to efficiency, we support the educational aspects of such programs. If Congress is interested in going one step further by adopting pay-for-performance based on utilization, we would recommend demonstration programs. Because of the sophisticated quality and clinical issues, it is essential that physicians are involved in the design and implementation. Many safeguards must be included to protect appropriate patient care.

Mr. Chairman and Members of the Committee, I hope this California information will prove helpful to the Committee. On behalf of the California Medical Association, I thank you for your time. We look forward to working with you. Thank you.

Chairman STARK. Thank you very much.

Dr. Mayer.

STATEMENT OF JOHN E. MAYER, JR., M.D., PRESIDENT, SOCIETY OF THORACIC SURGEONS

Dr. MAYER. Chairman. Stark, Mr. Camp, thank you for inviting me to testify. My name is John Mayer. I'm a heart surgeon at the Children's Hospital in Boston and Professor of Surgery at Harvard Medical School, and the current president of The Society of Thoracic Surgeons.

I wish to begin with the fundamental concept that if we are to succeed in addressing our health care cost and quality problems, physicians must be engaged not just with economic incentives, but for the first time, as a profession. From this perspective, I want to emphasize four main points:

First, measurement and feedback of performance to physicians is the most effective way of improving physician performance;

Second. feedback and profiling are really two very different concepts, with differing goals and effects;

Third, bundling of payments is a critical step toward aligning incentives for better quality and more appropriate care; and

Fourth, if we measure both patient outcomes and the cost of care in the right way, we can rapidly improve quality while simultaneously reducing cost.

We base these recommendations on our specialty's experience with the use of outcomes data to drive improvements in quality. We've been willing to invest our volunteer time and resources in these efforts as part of our professional responsibility to our patients. However, you should recognize that physicians are being pulled in opposite directions by their professional responsibilities on the one hand, and the perverse incentives in the current reimbursement system on the other. You have already heard how Medicare still pays more if we perform more services but does little to support quality improvement.

The two mechanisms you're investigating today, information feedback to physicians and bundling payments to align incentives with patient needs, can help resolve these conflicts. Collection and analysis of data on the quality of care, patient outcomes, is what should drive the health care system.

There are many examples of how this works from our cardiac surgical experience, including programs in the veterans hospitals in Northern New England, Virginia, as well as Michigan, and at the national level using the STS database. In each case, collection of outcomes data, risk adjustment and feedback to the local level has resulted in lower mortality rates, less variation and fewer complications. The American College of Cardiology has developed a heart cath outcomes registry, and we are working with them to link our databases to measure the quality and long-term effective-

ness of interventions in patients with coronary disease. We think this is the way of the future.

However, there is a critical distinction between feedback and profiling. Feedback is the use of data by the profession to improve physician performance. Profiling uses data to steer patients, assuming that economic carrots and sticks can best change physician behavior. We believe that professional feedback, not profiling, will be most likely to improve care on a systemwide basis.

Bundling of payments is a critical step toward aligning incentives for better quality and more appropriate care. Surgeons have always been paid this way, which includes both the surgical procedure and the post-operative care. As noted earlier, major procedures accounted for only a very small percentage of Medicare physician spending growth.

I agree with Dr. Berenson that bundled payments reward more effective care, not just more care. Any system that pays a la carte for each service or test only encourages more to be performed. A single payment for the care of a patient's condition for a defined period of time would free physicians to practice their profession in the most efficient and effective way. It would provide incentives to keep patients more involved in their own care; would allow physicians to use e-mail, telephone or home monitoring, physician extenders or whatever other methods resulted in better outcomes. In high-cost conditions, this approach should be the norm.

You have heard a little bit about the concerns about under-utilization. We think that if you couple bundled payments with outcome measurement, we can help prevent under-utilization and encourage efficiency and innovation.

Finally, combining information on quality and cost can save money. Our Virginia cardiac surgeons merged their STS clinical outcomes data with hospital cost data, worked together to identify and adopt best practices and reduced complications that save literally millions of dollars in Virginia every year.

We are currently trying to combine our outcomes and quality data with cost data from private health insurers and with Medicare, and if we can do this, we'll have a more powerful tool to improve quality and reduce costs for treating heart disease, which is still the number one killer in the United States.

In conclusion, I wish to recommend four steps that Congress could take to allow and encourage the medical profession to fulfill our responsibilities to patients and our responsibility to self-regulate:

First, recognize that the medical profession must be an integral part of any solution;

Second, provide Medicare support for the development of specialty or condition-based clinical electronic databases which are focused on patient outcomes;

Third, provide bonuses for measuring and analyzing patient outcomes to improve quality; and

Fourth, realign the reimbursement system to focus on integrated care based on specific patient needs by bundling payment for treatment of the conditions.

If these options are implemented carefully, they could be a major step toward improving quality and reducing costs in Medicare, and in health care nationwide.

Thank you for the opportunity to share my views with you.

[The prepared statement of Dr. Mayer follows:]

Statement of John E. Mayer, Jr., M.D President, Society of Thoracic Surgeons

Chairman Stark, Ranking Member Camp, members of the Subcommittee, thank you for inviting me to testify before you today regarding methods to improve both quality and efficiency among physicians treating Medicare beneficiaries. I am a heart surgeon at Children's Hospital in Boston and Professor of Surgery at Harvard Medical School, and I currently serve as the President of the Society of Thoracic Surgeons.

I'd like to make four main points for you here today which have a unifying theme of engaging medicine as a profession in addressing our healthcare cost and quality problems:

> Measurement and Feedback of performance to physicians is the most effective way of improving physician performance, and we have many examples. Feedback and profiling are two very different concepts, with differing goals which must be understood to achieve desired results. Bundling of payments is a critical step toward aligning incentives for better quality and more appropriate care. The ultimate goal is to measure both patient outcomes and cost of care, which will rapidly improve quality while simultaneously reducing cost.

Feedback as the most effective way to change how physicians make decisions

Cardiothoracic surgeons have an extensive history and culture of focusing on and improving the clinical outcomes of our patients, and based on our 3 million patient cardiac surgical database, we believe that we can legitimately claim to have prolonged millions of lives. We have done this because we believe that this is part of our professional responsibility without resorting to profiling, public reporting, or monetary incentives. We also have data indicating that improvements in clinical outcomes, such as reducing complications, result in cost reductions as well. However, as I will outline for you in a moment, physicians are now being pulled in opposite directions by our professional responsibilities to our patients and to society on the one hand and by the perverse incentives in the current reimbursement system in the other. We believe that the two main mechanisms you are investigating today—information feedback to physicians and bundling to align payment incentives with patient need, can help to address these conflicts. These two changes, if implemented correctly and executed carefully, can realign the incentives to enlist the medical profession in a rapid and continuous quality improvement cycle that can drive down costs while treating patients better. We believe our experience can serve as a guide for the Medicare program and physicians to get there.

To date, physician payment in Medicare has been set based on budget targets. Whether it is the "Sustainable" Growth Rate (SGR), or the Volume Performance Standards (VPS) before it, budget targets can look good to CBO or on a balance sheet. But budgetary targets don't help patient care. What's worse, the looming SGR-mandated payment reductions do not affect individual physician decision-making. And perhaps most tragic, budget driven reductions put off the more important work of replacing poor care with high quality care, avoiding unnecessary treatments, and preventing expensive complications.

What does help patients is clinical expertise, technical skill, and physician responsibility—and these are the province of the Profession of Medicine. The incentives in the Medicare program today are perverse, and are contrary to our professional responsibility as doctors. Medicare currently pays more if you perform more services, order more images, schedule more office visits. Hospitals are paid more if patients have more complications, and more ER visits. The primary care physician who does the best at keeping his or her patients healthy struggles because prevention is not rewarded at all. So in a sense, the Medicare reimbursement system encourages worse outcomes for patients. Our professional responsibility to society as physicians dictates otherwise.

We believe the changes in policy you are examining have been successful because they align with one very powerful motivator for all physicians: their responsibility as a profession to provide societal benefit in treating patients and responsibly shep-

herding scarce resources. I strongly believe changes in policy must be made to re-engage medicine *as a profession* in helping to solve some of the major quality and financial issues facing healthcare in the U.S., in general, and the Medicare program, in particular.

You may be thinking that we are simply saying "Trust us, leave it to the professional responsibility of physicians and all will be well," but what we are really suggesting is a "trust, but verify" scenario. Collection of data on quality of care—*patient outcomes*—is what should drive the healthcare system. We believe that a system of bundled payments coupled to feedback of outcomes information to physicians will help to do so. So trust physicians, but we also need to collect the data.

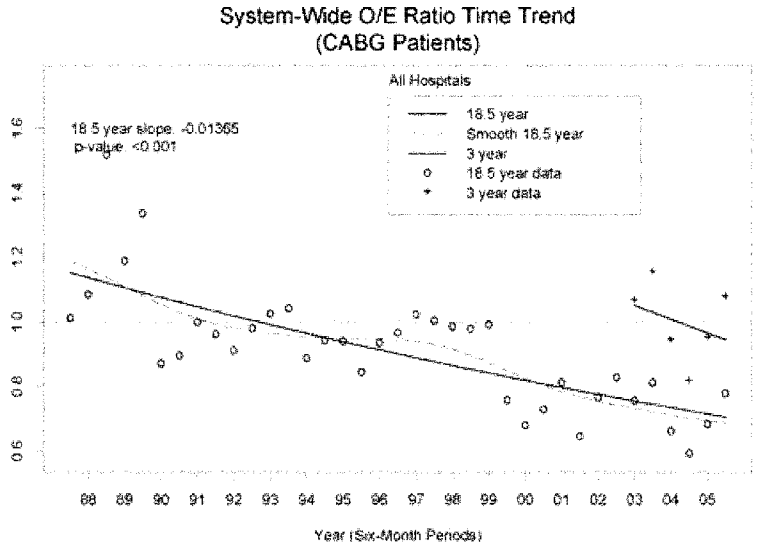
In surgery, we have historically focused primarily on quality improvement because our professional responsibility is foremost to improve patient care. However, we now recognize that this focus on quality can also reduce costs and that our professional responsibility to society requires that we wisely use societal resources.

The impact of feedback to physicians—of both **the quality of their outcomes and their resource use**—will be helpful. It has been said that, "You will improve that which you measure." We have found this to be true. If we measure process compliance, process compliance improves. If we measure patient results—or outcomes—that is what will improve. We should avoid measuring only cost, for the cheapest care is no care, and the least costly outcome may be death. Though feedback of data on resource utilization is likely to improve those utilization rates, we must be very careful in doing so. We believe that cost is most appropriately measured only in conjunction with outcomes so that we can provide care that is of value to the patient.

The STS experience with 18 years of quality measurement in cardiac surgery shows that feedback to physicians on both quality and efficiency may well be the most effective means of changing physician behavior to improve patient care and increase efficiency.

Perhaps the earliest example of feedback improving quality and reducing variation was the Northern New England Cardiovascular Study Group project in the late 1980's—using variation in outcomes as a tool for improvement, not as a means to profile. The surgeons in those states met to discuss results and implement the best practices. The mortality rate in cardiac surgery became the lowest in the country in those states, and variation among institutions disappeared. This is the goal of feedback.

In the VA system, cardiothoracic surgeons have been using an outcomes measurement/feedback system and have evaluated the observed-to-expected mortality rates in open heart surgery for two decades. While patients have been arriving older and much more ill, the results have steadily improved. Thus the ratio of the observed mortality rate to the expected mortality rate has declined continuously. The American College of Surgeons has adopted the VA methodology for their National Surgical Quality Improvement Program (NSQIP). These exemplify the type of Continuous Quality Improvement we could expect in Medicare if all of medicine could measure results and feed the data back to physicians.



It was an STS leader who performed the landmark clinical trial based upon the STS database with a grant from AHRQ. This was the largest Continuous Quality Improvement (CQI) trial in medicine where Dr. Bruce Ferguson was able to document that intervention in the form of education and formal CQI led to changes in physician practice that produced rapid improvements in care. Within 18 months of receiving feedback and education on two practices that improved outcomes in heart surgery patients, we saw a dramatic improvement.

The recently completed second part of this study focused on how surgeons can prevent further heart disease following bypass surgery (CABG). Basically answering "Can the STS influence our surgeons to use the "teachable moment" of hospitalization to get patients on correct medications following CABG?" And once again, there were no incentives other than the knowledge that it is probably the right thing to do.

This was a huge trial with 234 Control Sites, and 224 Treatment sites across the country. They measured the rates at which four separate medications were prescribed at discharge after coronary surgery. Every treatment site showed a significant increase in the rate these medicines were prescribed vs control groups in 18 months. They even created a patient web site created with "steerage" of patients at discharge to the Web site for additional information. This is an example of physicians taking responsibility for managing patient care beyond the treatment period.

This national RCT demonstrated that a professional society CQI program could speed adoption of these prevention therapies. Patients as well as physicians were successfully engaged in the CQI process and the results will improve the long-term patient outcomes following contemporary CABG.

Feedback and Profiling are two distinct concepts and will achieve vastly different results

This distinction is one that will be critical for all to understand. Feedback is the use of data to improve physician behavior, while profiling is use of data to discriminate among physicians and steer patients—without affecting the behavior of the provider. Physicians who may have had patients steered away from them by managed care, but have not improved their performance through feedback will continue to treat patients in the same way, and that benefits neither patients nor Medicare. The quality improvement driven by data collection and feedback promotes system-wide quality improvement and is not focused at the care of a single patient.

To take it one step further, and really achieve costs savings, we must bring costs of care into the equation with quality, and determine the "value" of care provided. In Virginia, cardiothoracic surgeons matched their STS quality data with Medicare's cost data, and calculated the value that each hospital and practice was delivering. But rather than using this information for profiling and competition, they shared the data, shared the methods for improving complication rates, and saved millions

of dollars each year by producing better outcomes for patients statewide. This is the best way to save money in Medicare—through higher quality results. The most recent results here show that doctors in Virginia reduced the incidence of sternal wound infections by 67 percent below the historically expected rates. Each prevented infection of this type saves $73,000.00. Rates of heart arrhythmia (each occurrence costing over $3,000) have been reduced statewide by 5 percent. Together these two improvements save millions of dollars each year, not to mention saving hundreds of lives.

In Michigan, all cardiothoracic surgeons in the state and all 31 hospitals (that perform cardiac surgery) voluntarily submit data to the STS database for analysis. Blue Cross/Blue Shield of Michigan has agreed to fund this data collection for not only their covered patients, but for all Medicare, Medicaid, and uninsured patients. The data are audited and fed back to the surgeons. The surgeons have shared results, and discuss with the top performers how they achieved their results. This Michigan QI project has reduced variation between sites in the most critical outcomes including mortality, atrial fibrillation, and kidney failure. Participants know that it has improved quality of care for the patients, and are confident that it will also save money. Moreover, focus on outcomes accelerates improvement well beyond what you would achieve from rewarding static process measures. In fact, the focus on measurement and improvement in outcomes has caused them to seek out and find new innovative processes worldwide that improve quality and reduce complications. By focusing on outcomes, they found discrete new methods in use in Australia that they are now implementing in Michigan. If they had focused solely on compliance with static process measures, these innovations may not have been sought nor found.

STS believes that similar approaches in other specialties will work in most areas of medicine and will help improve the quality and appropriateness of care and thereby reduce costs. STS is now teaming up with the American College of Cardiology (ACC) who have built their own database of 5 million patients undergoing heart catheterization. By doing so, we will measure the quality of care in patients with cardiovascular disease over the patient's entire history of the disease. We are beginning to work with health plans and payers, including United, Wellpoint, Blue Cross, and Aetna to combine the robust STS–ACC quality data with the plans' cost data including treatments, drug costs, and hospital costs. **These efforts are not for the primary purpose of profiling, and steering patients, but to actually improve the care provided while reducing costs.** We are asking Medicare to work with us to combine Medicare's claims data with our clinical data. If we can do this, we will have the total picture of what quality delivered at what cost in the treatment of heart disease—the number one killer of Americans, and by far the major cost center for Medicare.

All physicians believe they are giving the highest quality, most efficient care—until they are shown otherwise. The critical issues are high quality clinical data, a statistically valid method for risk-adjustment, and feedback of data to the local institution or practice level. We are all trained in science, and *data* doesn't just talk, it speaks very loudly. Once professionals know the truth, behavior shifts easily.

Bundling of payment is a critical step toward aligning incentives for better quality and more appropriate care.

The second focus of this hearing is on how bundled payments in Medicare might realign incentives from rewarding "more care" to rewarding "more effective care". To align payment with quality and efficiency, care delivery must be focused on patient need. Which is to say, payment should be organized around the disease or condition of the patient.

In my field of pediatric heart surgery, interdisciplinary teams of specialists come together for the benefit of children with congenital heart disease. This needs to be the norm in medicine, particularly in the high intensity, high risk areas of medical care.

Care delivery teams should be organized around major conditions, as well as around wellness and prevention. In the future, I believe we will have teams of providers who are expert in caring for specific conditions, as well as experts in keeping patients healthy. The question is, when will that future be realized?

Payment for treatment of Medicare beneficiaries ultimately should be made on the basis of a period or episode for treating each condition. Most in medicine are far from that point today, but there are areas of Medicare where it is working well to control spending growth and encourage only the most appropriate care. In cardiothoracic surgery, as well as nearly all major surgical procedures under Medicare, physicians are paid one fixed fee (in a bundle) for the care they provide. If I perform open heart surgery for a Medicare beneficiary, Medicare pays me one fee

for the procedure, patient visits, intensive care, and recovery care for 90 days regardless of what additional needs arise. If the patient requires me to spend more time with them, if I need to speak with the family and meet with the patient, or if the procedure requires more time in the operating room or more time in the intensive care unit, and there are other costs involved in the treatment of that specified condition, so be it. Medicare only pays one fixed fee. This may well be the reason why, in 2003, office visits in Medicare accounted for 29 percent of increased physician spending, minor procedures that are not paid in a bundle accounted for 26 percent of growth, and imaging (also not paid in a bundle) accounted for 18 percent of spending growth. Major procedures, frequently paid under bundled (or global) payments, were the smallest contributor to growth, accounting for only 3 percent of Medicare physician spending growth.

A bundled payment for treatment of many medical conditions under Medicare would shift the incentives from the current system that pays "a la carte" for each service or test, thus encouraging ever more to be performed; to an incentive to keep the patient healthy while performing only the most appropriate and helpful tests or procedures. Medicare should seriously consider a bundled payment model for the care of beneficiaries with the most costly diseases—especially chronic conditions.

The current incentive under a la carte Medicare fee for service payment urges professionals to perform as many services on each patient as possible, when instead, we should have a system that enables professionals to regulate themselves based upon what is most effective and most appropriate for the patient.

Exercise caution however, as a bundled payment without a measure of patient outcomes (or results), could reward underutilization. The coupling of outcome measures with bundled payment would align incentives, prevent underutilization, and encourage efficiency and innovation.

Conclusion

If we are able to successfully implement a system of measurement of results, outcome data feedback loops to physicians, and aligned incentives through bundled payment, we will have made major strides toward a system that will improve care continuously, and drive dramatic costs reductions.

So, how can such a system be operationalized? What can the Congress do now to allow and encourage the medical profession to help solve the current healthcare problems? We recommend four steps:

1. Recognize that the medical profession must be an integral part of any solution.
2. Provide Medicare support for the development of specialty or condition-based electronic clinical databases focused on patient outcomes, building on the efforts of groups such as the STS, the ACS, and the ACC.
3. Provide bonuses for the very difficult work of measuring the actual patient outcomes. This will become a critical check against *underprovision of services* in a bundled payment environment.
4. Realign the reimbursement system to focus on integrated care based on specific patient needs by bundling payment for treatment of the condition.

The options you are exploring today are important pieces of realigning incentives in Medicare. If they are implemented carefully, they could be a major step toward improving quality for patients while reducing costs in not only Medicare, but in our health care system nationwide.

Thank you for the opportunity to share my views and experience with you today.

Chairman STARK. I want to thank you. We have about 15 minutes till our rent expires on the room at one o'clock. I've talked with Mr. Camp, and if we are not able to let you expand in the time remaining, we might meet informally with any of you who have some time who aren't starving to death to talk a little more.

But I wanted to just cover a couple of points here. Dr. Berenson, you point out that 80 percent of what we spend in Medicare is on chronically ill, and by that I assume you mean they've got a couple of diseases and they are much sicker than average.

To the extent that, as Dr. Mayer said, you can quantify some research for cost, we have a problem in that if there's evidence—we have a problem getting the Congressional Budget Office often to

score savings for us, prospective savings, and particularly in new programs.

To the extent that you can help us, any of you, in providing empirical data that would help us convince the Congressional Budget Office where we talk about plans that save, that would be helpful to what we have to do in this pay-as-you-go problem in planning reimbursement for physicians.

But another comment is that it seems to me, and for those of you who are primary care docs, a primary care doc gets paid for basically face-to-face encounters. It would seem to me that at some point it's just simpler for the primary care doc to refer me off to a bunch of specialists than get involved with having to do research and get back to me and get me back again for another $65 encounter when you've got a waiting room full of people who've got flu and my incipient heart attacks. We're just not set up to reimburse the family care physicians.

I was importuned recently by a group that shall remain nameless who said they've got a business that will take care of managing care, or individual care, disease management. They are in an ancillary business. They said that the real reason they wanted to be identified as somebody providing disease management is that their stock would go from 10 times earnings to 20 times earnings by the New York analyst because they find that disease management is far sexier than providing home health care, which I think was their underlying business.

I would be leery of sort of putting this idea of bundling or management or the medical home out into the marketplace with people with less than the training that you gentlemen have had. But—and I get to a question—on the other hand, I wonder how many of you, particularly those of you in primary care, have the training in management programs and information technology, kind of business management, if you will.

It isn't necessarily—I mean, once you've determined that you want to check my weight and am I taking my Zocor and am I exercising, then the question becomes more like bill collectors. Do you call me at home during dinnertime to make sure, just before I'm about to have that second dessert? Or do you—once a month, do you check to make sure I've filled by Zocor prescription? Also it seemed to me to be unique to medical schools, that's the question, is do they train you in medical schools today, those of you who would go into family practice or internal medicine, to manage through the use of nurses and other practitioners, are you guys ready to do this?

Dr. KELLERMAN. Well, I think that's part of the medical home concept. For example, with our medical school, we have a rotation in ambulatory care geriatrics to try to teach some of those principles. But I think you're making a good point that right now we're paid fee-for-service to see somebody face-to-face, and the idea of the medical home is to look at information and better manage the patient.

Let me give you an example of something that we could do with health information technology. If I have an electronic health record in my office, some people think, well, that's a paperless office. The real value is a registry where I can see who my hundred patients

are with diabetes. I've got these fifty over here that are under good control. I don't need to worry about them as much. But what about these twenty-five over here that under poor control, and maybe I do want to call them at lunchtime and see if they're having the extra dessert? Or work with my team, which could be my nurses, potentially a social worker with community support organizations. So that's the thing that we need to get to with the medical home. Right now we don't have a reimbursement system that incentivizes me to do that.

Chairman STARK. Bob.

Dr. BERENSON. You've asked a very good question. Dr. Wagner, who I referred to, wrote one of the best articles I've ever read about 10 years ago in Millbank why primary care physicians don't do these activities now, and describes things like the tyranny of the urgent, when you've got a waiting room full of people who are sick, dealing with an elderly person with chronic problems, none of which seem to be urgent today, is pushed to the side. He does refer to the problems in medical education which focuses on solving problems rather than managing problems. So, there is an education element here to physicians to want to take this on. So, that is a challenge.

The other challenge I guess I would make is if a typical small practice, I was in a practice at the time of four internists. We had maybe 20 or 25 percent of our patients were Medicare patients, and let's say we picked 10 or 15 percent of those patients were in this category of needing chronic care management, you're now down to 2 or 3 percent of a patient population for whom this special care management would be needed, and are doctors going to redesign how they patient for that subpopulation? Which is why I'm persuaded we need to maybe consider a new payment model for that Medicare and private payers do for medical homes, that don't just focus on the small percentage of patients but large percentage of dollars represented by the Medicare population.

I actually think in this area if we had new payment models, you could—this isn't rocket science for physicians. They understand if they were in an environment that paid for these activities, the role of teams, I think primary care physicians are pretty accustomed to working in teams if that becomes the norm. So I think while there would be an education process, it's something that has to be taken on.

Chairman STARK. Are we just in effect trying to make each of you as primary care docs a little bit of a staff model managed care plan? In other words, are you going to be a one doc or a small group managed care plan with the same kinds of resources let's say in our are, Dr. Mahal, that Kaiser has with hundreds of thousands of people in our county, they had teams of people to call and get people back into see whomever they should see. But for a small office to do that takes, I would think, some kind of a——

Dr. BERENSON. Let me—could I take the first shot at that one?

Chairman STARK. Yeah.

Dr. BERENSON. I think it would be desirable if more physicians did go into multi-specialty group practices, and I think it's reasonable to try to figure out a tilt in payment policy to encourage that. But most physicians won't be in those practices. So, one of the in-

teresting models in the physician group practice demonstration that Medicare is—CMS is sponsoring right now in it's either Middlesex or Middletown, Connecticut. I keep for getting the name. The physicians are in ones and twos practices, but the care coordination is done in the local level by what used to be a physician hospital organization that was formed for managed care contracting. It is now the entity that provides the nurse support, the computer support, a lot of the activities. Case finding is in the hospital. There's a referral. In some cases, the nurse goes with the patient to the doctor's office.

So, the infrastructure is not in the doctor's office. It's a different model. But it's also not with some third-party disease management company two states over. It is community-based. I actually think that is a model that has some potential for what's—for small practices that really don't have the scale to take this on themselves.

Dr. MAHAL. Congressman, I'm a solo practitioner, and I have been coordinating the care of my patients for the 30 years that I've been in practice in our community in Freemont. It is possible to coordinate care. It is a question of the priorities that we set for ourselves. I totally agree with my two colleagues who have spoken earlier that advancing information technology for which a practicing doctor needs assistance in would advance the care coordination.

I think a vast majority of care should be coordinated through a primary care physician. There are some exceptions to that. As a gastroenterologist as well, I feel that I do a lot better at coordinating the care of the patient with active ulcerative colitis. For example, I have developed intuitions over the years by doing so much work with these patients that I catch their problems, if you may, with that sixth sense, the art form that I referred to earlier, Congressman, to keep them out of the hospital. I can really take care of my ulcerative colitis patients, seeing them very frequently, their emotional needs, their medical needs, their social needs, and reduce the hospitalization.

Another example would be a patient who is going through an oncological treatment. They're going through a six to 8 month chemotherapy period. Their best medical home, their best family care source at that time, is the oncologist that they are seeing, not me, who referred them to the oncologist.

So, there are several permutations of this process. Kaiser does a wonderful job of coordinating care, but from time to time, I see Kaiser patients who come over to get a second opinion because they are not getting what they think. So, you know, Americans will have their special needs, that—some of them are medical, some of them are emotional. But I think a multi-pronged approach to finding a mental home for patients is a good idea.

Dr. KELLERMAN. I just wanted to mention that what you're talking about also applies in the rural areas where resources are somewhat limited, but—and we have a lot of elderly patients in rural areas, but with the physician working with the hospital, with the home health agency, and, again, working as a team, we can better provide that than the current system.

Chairman STARK. With modern technology, you can really scan images 100 miles away over the Internet. But I want to let Mr.

Camp have a chance. I want to talk to Mayer about what the thoracic surgeons are doing, but Dave?

Mr. CAMP. Thank you, Mr. Chairman. Thank you all for your testimony. Dr. Mayer, there was a bundled payment demonstration in the early 'nineties, and can you tell me the reaction of thoracic surgeons to that demonstration?

Dr. MAYER. Well, there were obviously a number of centers that did apply and did find some advantages of being involved in that sort of thing, in that sort of program. There were the concerns that if you got better that you might actually be penalized for it because the reimbursement came down. I think if there was any complaint about the program it was probably that.I think all of us would like to get a reward on expenditure of intellectual capital, and I think in most of those situations, those were surgeon-led efforts, with the help of the hospital administration and the nursing, et cetera.

So, I think it was a reasonable notion to do that. We've recently proposed to do something similar in Virginia, again. It's the same group that I mentioned earlier where they actually looked at and they were proposing what was termed quality sharing, so that if the surgeons and everyone else involved in the care of post-coronary bypass patients could reduce complications and acquire savings for the institution, some of that ought to be shared with the surgeons who were leading that effort. That actually got hung up in CMS with worries about problems with Stark violations and other issues and that initiative has died.

Mr. CAMP. The Society actually has worked hard to encourage surgeons to improve quality and health outcomes, but the Society also has its national adult cardiac surgery database. Are surgeons participating in that?

Dr. MAYER. Yes. There are over 800 cardiac surgical units in the country that are participating. We estimate that that's over 75 percent of the cardiac surgical programs in the country. I think this has been embraced not only—primarily as a quality improvement tool. There is nothing more powerful than having your data fed back to you and see how you compare with everyone else.

We're a pretty competitive lot, and we certainly work pretty hard when we're not doing as well as our peers.

Mr. CAMP. Right. Thank you. I just have one last question. I appreciate all of your testimony. Dr. Berenson, obviously we're here to try to make sure that services are appropriately compensated. Several physician services are overvalued, but they're only reevaluated on an every 5-year period, and rarely are they decreased in price. So, what can we do to make sure that services are appropriately valued and reimbursed?

Dr. BERENSON. Yeah. Well, first go more than every 5 years. But this current process still basically requires specialty societies to survey members to estimate the time, and then the associated sort of difficulty associated with time, to determine the relative values. I think we've a major stake at this point in getting objective data. There's I think plenty of evidence that many of those prime estimates are overestimates. I was talking to Dr. Mayer earlier. The STS actually came forward in that process with actual objective data and recommended some devaluation of services.

I think either the AMA's ROC or the CMS should have the ability to actually for the top 50 or 100 procedures, that's where I would start, to actually get objective data, to get other sources of input from the NIH, from VA doctors, from others, so that we actually identify overpriced procedures.

Overpricing can happen because, as I've said in some of my articles, because CMS has some unrealistic values for how to—for practice expenses, and I can get into those details, because specialty societies don't come forward to identify their overpriced—the work value in their procedures. It would be a new approach, but I think it's one that is doable if there were some prodding from the Congress to make it happen.

Mr. CAMP. All right. Thank you. Thank you all for your testimony. Thank you, Mr. Chairman.

Dr. MAYER. Well, I would just say it's one of those other spinoff things from having this 3 million patient record database. We actually use data on operative time, how long patients were in the hospital, how long they were in the ICU, how long they were on the ventilator. That was the basis for our submission. We submitted all the cardiac surgical codes to the five-year review. As Bob described, most went up but actually some went down. We think that's the way it ought to work. But it's based on objective data. It's not a subjective opinion sort of thing. I think there's a great opportunity for trying to use that kind of approach throughout the rest of the Codes.

Chairman STARK. Well, I want to thank all of you. I'm sorry again that we didn't have more time, but I know we'll be seeing a lot of you again as we wind through this and try and come, one, to basically a short-term solution to a problem facing physicians, and build into that a longer term program that may be a better solution than just the 1-year fixes we've been doing in the past.

Thank you all very much, and the Committee will adjourn.

[Whereupon, at 1:00 p.m., the hearing was adjourned.]

[Submissions for the Record follow:]

Statement of American Academy of Ophthalmology

Introduction

Recent studies by the Government Accountability Office (GAO) and MedPAC raised valid issues about how to reform Medicare as an alternative to the sustainable growth rate (SGR) used in fee for service Medicare. Our statement focuses on two major recommendations they discussed at the May 10 hearing—that Medicare should move to profile physicians and to bundle or group services to beneficiaries. Policy leaders say that to make these tools effective, they must be tied to physician payment under Medicare.

Profiling

The GAO report released this month called for a link of Medicare physician pay to efficiency—defined as providing and ordering a level of services that meets the patient's health care needs, but is not excessive, given the patient's health status. The document claims the Centers for Medicare and Medicaid Services (CMS) has the tools available today to profile physician practices for efficiency.

Profiling is the collection of data to compare doctors on their costs of providing services and to rate them on the basis of the ratio of their actual costs to the expected costs for delivering a specified service or the care of a patient's condition over a defined period of time. Private purchasers have had recent experience with profiling.

Key problems with profiling are: 1) who defines the "expected" costs 2) how is the patient population risk adjusted and 3) what is the appropriate number of episodes of care required to evaluate efficiency

GAO says that if CMS had additional authority, it could pay physicians similarly to private sector plans which use profiling. A recent report conducted for the Massachusetts Medical Society on a recent private sector experience, gives us concern about the real value of linking Medicare payment to profiling. The Massachusetts study found questions about the accuracy of the data particularly related to patient diagnosis which is critical to determining patient risk or severity of illness. In addition, the report found that physician profiling at the individual level caused increased administrative burdens for insurers and unintended consequences for both physicians and their patients that affected quality of care.

- **Profiles must differentiate between sub-specialists and patients severity of illness**

While we acknowledge the increased demand by consumers and payers for more transparency in order to enable them to value the delivered services, the use of billing profiling by CMS is today unable to differentiate sub-specialists from generalists and among patients with differing co-morbidities. Grouper software often used in profiling, which purports to be able to compare doctors on the basis of cost on similar patient populations, makes assumptions of risk adjustment on the basis of administrative claims data which have never been validated because they are proprietary.

In particular, there needs to be adjustments for age, case mix and levels of chronic or acute conditions within the practice's patient population. Many ophthalmologists treat a high percentage of elderly patients with diabetes and the eye conditions associated with the disease. The number of years with the disease should be taken into account when formulating any profile. Furthermore, within the specialty of ophthalmology, those who are further trained within a subspecialty will likely see more severe or chronic patients.

In December 2006, CMS provided the first confidential feedback reports containing reporting and performance rates to the physicians who submitted reports on measures in early 2006. CMS also intends to give physicians who participate in its new Physicians Quality Reporting Initiative (PQRI), a larger bonus reporting program, confidential feedback on their performance on quality measures. This early attempt at profiling will be received by the individual physicians in mid 2008. At that time, the Academy and other medical groups will work with CMS to analyze the usefulness of the data.

- **CMS data will need significant refinement and validation before linking payment to profile**

Strategies to measure and encourage quality services and understand resource use must be crafted carefully to avoid serious unintended consequences. We applaud CMS's goal of encouraging physicians to provide the right care at the right time and in the right setting. Demonstrations that are underway through CMS will give us much of the analysis we need in order to proceed correctly. Congress should keep in mind that CMS is in the very early stages of an effort to properly measure physician resource use.

- **Even as a feedback mechanism, after data issues have been addressed, impact and value should be evaluated.**

Data used as part of a quality improvement program for educational purposes or feedback on review of medical record documentation should be presented to physicians in a user-friendly manner. The methods for collecting and analyzing the profile data must be fully disclosed to both the physician and the consumer. The methodology for determining the profiles must be explained to both providers and consumers in easily understandable language, because complex statistical analysis is the methodology often used.

Any established norms should be based on valid data collection and profiling methodologies, and must use a sample size that is of sufficient statistical power. Interpreting results that are based on insufficient sample size may lead to erroneous conclusions and inappropriate actions.

Data sources used to develop profiles of physicians have many limitations. This is especially true of surveys, medical records, and claims data because of their limited ability to assess patients' health status and wellness. These limitations must be clearly identified and acknowledged by Medicare or any other payer and other reviewers to itself, its patients, and its enrollees. Additionally, standards, guidelines, or practice parameters used for any physician profiling must be derived from the evidence-based publications that are developed and approved by the specialty organization that is the primary specialty of that physician.

Bundling to Reduce Overuse

MedPAC proposes payment reform that puts physicians at greater financial risk for services—giving physicians incentives to furnish and order services more effi-

ciently. Medicare already bundles preoperative and follow-up physician visits into global payments for surgical services. Specifically, MedPAC suggests a bundled rate that includes separately billable drugs and laboratory services under the current payment method. In fact, MedPAC is in the process of examining bundling the hospital and physician payments for a selected set of diagnostic related groups (DRGs) to increase efficiency and coordination of care. For example, they plan to examine the physician services furnished to patients before, during and after inpatient hospitalizations for medical DRGs to assess whether a global fee should be applied, similar to surgical DRGs.

The Academy, as a surgical specialty, has a lot of experience with bundling payment for surgical services and the disincentives under this approach for over utilization of ancillary services and visits related to a surgery. Bundling an episode of care for medical diagnoses can be done if the tools are there—Ophthalmologists have done that for diabetic retinopathy laser surgery with a global fee.

The Academy, however, has concerns about linking physician payments to hospital services because of adverse experience physicians have with the way hospitals allocate costs for the provision of services. Furthermore, it is unclear about how such a payment would work and whether or not it would place physicians at financial risk when it comes to allocation of payments.

Conclusion

We do not believe Medicare should move at this time to tie payment to physician profiles and efficiency measures. Data issues and the lack of adequate severity of illness adjustment currently threaten the relevance and the accuracy of a physician profile under Medicare. Because of this, we suggest pilot testing before proceeding on linking payment to profiles and measures. Even as a feed back mechanism, the impact and unintended consequences need to be studied before devoting significant resources to this endeavor.

For more information go to the Academy's Web site at www.aao.org

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Statement of American College of Physicians

ACP strongly believes that Medicare and other health plans should be reformed to advance the patient-centered medical home, a model of health-care delivery that has been proven to result in better quality, more efficient use of resources, reduced utilization, and higher patient satisfaction. The College greatly appreciates Subcommittee Chairman Stark and Ranking Member Camp convening today's hearing which will provide an opportunity to focus on key advantages of the patient-centered medical home.

In March, 2007, ACP, the American Academy of Family Physicians, American Academy of Pediatrics, and the American Osteopathic Association released a joint statement of principles that defines the characteristics of a patient-centered medical home. These four organizations represent 333,000 physicians and medical students. The joint principles are attached to this statement.

As described in the joint principles, a patient-centered health care medical home is a physician practice that has gone through a voluntary qualification process to demonstrate that it:

- Provides continuous access to a personal primary or principal care physician who accepts responsibility for treating and managing care for the whole patient through an a patient-centered medical home, rather than limiting practice to a single disease condition, organ system, or procedure,
- Supports the specific characteristics of care that the evidence shows result in the best possible outcomes for patients.
- Recognizes the importance of implementing systems-based approaches that will enable physicians and other clinicians to manage care, in partnership with their patients, and to engage in continuous quality improvement,
- Introduces transparency in consumer decision-making and accountability for getting better results by reporting on evidence-based quality, cost and patient experience measures of care.

The patient-centered medical home has the support of a broad collaborative of physician organizations, employers and other stakeholders. The Patient-Centered Primary Care Collaborative, of which ACP is a founding member, has submitted a statement to the record of this hearing that endorses the patient-centered medical home. The Collaborative includes employers that collectively employ more than 50

million Americans and primary care organizations that represent the physicians that provide primary care to the vast majority of Americans. Representatives of consumer organizations have been participating in the Collaborative's ongoing discussions and are expected to endorse and join the Collaborative in the near future. The Collaborative's joint statement of support for the patient-centered medical home has been submitted separately for the record of this hearing.

Evidence that a Patient-Centered Medical Home Will Improve Quality and Lower Costs

There is substantial and growing evidence that a health care system built upon a foundation of patient-centered medical home will improve outcomes, result in more efficient use of resources, and accelerate systems-based improvements in physician practices.

According to an analysis by the Center for Evaluative Clinical Sciences at Dartmouth, States that relied more on primary care:

- have lower Medicare spending (inpatient reimbursements and Part B payments),
- lower resource inputs (hospital beds, ICU beds, total physician labor, primary care labor, and medical specialist labor)
- lower utilization rates (physician visits, days in ICUs, days in the hospital, and fewer patients seeing 10 or more physicians), and
- better quality of care (fewer ICU deaths and a higher composite quality score).[1]

Starfield's review of dozens of studies on primary-care oriented health systems found that primary care is consistently associated with better health outcomes, lower costs, and greater equity in care.

- Primary care oriented countries, such as Australia, Canada, New Zealand, and the United Kingdom are rated higher than the United States on many aspects of care, including the public's view of the health care system not needing complete rebuilding, finding that the regular physicians' advice is helpful, and coordination of care. "The United States rates the poorest on all aspects of experienced care, including access, person-focused care over time, unnecessary tests, polypharmacy, adverse effects, and rating of medical care received." An orientation to primary care reduces sociodemographic and socioeconomic disparities.
- Overall, primary care-oriented countries have better care at lower cost.
- Within the United States, adults with a primary care physician rather than a specialist had 33 percent lower cost of care and were 19 percent less likely to die, after adjusting for demographic and health characteristics.
- Primary care physician supply is consistently associated with improved health outcomes for conditions like cancer, heart disease, stroke, infant mortality, low birth weight, life expectancy, and self-rated care.
- In both England and the United States, each additional primary care physician per 10,000 population is associated with a decrease in mortality rates of 3 to 10 percent.
- In the United States, an increase of one primary care physician is associated with 1.44 fewer deaths per 10,000 population.
- The association of primary care with decreased mortality is greater in the African-American population than in the white population.[2]

Another analysis found that when care is managed effectively in the ambulatory setting by primary care physicians, patients with chronic diseases like diabetes, congestive heart failure, and adult asthma have fewer complications, leading to fewer avoidable hospitalizations.[3]

Patient-centered primary care will also accelerate the transformation of physician practices by making the business case for physicians, including those in small practice settings, to acquire and implement health information technologies and other systems-based improvements that contribute to better outcomes.

"Patient-centeredness, shared decision-making, teaming, group visits, open access, outcome responsibility, the chronic care model, and disease management are among

[1] Dartmouth Atlas of Health Care, Variation among States in the Management of Severe Chronic Illness, 2006

[2] Starfield, presentation to The Commonwealth Fund, Primary Care Roundtable: Strengthening Adult Primary Care: Models and Policy Options, October 3, 2006

[3] Commonwealth Fund, Chartbook on Medicare, 2006

the proposals intended to transform medical practice. The electronic health record's greatest promise arguably lies in the support of these initiatives. . ."[4]

Reform of Medicare Payment Policies to Support a Patient-Centered Medical Home

Many physicians would like to redesign their own practices to become a patient-centered medical home, but are discouraged by doing so by Medicare payment policies that reward physicians for the volume of services rendered on an episodic basis, rather than for comprehensive, longitudinal, preventive, multi-disciplinary and coordinated care for the whole person. The authors of a recent survey found that "a gap exists between knowledge and practice—between physicians' endorsement of patient-centered care and their adoption of practices to promote it. Physicians reported several barriers to their adoption of patient-centered care practices, including lack of training and knowledge (63 percent) and costs (84 percent). Education, professional and technical assistance, and financial incentives might facilitate broader adoption of patient-centered care practices. With the right knowledge, tools, and practice environment, and in partnership with their patients, physicians should be well positioned to provide the services and care that their patients want and have the right to expect."[5]

Congress should enact legislation that leads to a fundamental redesign of Medicare payment policies to support a patient-centered medical home. Such redesign should include the following five key elements:

1. *Eliminate the SGR and provide stable, positive and predictable updates combined with performance-based additional payments for reporting on quality measures relating to care coordination and patient-centered care.*

The sustainable growth rate (SGR) formula must be eliminated. Unless Congress acts, the SGR will cause a cut of almost 10 percent in physician services in 2008, and a cut of almost 40 percent over the next several years. Cuts of this magnitude will make it impossible for physicians to invest in the systems and technologies needed to become a patient-centered medical home, will accelerate the trend of physicians turning away from primary care medicine, and create access problems as primary care physicians leave medicine in increasing numbers and fewer young physicians go into primary care.

Specifically, Congress should *enact legislation that would lead to elimination* of the SGR and replace it with an alternative update framework that will:

- Assure stable, positive and predictable baseline updates for all physicians.
- Set aside funds for a separate physicians' quality improvement pool that would allocate dollars to support voluntary, physician-initiated programs that have the greatest potential impact on improving quality and reducing costs, and allow for a portion of savings in other parts of Medicare (such as reduced hospital expenses under Part A) that are attributable to programs funded out of this pool to be allocated back to the physicians' quality improvement pool. Congress should direct that priority be given to those applications for funding under the quality pool that are most likely to improve care quality and efficiency by accelerating and supporting the ability of physicians to organize care processes to deliver patient-centered services through a medical home. Priority would also be given to programs that address regional variations in quality and cost of care. Our specific recommendations for revamping Medicare's Physician Quality Reporting Initiative are presented below. Revamp the Physicians Quality Reporting Initiative to focus on clinical and structural measures related to coordination of chronic diseases and other "high impact" interventions.

2. *Revamp the Physicians Quality Reporting Initiative to focus on clinical and structural measures related to coordination of chronic diseases and other "high impact" interventions.*

The PQRI pays physicians a "performance bonus" of up to 1.5 percent for reporting on measures of care that are applicable to their specialty and practice. Physicians will receive the same reporting bonus without regard to the impact of the measures on quality or cost of care, the costs to the practice associated with reporting on the measures, or the number of measures that apply to their specialty or practice. ACP believes that Congress should redesign the PQRI to:

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[4] Sidorov, Health Affairs, Volume 25, Number 4, 2006

[5] Commonwealth Fund study, "Adoption of Patient-Centered Care Practices by Physicians: Results from a National Survey" (*Archives of Internal Medicine,* Apr. 10, 2006)

- Assure that funding for the program is sufficient to offset the costs to physicians for reporting on the measures.
- Focus on structural (health information technologies) measures associated with patient-centered care through a medical home.
- Place priority on clinical measures for chronic diseases.
- Pay physicians on a "weighted basis" for reporting on structural and clinical measures that will have the greatest potential impact on quality and cost, so that physicians who are reporting on measure that will have a greater impact, or that require a greater investment in health information technologies, will receive a proportionately higher payment than physicians who report on lower impact measures that do not require a substantial investment in HIT.

3. Create incentives for physicians to acquire the health information technologies and systems to support patient-centered care in a medical home.

Medicare should create payment incentives to encourage physicians to acquire specific structural enhancements and tools that are directly related to care management in the ambulatory setting, such as patient registry systems, secure email, and evidence based clinical decision support, which can be measured and reported on. (That is, paying doctors for acquiring the systems needed to become medical homes). This recommendation would be implemented by the National Health Information Incentive Act of 2007, H.R. 1952, introduced on April 19, 2007 by Representatives Charles Gonzalez and Phil Gingrey. The bill has been referred to the Ways and Means Committee. ACP urges the Health Subcommittee and full Committee to report the bill favorably. This legislation is based on the Bridges to Excellence program, which uses a scoring system that provides higher payments for having a fully functional EMR system than having a very basic registry system, and a similar scoring model, with tiered payments, could be used for Medicare:

- Tier 1—the reporting on evidence-based standards of care; the maintenance of patient registries for the purpose of identifying and following up with at-risk patients and provision of educational resources to patients;
- Tier 2—the use of electronic systems to maintain patient records (EHRs); the use of clinical-decision support tools; the use of electronic orders for prescriptions and lab tests (e-prescribing), the use of patient reminders; use of e-consults (communication between patient/physician or other provider) when an identifiable medical service is provided; and managing patients with multiple chronic illnesses; [Practices can qualify that utilize three or more incentives].
- Tier 3—whether a practice's electronic systems interconnect and whether they are "interoperable" with other systems; whether it uses nationally accepted medical code sets and whether it can automatically send, receive and integrate data such as lab results and medical histories from other organizations' systems.

Such tiered payments for systems improvements could either be in the form of a tiered "add on" to the Medicare office visit payment that would increase as the practice achieves a higher tier, or in the form of a la carte coding and payment mechanisms to allow physicians to report when they use individual elements inherent to patient-centered care, such as use of a registry and use of clinical decision support. Congress should allocate funding to pay physicians when they appropriately use and report these tools and/or direct HHS to exempt the expenditures associated with these tools from the budget neutrality requirement pertaining to payments for Medicare Part B services.

4. Provide oversight of the Medicare Demonstration Project on Patient Centered Medical Homes

The Tax Relief and Health Care Act of 2006 mandates that CMS implement a demonstration project of a Medicare medical home in up to eight states nationwide. ACP supports and appreciates Congress's support for the Medicare Medical Home demonstration project but urges this Subcommittee to exercise oversight to assure that CMS implements it in a timely manner and provides sufficient funding for physician practices that choose to participate.

5. Require that CMS develop and implement additional changes in Medicare payment methodologies to support patient-centered primary and principal care for (a) practices that qualify as patient-centered medical homes and (b) practices that are not fully qualified as PC–MHs but are able to provide defined services, supported by systems improvements, associated with patient-centered care.

Physicians in practices that qualify as a patient-centered medical home should be given the option (based on standards to be established in statute) of being paid

under an alternative to traditional Medicare fee-for-service. This alternative model would consist of the following:

- Bundled, severity-adjusted care coordination fee paid on a monthly basis for the physician and non-physician clinical staff work required to manage care outside a face-to-face visit and the health information technology and system redesign incurred by the practice.
- This bundled payment would be combined with per visit FFS payment for office visits and performance based bonus payments based on evidence based measures of care

Yesterday, Representative Gene Green and Senator Blanche Lincoln introduced the Geriatric Care Improvement Act of 2007, which will create a new Medicare benefit for geriatric assessments of patients with multiple chronic disease and/or dementia and monthly care management fees to physicians who enter into an agreement with HHS to provide ongoing care coordination services to such patients. ACP strongly supports this bill and urges that it be reported out favorably by the Subcommittee.

For physicians who are not practicing in a qualified patient-centered medical home, Medicare should be directed to pay separately for the following CPT/HCPCS codes that involve coordinating patient care for which Medicare currently does not make separate payment.

- Physician supervision of nurse-provided patient self-management education
- Physician review of data stored and transmitted electronically, e.g. data from remote monitoring devices
- Care plan oversight of patient outside the home health, hospice, and nursing facility setting—this is reported through CPT 99340, which is described in item #3, "Create a specific, new alternative and optional patient centered medical home benefit. . ."
- Anticoagulant therapy management
- New physician team conference codes
- New telephone service codes (scheduled to appear in CPT in 2008)

Conclusion

The 110th Congress has an historic opportunity to join with ACP, other physician organizations, employers, and health plans to redesign the American health care system to deliver the care that patients need and want, to recognize the value of care that is managed by a patient's personal physician, to support the value of primary care medicine in improving outcomes, and to create the systems needed to help physicians deliver the best possible care to patients. The College's policy recommendations and implementation road map are offered today as a comprehensive plan for Medicare to realign payment policies to support comprehensive, coordinated, and longitudinal care for beneficiaries through a physician-directed, patient-centered medical home.

American Academy of Family Physicians (AAFP)

American Academy of Pediatrics (AAP)

American College of Physicians (ACP)

American Osteopathic Association (AOA)

Joint Principles of the Patient-Centered Medical Home

March 2007

Introduction

The Patient-Centered Medical Home (PC-MH) is an approach to providing comprehensive primary care for children, youth and adults. The PC-MH is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family.The AAP, AFFP, ACCP, and AOA, representing approximately 333,000 physicians, have developed the following joint principles to describew the characteristics of the PC-MH.

Principles

Personal physician—*each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.*

Physician directed medical practice —*the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.*

Whole person orientation—*the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.*

Care is coordinated and/or integrated *across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.*

Quality and safety *are hallmarks of the medical home:*

- Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients, and the patient's family.
- Evidence-based medicine and clinical decision-support tools guide decision making
- Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.
- Patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met
- Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication
- Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model.
- Patients and families participate in quality improvement activities at the practice level.

Enhanced access *to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.*

Payment *appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework:*

- It should reflect the value of physician and non-physician staff patient-centered care management work that falls outside of the face-to-face visit.
- It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources.
- It should support adoption and use of health information technology for quality improvement;
- It should support provision of enhanced communication access such as secure e-mail and telephone consultation;
- It should recognize the value of physician work associated with remote monitoring of clinical data using technology.
- It should allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits).
- It should recognize case mix differences in the patient population being treated within the practice.It should allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting.
- It should allow for additional payments for achieving measurable and continuous quality improvements.

Background of the Medical Home Concept

The American Academy of Pediatrics (AAP) introduced the medical home concept in 1967, initially referring to a central location for archiving a child's medical record. In its 2002 policy statement, the AAP expanded the medical home concept to include these operational characteristics: accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective care.

The American Academy of Family Physicians (AAFP) and the American College of Physicians (ACP) have since developed their own models for improving patient care called the "medical home" (AAFP, 2004) or "advanced medical home" (ACP, 2006).

For More Information:

American Academy of Family Physicians
http://www.futurefamilymed.org
American Academy of Pediatrics: http://aappolicy.aappublications.org/policy_statement/index.dtl#M
American College of Physicians
http://www.acponline.org/advocacy/?hp
American Osteopathic Association

Statement of American College of Radiology

The American College of Radiology (ACR) representing more than 32,000 radiologists, radiation oncologists, and medical physicist members is pleased to submit this statement for the record regarding the hearing on options to improve quality and efficiency among Medicare physicians.

Fundamental First Steps

There are fundamental steps that need to be taken as Medicare strives to achieve the level of efficiency needed in order to maintain solvency into the future. First, the Federal Government must encourage and provide incentives for physicians to acquire the necessary health information technology systems in order to deliver integrated care across multiple provider settings. The upfront expense for many physician practices to purchase, integrate, and operate these systems is often too great an undertaking, resulting in little or no financial benefit for the physician compared to the benefit realized by Medicare and other insurers. In addition, while Medicare takes steps toward greater efficiency in the delivery of physician services, it must move away from the current methodology for reimbursing physicians under the Sustainable Growth Rate (SGR) formula. However, we caution Congress not make major changes to the payment system without solid evidence-based solutions that have been proven to resolve the existing problems. Only with stable and predictable payments can doctors begin to invest resources in the technology and processes that lead to greater efficiency.

Growth in Volume of Imaging Services

The ACR believes that as the stewards of the Medicare program, Congress must ensure that beneficiaries continue to have access to the highest quality physician care and that this care is delivered in an efficient and safe manner. In the case of diagnostic imaging and image-guided therapy, increased volume and intensity has been shown, in specific clinical circumstances, to lower overall cost by reducing unnecessary hospital admission and surgery. Overall growth in volume and intensity of imaging in the 21st century is appropriate, and may be appropriate at a higher level as compared to the average growth of all medical services, because that growth represents a natural evolution of health care delivery in which diagnosis and treatment is made more rapidly and more accurately. (See Attachment A)

Accreditation Requirement and Standards for Physicians Performing Imaging

There is no doubt that inappropriate growth of imaging exists and we share Congress's desire to make certain that the Medicare dollar is spent wisely. The Medicare Payment Advisory Commission (MedPAC) has put forth numerous recommendations over the years on ways to improve quality and efficiency in the delivery of medical imaging services. In 2005 the Commission recommended that standards be implemented for physicians who perform and interpret imaging studies. MedPAC mentions how much of the recent growth in imaging has taken place in physician offices where there is less quality oversight than in the hospital or Inde-

pendent Diagnostic Testing Facility (IDTF) setting. The ACR believes that in order to ensure that imaging services provided outside the hospital are appropriate, safe and cost effective, Medicare should require that complex procedures such as those in nuclear cardiology, MRI, CT, and PET are performed by experienced and qualified physician specialists working with well trained technical staff in an accredited facility or physician office. Private insurers requiring accreditation for facilities providing advanced diagnostic imaging have witnessed an increase in quality of care and patient safety, as well as a reduction in repeat tests that have led to cost savings for their programs. In fact, UnitedHealthcare has recently announced that beginning in March of 2008 all beneficiaries receiving advanced medical imaging (MRI, CT, PET, nuclear medicine, and nuclear cardiology) must go to an accredited facility for those services.

Use of Appropriateness Criteria and Feedback for Physicians Ordering Imaging

Beyond patient safety and quality measures such as accreditation, Medicare should implement programs to ensure that seniors are receiving appropriate imaging—the right test, at the right time, for the right reason. Private insurers have found that a disproportionate number of imaging studies are being ordered by a relatively small number of physicians. To that end, the ACR encourages the consultation of Appropriateness Criteria when determining if and when a patient should receive an imaging study. Over the years, the ACR has developed Appropriateness Criteria for use by primary care physicians as well as specialists consisting of evidence-based, expert criteria for selecting the most appropriate imaging for patients depending on the symptoms they present and their medical history. Programs developed by Medicare should include a reporting and feedback component where referring physicians can see how their ordering patterns compare to their colleagues. When using Appropriateness Criteria within a program such as a Radiology Order Entry system (ROE), the ordering patterns of referring physicians can be successfully shifted through educational feedback reports, with the potential to result in savings for the payer. In the end, timely and appropriate imaging can produce better patient outcomes, through more precise treatment and lowered morbidity and mortality.

Bundled Payments

In its mandated report to Congress on alternatives to the SGR, MedPAC presented the option of bundling physician payments in order to reduce overuse of services. The Commission's logic is that a larger unit of payment puts physicians at a greater financial risk and provides the incentive to order services judiciously. However, the ACR believes the strategy of bundling payments to physicians has the potential to lead to more problems than it would solve as was witnessed when the private sector experimented with capitation in the 1990s. Questions remain as to how services rendered by a physician in a consulting role, such as is the case with diagnostic radiology, would fit into the concept of bundling. It is not clear that the incentive for a physician to judiciously order images is provided under this option, and in fact it may have the opposite effect. Furthermore, to extend the concept of bundled payments beyond a single episode of care and fully integrate it into the general population of outpatients, in the multitude of complex patient care situations occurring over variable time courses, at multiple locations and involving multiple and often independent provider decision makers would require a system design so complex that it would likely be administratively unmanageable. The ACR asks that the Health Subcommittee explore this alternative only after careful evidence-based deliberation and in consultation with all provider stakeholders. It is our belief that improving health care efficiencies must be approached from the standpoint of quality with a focus on utilization controls based on appropriateness of care and physician collaboration, with the ultimate goal of improving outcomes, rather than having the primary focus on achieving savings.

The ACR looks forward to working with Congress this year towards the shared goals of improving quality and efficiency through ensuring that Medicare pays for the safest, highest quality, appropriate imaging services for beneficiaries.

Attachment A

1. Rao PM, Rhea JT, Novelline RA, Mostafavi AA, McCabe CJ. Effect of computed tomography of the appendix on treatment of patients and use of hospital resources. NEJM. 1998;338(3):141–146.

The authors evaluated 100 patients who had CT for suspected appendicitis. Fifty-three had appendicitis; 47 did not. After the cost of CT, overall savings was $447 per patient ($44,731).

2. Jordan JE, Donaldson SS, Enzmann DR. Cost effectiveness and outcome assessment of magnetic resonance imaging in diagnosing cord compression. Cancer. 1998;75(10):2579–2586.

This article is both a retrospective review and literature review. The authors found that with the use of MR in imaging patients with diagnosed cord compression, costs were reduced by 65 percent. Imaging studies utilized prior to MRI for diagnosis included myelography, CT, plain film and nuclear medicine. The average cost for diagnosis in these groups dropped from $3664/patient to $2283/patient. The lack of hospitalization costs with myelography contributed significantly to the reduced cost with MRI diagnosis.

3. Garcia Pena BM, Taylor GA, Lund DP, Mandl KD. Effect of computed tomography on patient management and costs in children with suspected appendicitis. Pediatrics. 1999:104:440–446.

CT was obtained with three strategies: 1) obtain on all patients and discharge if nl, 2) obtain on all pts and admit all, 3) selectively obtain CT if wbc>10,000.

All strategies decreased the number of hospital days, negative laparotomies and the per patient cost. Savings for strategy 1 was $2018/patient, for strategy 2 $554/patient, and for strategy 3 $691/patient.

4. Rhea JT, Rao PM, Novelline RA, McCabe CJ. A focused appendiceal CT technique to reduce the cost of caring for patients with clinically suspected appendicitis. AJR. 1997;169:113–118.

Use of focused CT reduced both variable and total cost by $23,030 and $ 45,556 respectively per 100 patients. Costs were reduced through decreased number of negative laparotomies and decreased number of hospital days (cost of one negative appendectomy equals the cost of 18 appendiceal CT scans).

5. Rosen MP, Sands DZ, Longmaid HE 3rd, Reynolds KF, Wagner M, Raptopoulos V. Impact of abdominal CT on the management of patients presenting to the emergency department with acute abdominal pain. AJR. 2000;174:1391–1396.

This is a review of fifty-seven patients who presented to the emergency room with acute abdominal pain of a nontraumatic origin. CT added significantly to the confidence level of the emergency room physician's diagnosis evaluated subjectively. The use of CT averted the admission of ten of 42 of these patients, approximately 24 percent. Furthermore, patient management was altered in 60 percent of patients.

6. Rosen MP, Siewert B, Sands DZ, Bromberg R, Edlow J, Raptopoulos V. Value of abdominal CT in the emergency department for patients with abdominal pain. Eur Radiol. 2003;13:418–424.

Patients with abdominal pain who presented to a teaching facility were evaluated with CT when appropriate. This article demonstrated that 17 percent of hospitals admissions and 62 percent of surgeries were avoided based on the CT findings. There was also a significant benefit derived by the treating physician markedly improving their confidence level with their diagnoses.

Statement of American Health Information Management Association

Chairman Stark and Members of the Ways and Means Subcommittee on Health, thank you for holding a hearing on "Options to Improve Quality and Efficiency Among Medicare Physicians." This is a critical issue and the American Health Information Management Association (AHIMA) is honored to provide the subcommittee with information that we believe directly impacts the questions noted in your hearing announcement.

As you know, the emergence of health information technology as a key policy issue has helped move the healthcare quality issue to the forefront of healthcare policy discussions. To obtain more information for quality monitoring, healthcare claims forms have been changed to collect more information on the care provided to individuals. This has been done to improve the delivery of quality healthcare and to insure fair and equitable reimbursement for services provided.

As the Subcommittee considers the hearing testimony, we urge you to consider how upgrading the ICD–9-CM classification system to ICD–10–CM and ICD–10–PCS could improve the information and knowledge contained in the Medicare system, improve the efficiency of data collection and therefore reduce the cost of obtain-

ing the information needed for Medicare processes. This will also reduce the costs incurred by the providers who must supply data to various contractors of the Centers for Medicare and Medicaid Services (CMS) for healthcare claims and other healthcare reporting requirements.

In 2005, AHIMA testified before the Ways and Means Health Subcommittee on the need for and advantages of U.S. adoption and implementation of the ICD–10–CM (diagnoses) and ICD–10–PCS (inpatient procedures) classification systems. These systems were designed and produced by the Department of Health and Human Services (HHS) in the mid 1990's and are still awaiting formal adoption and implementation. To date, neither the Congress nor the Secretary has taken action that would result in the actual implementation and use of these classification systems. Yet, in the case of physicians and in contrast to ICD–9-CM, ICD–10–CM adoption would provide the government with more accurate information to determine quality, severity, and payment. In addition, if quickly adopted, ICD–10–CM would allow physicians to implement new health information technology without the threat of having to make retroactive changes (much more expensive) to their HIT systems at some undetermined time in the future.

Briefly, adoption of ICD–10–CM now would improve the situation for Medicare and its physicians by:

- Providing the detail related to diagnoses that would allow CMS to judge the severity of the patient, which in turn would better identify the proper Evaluation/Management (E/M) level of care reported on the Medicare claim.
- Providing the detail related to diagnoses that would point to the necessary medical services not easily identified in the very vague and incomplete descriptions provided by ICD–9-CM, due to the rationing of ICD–9-CM codes that has had to occur in recent years because of the limited number of codes remaining. If CMS accepted all diagnoses codes that can be submitted electronically, then in many complicated situations—generally higher cost encounters and admissions—complications and co-morbidities could be identified without the need to request additional information from the provider (usually in paper form)This would also alleviate the need to review such data manually.
- Providing the detail necessary to identify not only complications, co-morbidities, or present on admission diagnoses, but also enough detail to permit more automated processing. The additional detail provided in ICD–10–CM will actually make it easier to identify fraud and abuse than currently because coders will not have to guess on what codes to enter and the additional detail will more clearly support or not support other codes and items on the claim form.
- Providing more detail in the claim so that physicians will incur less costs by not having to provide additional information, either with the claim or in response for more information from the Medicare contractor.

As members of the Health Subcommittee recognize, the detail behind the ICD–9-CM upgrade and the need to implement the ICD–10–CM and ICD–10–PCS, is significant. Had ICD–10–CM and ICD–10–PCS been implemented, the changes now being made to the Medicare inpatient prospective payment system would have been significantly easier for Medicare and the provider community to adopt. Costs will continue to increase for the Medicare program each year the implementation of ICD–10–CM and ICD–10–PCS is delayed. In 2002, CMS testified to the National Committee on Vital and Health Statistics (NCVHS) that it desired to move to ICD–10 as soon as possible. The NCVHS in turn recommended adoption at the end of its hearing review of the Rand study on the issue in 2003. The subcommittee needs to consider that our nation has dedicated funding to maintain ICD–10–PCS and ICD–10–CM since the mid 1990's—CMS maintains ICD–10–PCS while the CDC has responsibility for ICD–10–CM—and yet we have received no benefit from the detail because of the implementation delays.

The ICD–10 codes possess many additional and beneficial uses beyond the subcommittee's current discussion. AHIMA would be happy to respond to questions on these uses as well as address any questions or concerns the subcommittee members might have with our comments. We urge the subcommittee to consider recommending the adoption and implementation of the ICD–10 classifications either as a stand alone legislation, or as a part of any health information technology or Medicare legislation Congress may consider. It is also important that the subcommittee ensure the adoption and implementation of the upgraded versions of the HIPAA transactions necessary to insure that such data can be carried in the claims system. Again, additional detail can be provided if the committee needs it.

Action by the subcommittee and the Congress before the fall recess will allow the U.S. to make the conversion to ICD–10 classifications by October 1, 2011. Moving

to ICD–10–CM and ICD–10–PCS is already long overdue. Please take the necessary steps to ensure this date is not delayed any further.

Statement of American Occupational Therapy Association

The American Occupational Therapy Association (AOTA) submits this statement for the record of the May 9, 2007 hearing. While the hearing is focused on potential methods to improve efficiency among physicians in Medicare, AOTA appreciates the opportunity to provide comment on what AOTA is doing in order to improve efficiency among occupational therapists in Medicare. As the Committee looks at alternatives within the physician fee schedule, AOTA would also like to highlight some areas in Medicare where the Committee should focus, particularly in regard to AOTA's efforts relating to the physician quality reporting initiative (PQRI) and the Medicare Part B outpatient therapy caps.

The Balanced Budget Act of 1997 [Public Law 105–33] moved outpatient rehabilitation services, including occupational therapy, to the physician fee schedule. Occupational therapists and occupational therapy assistants are subject to yearly proposed cuts to the physician fee schedule. AOTA applauds past congressional action to avoid the proposed cuts to the physician fee schedule and is committed to working with Congress to avoid the proposed 10 percent cut for 2008. Simultaneously, therapists must also confront the uncertainty of the arbitrary therapy cap which literally prohibits care for high cost patients.

Physician Quality Reporting Initiative (PQRI)

The Tax Relief and Health Care Act (TRHCA) of 2006 included a provision that directed the Secretary of Health and Human Services to implement a system for the reporting by ?eligible professionals' of data on quality measures. CMS has recognized occupational therapists as professionals eligible to participate in the system, and AOTA is working diligently to address new quality and payment options for Medicare Part B outpatient therapy, which take effect July 1, 2007.

AOTA is positioned to begin participation in the deliberations of the Ambulatory Care Quality Alliance (AQA), the National Quality Forum (NQF), and the Physician Consortium. These three consensus organizations recognized by Congress in the TRHCA inform the physician quality reporting initiative at CMS.

AOTA is also developing outcomes measures for occupational therapy as part of its Centennial Vision and Strategic Plan. A committee of distinguished occupational therapy practitioners with experience in outcomes measures has been formed and is in the process of examining existing outcomes measurement tools and determining the most appropriate measures for occupational therapy.

AOTA continues to rely on the work done as part of its Evidence-Based Literature Review Project. AOTA offers a series of Evidence Briefs to inform the practice of occupational therapy. These summaries of articles selected from scientific literature cover a wide variety of areas of occupational therapy practice including: attention deficit/hyperactivity disorder, brain injury, cerebral palsy, children with behavioral and psychosocial needs, chronic pain, developmental delay in young children, multiple sclerosis, older adults, Parkinson's disease, school-based interventions, stroke, and substance use disorders.

These documents offer a bridge between scientific research and clinical practice to aide occupational therapy practitioners in providing therapy that is based on evidence in order to provide efficient and effective care and to improve patient outcomes.

Therapy Caps

The annual cap on outpatient rehabilitation, commonly referred to as the "$1,500" cap, imposed by the Balanced Budget Act of 1997 and currently under an exceptions process through Congressional action, would, if implemented, limit access to occupational therapy that would enable an individual to fully recover from a stroke, to overcome limitations resulting from severe burns, or to achieve independence in self-care to enable living at home among other illnesses or injuries. AOTA has worked for many years to repeal this cap and appreciates Congress' willingness to stop implementation. Most recently, a 1-year extension of the exceptions process was included in the Tax Relief and Health Care Act of 2006 [P.L. 109–432], however, that will expire on December 31, 2007 unless Congress takes action this year.

MedPAC has expressed concerns with the therapy caps because they do not discriminate between necessary care and unnecessary utilization. AOTA remains committed to working with Congress and CMS to deter unnecessary care or overutiliza-

tion. AOTA has held discussions with Congress, CMS, and other provider and consumer groups to determine ways to refine the exceptions process to ensure that patients continue to receive appropriate care. Efficient and effective delivery of therapy services is also about ensuring access to services that have a proven impact on lifestyle choices, healthy living, and avoiding illness and injury (such as those resulting from falling, poor driving, or limits in self-care).

AOTA strongly supports the Medicare Access to Rehabilitation Services Act of 2007 (S. 450/H.R. 748). AOTA supports passage of legislation that would repeal the caps, and is dedicated to working with CMS, Congress, and other provider and consumer groups to find an appropriate long-term solution. Financial limitations to proper therapy services impede the therapists' ability to care for their patients appropriately and use professional judgment effectively, and ultimately hinder the ability of a therapist to provide high-quality, efficient care to Medicare beneficiaries.

AOTA is the nationally recognized professional association of 36,000 occupational therapists, occupational therapy assistants, and students of occupational therapy. Occupational therapy is a health, wellness, and rehabilitation profession working with people experiencing stroke, spinal cord injuries, cancer, congenital conditions, developmental delay, mental illness, and other conditions. It helps people regain, develop, and build skills that are essential for independent functioning, health, and well-being. Occupational therapy is provided in a wide range of settings including day care, schools, hospitals, skilled nursing facilities, home health, outpatient rehabilitation clinics, psychiatric facilities, and community programs.

Occupational therapy professionals assist those with traumatic injuries—young and old alike—to return to active, satisfying lives by showing survivors new ways to perform activities of daily living, including how to dress, eat, bathe, cook, do laundry, drive, and work. It helps older people with common problems like stroke, arthritis, hip fractures and replacements, and cognitive problems like dementia. In addition, occupational therapists work with individuals with chronic disabilities including mental retardation, cerebral palsy, and mental illness to assist them to live productive lives. Occupational therapy practitioners also provide care to Veterans who suffer from traumatic brain injuries, post-traumatic stress disorder, spinal cord injuries, and other conditions. By providing strategies for doing work and home tasks, maintaining mobility, and continuing self-care, occupational therapy professionals can improve quality of life, speed healing, reduce the chance of further injury, and promote productivity and community participation for Veterans.

Statement of the Renal Physicians Association

The Renal Physicians Association (RPA) is the professional organization of nephrologists whose goals are to ensure optimal care under the highest standards of medical practice for patients with renal disease and related disorders. RPA acts as the national representative for physicians engaged in the study and management of patients with renal disease. RPA greatly appreciates the interest of Ways and Means Health Subcommittee Chair Pete Stark and Ranking Minority Member Dave Camp in exploring new methodological options for enhancing the quality and efficiency of care delivered by Medicare physicians. Further, we appreciate the Subcommittee's efforts to exercise its oversight authority as the Centers for Medicare and Medicaid Services carries out its fiduciary responsibility to maximize the effectiveness of Medicare program spending.

RPA believes it has a unique perspective to offer on the issues being considered by the Subcommittee, as nephrologists have been reimbursed through the use of a monthly capitated payment (MCP) system for the bundle of physicians' services associated with the care provided to patients with end stage renal disease (ESRD) for over thirty years. Further, nephrologists have been involved in the gathering and reporting of clinical performance measure (CPM) data since 1994 through the CMS Core Indicators Project. As a result, provision of care to chronically ill patients under bundling and quality measurement structures that are just now being proposed broadly across all specialties has been a way of life for nephrologists for many years, and thus RPA believes our insights would be of use to the Subcommittee.

In this collaborative spirit, we offer the following recommendations for consideration in the development of new methodologies to improve the quality and efficiency of the care provided by Medicare physicians. These recommendations are organized into two sections, the first addressing quality related issues and the second relating to the reimbursement structure issues involved in the development of bundled payment systems and similar models.

Quality Issues

- RPA believes that in order to develop an effective and workable payment methodology linking reimbursement to quality, Congress, CMS, MedPAC and other policymakers must actively involve and draw on the intellectual resources and experience of the physician community throughout the process. This will help to ensure that the development and final products emphasize the expected benefits of a modified payment methodology and minimize negative unintended consequences.
- RPA supports the development of performance-based payment system that considers and separately rewards both high quality patient care and measurable improved performance.
- RPA believes that for such a revised payment methodology to be effective longitudinally, the system must not disrupt the resource-based relative value scale (RBRVS) system, and must for the purposes of the incentive payments have budget neutrality waived. Incentive payments should not be derived by decreasing usual payments or establishing a withhold from the usual payments.
- RPA believes that to effectively implement a payment methodology linking reimbursement to quality, Congress must consider fundamental change to the policy structure underlying the Medicare program, specifically assessing the desegregation of the Medicare Part A and Part B funding pools. RPA believes that the artificial separation of inpatient and outpatient reimbursement does not allow for enhanced Medicare program cost efficiency through the investment of Part A savings in outpatient care services.. Physician activities that improve quality and produce savings by decreasing hospitalizations ought to be accounted for in the adjudication of the funds available for physician incentive reimbursement.
- RPA believes that Congress must support substantial research in both the pertinent basic science and health services arenas, especially related to outcomes research, in order to strengthen the essential and necessary scientific evidence supporting a transition to a performance-based payment system.

Reimbursement Structure Issues

- RPA supports the use of bundled payment systems to provide medically appropriate care to specific patient sub-populations, and to promote efficient use of Medicare program resources. RPA believes that the reimbursement for bundled payment systems must not only cover the services included in the bundle but also be sufficient to promote the use of electronic medical records, integration of emerging technologies, and other innovations in medical practice. Further, RPA believes that a mechanism for periodic review of the bundle must be included when the bundle is developed, with review of the reimbursement for the bundle being required if and when services are added to or removed from the bundle.
- RPA believes that physician reimbursement system revisions should include assurance of reasonable payment that encourages the medically appropriate site of care to be utilized, including payment at all sites of care where services are provided. Such a policy revision would address situations where the patient is admitted to the hospital for services that are medically appropriate to be provided in the outpatient setting but are often provided in the inpatient setting due to the absence of a payment mechanism in the outpatient setting. For example, in renal care, patients with acute kidney failure who are expected to regain their renal function often cannot be dialyzed in the outpatient setting because of the difficulty that dialysis facilities and outpatient hospital departments experience in being reimbursed for the facility services related to dialysis. Review and revision of such seemingly arbitrary reimbursement guidelines would facilitate more efficient use of Medicare program resources.
- RPA believes that expanded coverage for medically appropriate utilization of services to maintain and improve quality of care should be provided. While the expansion of covered preventive services in the Medicare program in areas such as diabetes treatment represents a significant step forward, the potential for achieving greater cost-efficiency in this area is profound. For example, in kidney care there are a variety of interventions and treatment modalities specific to the ESRD patient population that would enhance the quality of care provided but for which there currently is either no Medicare reimbursement or such reimbursement is extremely difficult to obtain. Examples of these services include certain procedures related to monitoring and maintaining the patient's vascular access, use of essential oral medications including phosphate binders and multivitamins, and provision of nutritional supplements. Coverage of these services over time will likely lead to decreased per-patient costs over time.

- RPA believes that reimbursement for effort and practice costs associated with required quality improvement and patient safety services should be accounted for as payment system revisions are developed. Recognizing that programs such as the Physicians Quality Reporting Initiative (PQRI) and other CMS managed demonstration projects are currently only voluntary, before these programs are made mandatory, there should be corresponding consideration of the expenses to the physician's practice of providing these services. In renal care, while it is appropriate that nephrologists should be expected to lead continuous quality improvement (CQI) processes in dialysis facilities and their own practices, assuming responsibility for the full cost of these services should not be part of that expectation.

Conclusion

RPA supports Congress' efforts to seek improvement in the quality and efficiency of the care provided by Medicare physicians to program beneficiaries. We urge Congress to approach these issues thoughtfully and deliberately in order to minimize the impact of any unforeseen negative consequences. In the area of quality improvement, we urge Congress to (1) continue its efforts to include physicians in the development of such a system; (2) direct CMS to develop a performance-based system that rewards both high performance and measurable improved performance; (3) ensure that such a system does not disrupt the RBRVS system and identifies separate funding for incentive payments; (4) assess desegregation of the Medicare Part A and Part B funding pools; and (5) support the basic research and health services research necessary to make such change evidence-based. With regard to reimbursement structures, Congress should (1) require periodic review of any bundled payment, and the bundle of services itself; (2) provide reasonable payment that encourages the medically appropriate site of care to be utilized; (3) expand coverage for medically appropriate preventive services, especially in the treatment of chronic diseases; and (4) account for the effort and practice costs associated with enhanced quality improvement and patient safety services. Once again, RPA appreciates the opportunity to provide our perspective on these issues to the Committee, and we make ourselves available as a resource to the Committee in its future efforts to ensure the best possible health outcomes and quality of life for all Medicare beneficiaries, and especially those with kidney disease.

Statement of University of North Carolina at Chapel Hill

In 1999, the state of North Carolina enacted landmark legislation, which licensed Clinical Pharmacist Practitioners as mid-level pharmacist practitioners with the North Carolina Medical Board. The Medical Practice Act (G.S. 90–18.4) states (a) any pharmacist who is approved under the provision of G.S. 90–18(c) 3a to perform medical acts, tasks, and functions may use the title "Clinical Pharmacist Practitioner." It further states that a CPP may implement drug therapy and order laboratory tests pursuant to a drug therapy agreement. The NC Pharmacy Practice Act 90–85.3 defines CPP's as having the authority to collaborate with physicians in determining the appropriate health care for a patient.

In order to qualify as a CPP, a pharmacist is required to complete advanced training and certification and be approved by both the NC Board of Pharmacy and Board of Medicine. This expands the scope of practice of a clinical pharmacist to allow for prescriptive authority and complex medical decision-making. This legislative action in the North Carolina General Assembly, allowed CPP's to establish their own practices, often within a physician's office or clinic, focusing only on the provision of clinical services in collaboration with physicians. CPP's deliver care and function as mid-level providers in a manner equivalent to nurse practitioners and physician assistants. In all cases, CPP's provide very detailed evaluation and management of extremely high risk patients with multiple co-morbidities who are at risk for bad outcomes (i.e. hospitalization, ER visits, etc.) unless their clinical status for diabetes, CHF, COPD, anticoagulation, etc. is closely monitored. The attending physician provides direct oversight as required by the incident-to guidelines.

Clinical Pharmacist Practitioners (CPPs) are North Carolina registered pharmacists who have an advanced scope of practice, similar to Nurse Practitioners, who via collaborative practice agreements with supervising physicians, provide direct patient care under the supervision of a physician. Accordingly, CPPs are considered mid-level providers, however, pharmacists, at any practice level, are the only health care practitioners who are not recognized under Part B of the Social Security Act.

Why is that the case? Consequently, CPPs are not allowed to bill for seeing Medicare-eligible patients for provision of clinical care. Thousands of high-risk patients (i.e., hypertension, diabetes, CHF, anticoagulation, chronic pain) in North Carolina (and beyond) risk a critical interruption in care when they are not allowed access to the entire spectrum of health care providers.

In 2004, HR 4724, which was intended to cover a higher level of a collaborating pharmacy practitioner which largely exists only in North Carolina and New Mexico at present. This piece of legislation, submitted in 2004 by then-Representative Richard Burr as a stand-alone bill, went nowhere, even though it was supported by all of the national pharmacy organizations and the American Medical Association. Such legislation, had it passed, would not have enabled all pharmacists, such as dispensing pharmacists, to receive reimbursement for Part D-related activities, but only for those advanced practice pharmacists who provide patient care activities under Part B, such as through a collaborative agreement with a physician. At present, there are at least 41 states that have state legislation approved for expanded clinical roles for pharmacists, such as noted above. The only barrier is our Federal government.

In reading your e-mail message, we noticed that Rep. Stark suggested that a review of the payment systems for fee-for-service providers, and that the majority of Medicare beneficiaries and payments are under the fee-for-service system. If you are looking for efficient and appropriate health care provision, then we would submit that you also take a look at the use of advanced practice pharmacists, to provide health care, decrease medication costs through application of pharmacotherapy, and monitor for and reduce the risk of adverse drug events. The attached document outlines the benefits of clinical pharmacists in managing care and it attendant costs, and while it is several years old, it delineates the value, both in patient outcomes, and in cost savings (e.g., $14 to $17 *saved* for each dollar spent) in the Medicare population.

We have also noticed that the Chair of the Medicare Payment Advisory Commission testified at your hearing. We would respectfully suggest that you review the MedPAC report on Clinical Pharmacists, produced in 2002.

We would love to talk to anyone who is interested in improving health care for our nation's seniors, with a potential cost savings to the system. The Medicare recipients in our state, and all others for that matter, depend upon your support of this request to consider including advanced practice pharmacists as approved health care providers under Medicare Part B. Just ask yourself one question: If the Federal government will not let pharmacists take care of America's prescription drug use problem, then who will? Physicians are too overloaded to work on this issue, and there is a national shortage of nurses. Imagine how you could start to fix the Medicare Part D problems if you truly let pharmacists come to the table and do it. Most often, your best solutions are not related to more technology or regulations, but actually are right in front of you, in the communities across the country, where problems can be dealt with face-to-face. Please support advanced practice pharmacists, the most accessible health care provider in the community.

Please enter these comments into the record, but more importantly, please call upon us to continue the conversation.

Sincerely,

Timothy J. Ives, Pharm.D., M.P.H., BCPS, FCCP, CPP
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