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EXPLORING OPTIONS FOR IMPROVING THE MEDICARE PHYSICIAN PAYMENT SYSTEM

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE
HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

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EXPLORING OPTIONS FOR IMPROVING THE MEDICARE PHYSICIAN PAYMENT SYSTEM

TUESDAY, MARCH 6, 2007

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

The subcommittee met, pursuant to call, at 9:35 a.m., in room 2123 of the Rayburn House Office Building, Hon. Frank Pallone, Jr. (chairman) presiding.

Members present: Representatives Eshoo, Green, DeGette, Capps, Allen, Baldwin, Solis, Ross, Hooley, Matheson, Dingell, Deal, Hall, Wilson, Shadegg, Murphy, Burgess, and Barton.

Staff present: Robert Clark, Yvette Fontenot, Amy Hall, Christie Houlihan, Jodi Seth, Bridgett Taylor, Brin Frazier, Chad Grant, Ryan Long, Katherine Martin, Melissa Bartlett.

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

Mr. PALLONE. I would like to call the meeting to order. Today we are having a hearing on exploring options for improving the Medicare physician payment system, and I am glad to see that Mr. Hackbarth—we have two panels. The first is just Mr. Hackbarth. And I will recognize myself now for an opening statement. Since we are talking about physician services today, I figured I would try to couch my statement in medical terms so I am going to begin with a diagnosis. For the past several years physicians participating in Medicare have been threatened with payment cuts and these payments cuts are the result of the complex formula used to reimburse physicians, specifically physician payments are tied to an expenditure target known as a sustainable growth rate or SGR.

As spending for physician services exceeds this spending target then payments are reduced. Congress, however, has stepped in each time to prevent these cuts from taking place and instead we have provided physicians with a freeze in payments or slight increase depending on the year. At the same time we are grossly overpaying managed care plans that participate in Medicare. According to the MedPAC report released last week payments to Medicare Advantage plans are 12 percent higher than payments for physicians in traditional fee for service. These overpayments haven't bought us much either. There is no discernible difference in the quality of care or health outcomes for beneficiaries enrolled

in private plans versus those who are enrolled in traditional fee for service.

If the current system is left unchanged the prognosis is grim in my opinion. Physicians are already slated to receive annual payment cuts over the next 10 years. Each year that Congress steps in to avert these payment cuts from going into effect that increases the size of the cuts that doctors face in later years. As a result of previous interventions doctors will face a cut of 10 percent in 2008 and additional cuts over the next 10 years. The predicted payment cuts could have serious implications for beneficiaries, including jeopardizing their access to medical services, and while doctors don't seem to be refusing Medicare patients yet, I have little doubt that if Congress were to allow these payment cuts to go into place many doctors would drop out of the program altogether.

Furthermore, if we do not correct the payment inequities between Medicare Advantage plans and traditional fee for service seniors are going to be forced into private managed care where their choice of doctors and their access to services will be severely constrained. We must preserve in my opinion the right of beneficiaries to select a doctor of their choosing which has been the hallmark of the Medicare program since it was created over 40 years ago. Beneficiaries will face access problems also if they can no longer afford the growing cost of their part B premium. Our seniors have already faced 3 years of record premium increases under Medicare. Currently, the part B premium is $93.50 per month. I remember when people would complain about it being $40 or $50. In 2008 the part B premium is expected to increase by approximately $15 to $109.40 per month. These increases are eating up a larger share of senior Social Security checks and forcing them to make tough choices between medical care they need and other necessities.

So what is the course of treatment now that we have the diagnosis and the prognosis, what is the course of treatment, and first and foremost we need to level the playing field between Medicare Advantage plans and traditional fee for service Medicare by establishing neutral payment systems. We should also eliminate the slush fund used to provide extra payments for preferred provider organizations. These two steps alone will go a long way at reducing unnecessary costs in the program and preserving access for seniors. The harder part is deciding how to fix the payment structure. The MedPAC report that we will hear about today will hopefully provide us with a good starting point as we examine our options.

From what I have seen so far, I think there are some good ideas included in this report, and I am eager to learn more about them from Mr. Hackbarth. I think it is important to note, however, that the task before us is a difficult one. We all know that. The commissioners themselves admit that they could not agree on a single approach or how to fix the problems associated with the SGR and that should be some indication of the challenges that Congress faces as we attempt to come up with a solution.

Needless to say, we have our work cut out for us but that shouldn't deter us. I have said before, and I will say again, that we need a permanent solution to this problem. We should no longer settle for short-term fixes that simply kick the can down the road.

In sum, we need to roll up our sleeves and get to work. I am looking forward to hearing from our witnesses today and working with all interested parties including my colleagues on both sides of the aisle to find a solution. I think that is important. It is really important for us, I believe, to work in a bipartisan fashion on this issue.

I think we all want to provide physicians with a stable and predictable payment system as well as preserve beneficiaries access to care. I think I would just end by saying that I think the worse thing is when we have a reimbursement rate or system that is not based on what is actually happening out there when the government doesn't look at things practically in terms of what the real costs are and comes up with systems that are not really related to actual costs then we get into trouble, and that is what we need to fix. So thank you again. I will now recognize the ranking member for an opening statement.

OPENING STATEMENT OF HON. NATHAN DEAL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA

Mr. DEAL. Thank you, Mr. Chairman. Medicare physician payment has been an issue that has come before this committee several times over the last several years. In fact, I think we had two hearings that related to the subject during the last Congress. I am glad to see what we are looking at possible reforms again today because I do think that is something that we have to wrestle with. I think the report of MedPAC and the lack of consensus among the commissioners themselves indicates how complex this issue really is and how difficult it is to arrive at a solution that will satisfy everybody, and I am hopeful that we can use this as a springboard for coming to more long-term solution.

I personally would have hoped that maybe MedPAC could have given us a little more definitive guide path but there again I think that fact recognizes the complexity of the issue and the difficulty of the commissioners themselves to come to consensus. The incentives in the existing payment system reward those physicians whose practices see a high volume of cases while paying much less attention to the quality of the services performed. This has led to the dramatic growth that we have seen in certain services. And here I think lies the significant weakness of the SGR because while it takes automatic action to check the cost of the service provided it does little to address the number of time that service is provided.

Both of the components, the volume of services and the price paid for the service, must be considered during reform of physician payment. As the MedPAC report notes beneficiaries that receive more services do not necessarily experience better quality of care or better outcomes. I think this dynamic between the growth and the number of services and how much is paid for the service is why it is so important that the committee focuses on reforms which emphasize that patients receive high quality care. I believe we took a step in the right direction last year by providing a bonus payment for those physicians that voluntary report quality measures this year, and I hope that we can expand upon it again during this Congress. I thank you, Mr. Chairman.

Mr. PALLONE. Thank you. And then we will continue with the opening statements. I recognize the gentlewoman from California, Ms. Eshoo.

OPENING STATEMENT OF HON. ANNA G. ESHOO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Ms. ESHOO. First, Mr. Chairman, thank you for holding this hearing. We have had hearings before. We know we have a very large issue facing us that I hope we will finally address. Physicians and patients are deeply affected by this across the country. I could go member by member here. My staff has given me the numbers affecting each one of our congressional districts, the members that are here, and that really is a microcosm for the rest of the Congress. It is costly, and I think that is why the now minority really didn't get to address it.

Every year there is a rush and a push on Congress to do something about physician reimbursements and we have come up with very temporary fixes, and this really calls for all of us putting our heads together. And I look forward to asking questions today, and I will place my statement in the record. But thank you for having this hearing. I think it is going to be instructive, and hopefully it will be a guide for how we can reform. Thank you.

[The prepared statement of Ms. Eshoo follows:]

PREPARED STATEMENT OF HON. ANNA G. ESHOO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. Chairman, this committee has held many hearings examining the Medicare physician payment system over the last several years. We've waited far too long to act on this issue and physicians and their patients have suffered as a result.

I hope today's hearing will be different from those of the past and that Congress will use this hearing as a guide for drafting, introducing and passing legislation that is long overdue. So thank you again, Chairman Dingell, for making this issue a priority for the committee in the 110th Congress.

Last week, MedPAC released a report to Congress analyzing the current state of Medicare physician payments. Although the report did not contain a specific recommendation for how we ought to fix this problem, it did recommend two things: payment accuracy for physicians must be improved. To do so, the sustainable growth rate (SGR) payment formula should be abandoned in its current form.

If we continue to use expenditure targets, they must involve two new themes: they must apply to all Medicare expenditures (hospitals in addition to physicians); and they must be applied at a smaller geographical scale, rather than the current SGR formula which is applied at the national level.

With respect to the SGR, serious reforms are necessary and they're needed now. Last year many of my colleagues and I recommended that we eliminate the SGR and replace it with the Medicare Economic Index (MEI). The MEI is an index based on actual medical practice costs. It is used to reimburse all other providers in the Medicare program (including hospitals, health plans and nursing homes). MedPAC and many State medical associations have been supportive of past proposals to eliminate the SGR payment formula and adopt the MEI for physician payments.

The SGR, however, is inappropriately tied to a non-medical index, the Gross Domestic Product (GDP), which has resulted in proposed physician payment cuts of more than 4 percent each year since 2003. If Congress doesn't act now, Medicare physician payment rates will be cut by roughly 10 percent on January 1, 2008. Congress scrambles every year to enact a last-minute fix. What we really need is a permanent fix, and replacing the SGR with the MEI will do this.

MedPAC's recommendation to scale expenditure targets to geographic areas leads me to raise a related issue of considerable concern to me, that of the Geographic Payment Locality. Despite major demographic changes across the country since 1966, the Geographic Payment Locality hasn't been updated in any meaningful way. The result is that physicians in 32 states and 174 counties are currently inac-

curately underpaid by up to 14 percent per year. Although the geographic payment locality is not a national problem, it's a huge problem for the affected localities.

For example, in Ranking Member Deal's district, Pickens County physicians were underpaid by 12 percent in 2006. In Ranking Member Barton's district, Ellis County physicians were underpaid by 7.5 percent. In Chairman Dingell's district, physicians in Monroe and Livingston Counties were underpaid by 5.4 percent last year.

And in my district, Santa Cruz County physicians are underpaid by 10.2 percent. As of June 1 of last year, physicians in Santa Cruz County are no longer accepting new Medicare patients. This means that patients in Santa Cruz must travel at least 25 miles to neighboring Santa Clara County to receive care, if they are lucky enough to find a doctor who will accept new Medicare patients.

We have to be careful moving forward: it makes absolutely no sense to even consider applying new expenditure targets to 41-year-old geographies. We must first reform the payment localities, and the locality-based payment levels so they reflect actual real costs in the geographic units that we're developing. Otherwise, we'll only compound an already overwhelming problem.

I urge you, Mr. Chairman, and members of our committee to listen carefully to the expert opinions of our witnesses today and make a commitment to reform the Medicare Physician Payment system before the summer recess.

We've spent far too long investigating this issue. It's time to act.

Mr. PALLONE. Thank you. I recognize the gentleman from Texas, Dr. Burgess.

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

Mr. BURGESS. Thank you, Mr. Chairman. In anticipating I won't get through all of this in 3 minutes, I am going to claim the time of everyone who is not here on my side. Alan Greenspan right before he retired as Chairman of the Federal Reserve Board came and did a victory lap around the Hill last January, and he met with a group of us on my side of the aisle, and sure enough the questions came up are we going to be able to sustain Medicare spending, the same sort of things we hear David Walker, the comptroller, talk about.

Alan Greenspan was saying, he said I think ultimately you will be able to solve those problems. It will be difficult but you will be able to do it. My bigger concern, said Mr. Greenspan, is there will be no one there to deliver the services by the time you get there. And I share Mr. Greenspan's concern. I am very anxious to hear from our witnesses today. Before we go home for the Easter break, I will be reintroducing legislation much as I did last year in Congress to deal with this program. Since MedPAC has not addressed a solution to the SGR problem, I will fill the void.

But let me just go through with the committee today some of the principles that I think we must have in that legislation when it comes forward at the end of the month. Congress must develop a physician work force incentive that will insure future beneficiaries accessibility and keep doctors in the game. This has got to be complimentary to Medicare physician payment reform. The current Medicare physician payment system exacerbates negative physician work force trends. Therefore, the SGR ultimately cannot be reformed. It is just simply going to have to be eliminated or replaced with something else. I vote for MEI.

Reimbursement must fairly compensate physicians who provide services covered by Medicare. Any new system must be able to adjust for growth and services but also be agile enough to determine what constitutes appropriate growth and service volume and when

growth results in better patient outcomes that is recognized. That was the issue that Charlie Norwood brought up last year and hammered home when we had a similar panel to this last fall. Since Medicare is an integrated program the measure of appropriateness should take into account the growth in certain service resulting in the decrease or avoidance of other services covered elsewhere in the Medicare program.

We keep loading stuff onto part B. We expand the premium for senior citizens. We cut the reimbursement rate to physicians but this is money that we are no longer having to spend in part A, part C, and part D. Medicare truly should be, if it is an integrated program, it should be reflective of that fact and not punitive to part B and ultimately punitive to seniors and to physicians who are involved in the part B program, so Congress must de-link any future cost containment to trends in the economy that are completely external to medicine.

The doctors who practice medicine in this country have no control over what we do up here in Washington that ultimately affects the economy. Quality reporting, I am a big believer in it, but I will tell you what, and I believe this to be true, if you drive out the quality physicians, and I am talking about the doctors who are 45 to 65 years of age, if you drive those individuals out of the practice of medicine for our senior citizens it is going to cost you a heck of a lot of money to bring that quality back to speed and you will never recover. The result is we will have the scope of practice issues where we have people other than physicians delivering care to arguably what are our most complex patients in this country, our Medicare patients. I will yield back, Mr. Chairman.

Mr. PALLONE. Thank you, Doctor. Next I recognize the gentlewoman from Colorado, Ms. DeGette.

OPENING STATEMENT OF HON. DIANA DEGETTE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF COLORADO

Ms. DEGETTE. Thank you very much, Mr. Chairman. I would like to add my thanks to the other committee members for you having this hearing today. For the last few years we have an annual ritual in my office, which is we answer all the phone calls from the doctors in my district begging me to fix the reimbursement problem, and understandably they can't understand or comprehend why we come to the brink of significant reimbursement cuts every year only to make minor increases on December 31. Most physicians at the end of the day are small businessmen and women who need to make their payroll and cover their rent, pay for equipment upgrades, and plan for the coming year.

They need the continuity of predictable reimbursement so that they can adequately plan for the future and spend their time doing what they are good at which is caring for patients. So in 2005 we heard all these same pleas for help, and we decided to start down the road to make changes. In the Deficit Reduction Act we called upon MedPAC to examine alternative methods for reimbursing physicians while also controlling levels of expenditures. I, like most of my colleagues here on the committee, was hopeful that MedPAC

would be able to coalesce around a plan that could begin the process of developing a reimbursement system that made sense.

So that is why I was disappointed to learn that the result of the study was not consensus but simply more discussion. It seems like as we pull the physician reimbursement system away from the precipitous of cuts every year so too do we pull a long-term fix away from successful development. And I think, Mr. Chairman, you and the other members on this side of the aisle, and I think our colleagues on the other side too, will agree this has just simply got to stop. In the absence of a concrete plan for fixing our physician reimbursement system, I hope that our hearing today will start a process that will eventually result in a usable model.

We have all spent a lot more time than we should have on this issue, including the physicians, and it is time that we put patients first, roll up our sleeves, and develop a system that rewards high quality care at a reasonable price. Despite my disappointment over not having a final solution to our problem, I am happy to see that we are breaking the issue down to some important fundamentals. I am looking forward to hearing discussion of a pay for performance model, and I also want to hear how a system can be constructed that supports coordination of care among providers and rewards achieving the best outcome, not necessarily the specific services that were provided.

Finally, I am interested in hearing how regional differences in utilization can be better understood so we don't just reward good behavior but we try to replicate it nationwide. Mr. Chairman, despite my concerns, I do appreciate the work that has been done to date, and I hope the discussion today generates ideas that will eventually lead to plans to move forward. And I yield back any time I might have. Thanks.

Mr. PALLONE. Thank you. I recognize the gentlewoman from California, Mrs. Capps.

OPENING STATEMENT OF HON. LOIS CAPPS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mrs. CAPPS. Thank you, Chairman Pallone. I believe we all agree that there is a dire need to reform the current Medicare physician reimbursement system. I am very pleased that early on in this session of Congress that you have called this hearing, thankful that our witnesses are here. We have discussed this topic in this committee quite often over the past few years, and I think we all would agree now that the first step is replacing the SGR formula. It is fundamentally flawed, needs to be scrapped, so that we can develop a better system. We need to set the stage for long-term solution that does not rely on enacting last minute 1-year updates and threatening long-term solvency concerns.

So that is one of the reasons I am very happy that we are starting this discussion early on in the 110th Congress. It should give us time now at this time to really take some action as soon as possible. I hope that as we proceed with devising a solution to the overall Medicare physician fee problem we will also consider another related subject that deserves its own hearings and its own fix and that is a geographic adjustment issue. I brought this up before many times in this committee, and I am going to continue to do so.

It is really something I would say almost every member who is here today at this hearing and many others as well are very concerned about it because it affects our districts.

In fact, there are 175 counties in 32 States where physicians are paid 5 to 14 percent less than the Medicare assigned geographic cost factors because they are assigned to inappropriate localities. In my own district physicians in Santa Barbara and San Luis Obispo counties currently receive reimbursements much lower than the actual geographic cost factors in those counties. There are proposals out there but none have been acted on, and I want to take this opportunity to stress how important a fix would be to our constituents. It is heartbreaking to hear physicians closing up shop, beneficiaries who can't find a doctor who will take a new patient on Medicare. It is such a common theme across this country.

Just a few days ago, I heard that the last psychiatry practice in San Luis Obispo County had to close its doors. With each physician who leaves a number of patients are left to find new doctors further away, wait longer for appointments, and this is a situation we cannot allow to go on any longer. Congress needs to act quickly to address the overall Medicare physician payment system as well as the geographic practice cost index. I am sure we are going to hear from our witnesses today and I agree with them that we cannot improve our health care delivery in this country when physicians cannot afford to sustain their practice and when patients are left with inadequate access to care. With that, I will yield back the balance of my time.

Mr. PALLONE. Thank you. The gentlewoman from Oregon, Ms. Hooley, is recognized.

OPENING STATEMENT OF HON. DARLENE HOOLEY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OREGON

Ms. HOOLEY. Thank you, Mr. Chair. Good morning, Mr. Hackbarth. It is particularly nice to welcome an Oregonian to this committee. Medicare physician payment reform is a critical issue for Congress to address this year. Physicians will face a 10 percent cut in payment next year if Congress fails to act. The health of Medicare cannot afford for Congress to keep relying on year-end stop gap measures to address the physician payment shortfalls like we did last year. Our dedicated physicians deserve better than to be forced to wait until the last days of the year to find out if they can afford to provide services to Medicare beneficiaries in the future.

I firmly believe that a long-term fix for the physician reimbursement system is absolutely critical. Cutting physician reimbursement rates put an increased burden on an already strained system. Some seniors cannot get access to a physician because they have stopped accepting Medicare patients, and again I think you will hear this over and over again. There is a patient access issue, and we cannot let the Medicare system and our seniors be put at risk by failing to act on physician payment reform. Oregon's physicians provide care more efficiently than physicians in many parts of the country. The alternatives to the SGR discussed in your report are a good start toward addressing geographic disparities in how care is provided.

It is important to assure that physicians who provide inappropriate level of care for their patients like the vast majority of physicians in Oregon benefit from the savings that they create in the system. I also want to insure that physician payment reform will not create a system under which providers with disproportionately sicker patient population will be punished. Medicare beneficiaries from underserved and rural areas are more likely to see patients in worse health than beneficiaries elsewhere. Any move toward pay for performance must insure that the providers are not punished for taking on the tough cases. We need to encourage providers to see the sickest patients as well as the healthy ones.

Although I appreciate MedPAC's work in assessing alternatives to the sustainable growth rate, I think that MedPAC has not done enough to consider the impact of proposals on physicians practicing in rural areas. I think this may be in part because the commissioners with real health backgrounds are under represented on MedPAC. In the future I hope to see a more balanced representation of rural versus urban and suburban commissioners appointed. Thank you, Mr. Chair, and I look forward to discussing these issues more with you. Thank you for being here.

Mr. PALLONE. Thank you. I now recognize the gentleman from Pennsylvania, Mr. Murphy.

OPENING STATEMENT OF HON. TIM MURPHY, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Mr. MURPHY. Thank you, Mr. Chairman, and thank you for your high level of interest in helping to fix a number of things about health care particularly because our health care system is broken and must be reformed and fixing the system is not about who is paying, it is about what we are paying for. A broken system is not fixed only by shifting additional payments to seniors, families, employers or taxpayers. Affordability must begin with fundamental reforms to quality and accessibility. Every year Congress steps in to avoid a reduction in Medicare payments for our doctors. The two alternatives identified by the Medicare payment advisory commission to fix this problems involve repealing formulas and implementing pay for performance under Medicare to all providers including inpatient and outpatient hospital services, post acute care services, and even part D services.

I am pleased MedPAC's recommendations to reward high quality care and reduce fraud and abuse is taking place. Whether the payment system remains unchanged or is replaced either change will require significant increase in funding. While it is important to reduce waste, fraud, and abuse in our Federal health care programs rather than simply reducing care and payment to our doctors, I have identified and plan on introducing further legislation to achieve over $300 billion in annual savings and a lot of lives. A few of these examples of savings include $50 billion and 90,000 lives saved annually by providing incentive payments to hospitals from publicly reporting and reducing deadly health care associated infections, expanding the number of volunteer doctors at community health centers to insure that every family has a neighborhood doctor since community health centers save about 30 percent of Medic-

aid cases yielding an annual savings of about $17 billion, eliminating higher discriminatory co-payments under Medicare for our nation's seniors for outpatient health care services and untreated mental health services, which also save money.

Establishing collaborations and demonstration projects to improve the effectiveness of health information technology which can save $162 billion annually by reducing redundant tests, medical errors and mis-diagnoses. We have so much work to do here and I hope that this committee will work towards actually improving and renovating our health care system and not just continue a pattern that Congress has had for several decades of trying to find ways to save money on health care by cutting payments. We want to make sure that physicians and hospitals work effectively, but a fundamental part of that should be the leadership that this Congress and this committee takes in showing how we can do it better, more effectively, more efficiently save money and save lives in the process by transforming our nation's health care system. The Federal Government will be saving billions of dollars and thousands of lives. Thank you, Mr. Chairman.

Mr. PALLONE. Thank you. Mr. Green is recognized.

OPENING STATEMENT OF HON. GENE GREEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. GREEN. Thank you, Mr. Chairman, for holding the hearing. I would ask unanimous consent to place my full statement in the record. It has been over a decade since a physician fee schedule was put into place to help control increases in Medicare payments of physicians. Unfortunately, payments for physician services match the SGR and expenditure targets for only the first 5 years since the actual expenditures exceeded the target by so much that even Medicare trustees no longer consider the system realistic. We also know that the system isn't realistic on the physician level since red flags about spending growth have done little to affect physician behavior, and both physicians and the Medicare trustees know that Congress will eventually enact stop gap measures to prevent scheduled cuts making the system virtually irrelevant.

The budgetary reality is staring us in the face. They mandate that we fix this system before we start to see serious access problems created in Medicare. The GAO has reassured us that beneficiaries generally enjoy good access to care but I worry about the future where fewer doctors may be willing to treat Medicare beneficiaries simply because of the reimbursement problems. In areas like mine that rely heavily on Medicare and Medicaid it probably won't be a situation where doctors will stop taking Medicare. Rather, we will see access problems created by attrition where the gap created by physicians retirements are not filled by new crops of doctors willing to take Medicare patients.

If we reach that point, Medicare will have failed in its mission to provide quality and access to health care for all our seniors. There is no question the system contains some inherent flaws that must be addressed to insure the long-term viability of Medicare and access to beneficiaries. While the current system essentially penalizes physicians for increased service volume it does not distinguish between simple over utilization and increased utilization ac-

tually leads to better health outcomes. Unfortunately, the system does not recognize its spending on certain physician services often alleviates the needs for much more expensive inpatient services.

I am glad to hear that MedPAC discussed the idea of different providers working together to devise a system that works for Medicare beneficiaries and Medicare providers. We have to facilitate some movement between part A and part B and find some ways to realize in the budget that costs that occur in part B can lead to savings in part A, not to mention a better quality of life for our beneficiaries who would prefer a doctor's visit to a stay in the hospital any day. I am also glad MedPAC sees the need to improve benefits for fee for service Medicare which had slowly begun to offer some preventative benefits.

Mr. Chairman, I have a full statement I would like to put in the record. And the frustration, I guess, is we would hope at least in the odd-numbered years early in the year we would have a fix that we could do permanently. But I understand our budget realizations, but I would like us to at least do the permanent fix as early as possible so doctors and providers will be able to understand that they don't have to wait until maybe next February or March to hear about it, that we can actually do it even before December of this year. And I yield back my time.

[The prepared statement of Mr. Green follows:]

PREPARED STATEMENT OF HON. GENE GREEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Thank you, Mr. Chairman, for holding this hearing on physician reimbursement from Medicare.

It has been over a decade since the physician fee schedule was put in place to help control increases in Medicare payments to physicians.

Unfortunately, payments for physician services matched the SGR and expenditure targets for only the first 5 years.

Since then, the actual expenditures have exceeded the target by so much that even the Medicare trustees no longer consider the system realistic.

We also know the system isn't realistic at the physician level, since red flags about spending growth have done little to affect physician behavior.

And both physicians and the Medicare trustees know that Congress will eventually enact stop-gap measures to prevent scheduled cuts—making the system virtually irrelevant.

The budgetary realities are staring us in the face, and they mandate that we fix this system before we start to see serious access to care problems in Medicare.

The GAO has reassured us that beneficiaries generally enjoy good access to care, but I worry about a future where fewer doctors may be willing to treat Medicare beneficiaries simply because of reimbursement problems.

In areas like mine that rely heavily on Medicare and Medicaid, it probably won't be a situation where doctors stop taking Medicare.

Rather, we'll see access problems created by attrition—where the gap created physician retirements is not filled by new crops of doctors willing to take Medicare patients.

If we reach that point, Medicare will have failed in its mission to provide equality in access to health care for our senior citizens.

There is no question that this system contains some inherent flaws that must be addressed to ensure the long term viability of Medicare and access to beneficiaries.

While the current system essentially penalized physicians for increased service volume, it does not distinguish between simple overutilization and increased utilization that actually leads to better health outcomes.

Unfortunately, the system does not recognize that spending on certain physician services often alleviates the need for much more expensive inpatient services.

I am glad to hear MedPAC discuss the idea of different providers working together.

If we want to devise a system that works for Medicare beneficiaries and Medicare providers, we have to facilitate some movement between part A and part B and find some way to realize in the budget that costs incurred in part B can lead to savings in part A—not to mention a better quality of life for our beneficiaries, who would prefer a doctor's visit to a hospital stay any day of the week.

I am also glad that MedPAC sees the need to improve benefits in fee-for-service Medicare, which has slowly begun to offer some preventive benefits.

Congress has included some preventive benefits in Medicare and we want utilization of these benefits to be high.

Yet the irony is that the current payment system would penalize physicians at the end of the year for actually utilizing these benefits.

I doubt the SGR is behind the 2 percent take-up rates associated with the Welcome to Medicare physical and the diabetes screening benefit, but the system has to encourage the use of these benefits that are clearly cost-savers in the long run.

I agree with MedPAC that any new system we devise should encourage coordination of the care delivered under the Medicare program.

Two-thirds of Medicare spending goes to treat beneficiaries who suffer from five or more chronic conditions.

If we are going to give these beneficiaries the quality care they deserve, we have to find ways to move beyond the acute-care, condition-specific manner in which health care is delivered and financed under this system.

For several Congresses now, Senator Blanche Lincoln and I have been working on legislation to improve and coordinate Geriatric and Chronic Care under Medicare.

And we're working to revamp that legislation to create the right incentives for physicians so that Medicare beneficiaries can find a true medical home, where their care will be comprehensive and coordinated.

I am glad to see that MedPAC has laid out some interesting options for us on that front and others, as we try to solve this unavoidable problem.

And I appreciate our witnesses being here today to lend us their expertise.

With that, Mr. Chairman, I yield back my time.

Mr. PALLONE. Thank you. And that is our goal obviously so I appreciate what you said. And I now recognize the gentlewoman from Wisconsin, Ms. Baldwin.

OPENING STATEMENT OF HON. TAMMY BALDWIN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WISCONSIN

Ms. BALDWIN. Thank you, Mr. Chairman. I join my colleagues who have spoken before in underscoring the importance of addressing this issue, and I really look forward to today's witness testimony and discussion. Like many other members, I support enacting a long-term fix to the Medicare physician payment issue rather than continuing to do the yearly or biannual fixes. These short-term solutions, band-aids really, are unfair. They are unfair to the physicians who at the end of the short-term fix are once again faced with projected cuts. They are unfair to the Medicare beneficiaries who may face access issues if cuts are enacted and are unfair to taxpayers because the cost of providing a fix gets more and more expensive with each passing year.

Put simply, the issue needs to be addressed. I welcome today's opportunity to focus on MedPAC's recently released report, and I am looking forward to exploring some of the newer options that the report proposes. Being from Wisconsin, I am especially interested in exploring MedPAC's views on geographic disparities in Medicare expenditures. Growth and volume of physician services has contributed to the increase in Medicare expenditures, which then leads to the physician payment cuts. Wisconsin tends to have lower than average volume of services and lower Medicare expenditures, yet

when the cuts are proposed they apply nationally so doctors in Wisconsin are being punished for the increased volume in services being provided in high payment localities.

I think this is unfair and I am glad to see that MedPAC acknowledged this in their recent report. Lastly, I would like to emphasize that this issue and what we choose to do regarding this issue has huge ramifications for Medicare beneficiaries. If we do nothing beneficiaries might face access issues. If we provide a fix without protecting part B premiums from increases beneficiaries face unacceptably high premiums. And if we enact a fix that increases Medicare spending then we will potentially move up the date that we reach the 45 percent trigger that was included in the MMA and will have to cut Medicare spending. So while we tend to talk about physicians when we consider this issue it has a huge impact on Medicare beneficiaries.

I thank the witnesses for coming today. I look forward to your testimony and our discussion that will follow. I yield back, Mr. Chairman.

Mr. PALLONE. Thank the gentlewoman, and I would recognize our chairman of the full committee, Mr. Dingell.

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

Mr. DINGELL. I thank you, and I commend you for these hearings today. They are very much needed. I want to applaud the vigorous and wise way in which you are conducting the business of the committee. I welcome Dr. Hackbarth, the chairman of the Medicare Payment Advisory Commission, here. And also Mr. Steinwald from the Government Accountability Office and Dr. Fisher from Dartmouth University who have all thought greatly about the question at hand. Also to Dr. Thames from AARP, I thank him for bringing wise counsel and a good beneficiary perspective to this discussion.

As we know, physicians are facing a 10 percent cut in their Medicare payments in 2008, as well as continued reductions in later years. No one can operate a business in that kind of environment. If your employer presented you with the prospect of a large pay cut for 10 years in a row, I am certain you would not continue in that line of work. More importantly, these payment reductions make running a quality health care practice difficult at best. At worse they provide the wrong incentives for the kind of care that Medicare beneficiaries should receive. Our goal should be to align the payment incentives so the patients are getting the right care at the right time. While I am not an advocate of pay for performance systems, we do need to create the right incentives for providers to incorporate technology into the practice of medicine to improve care outcomes and efficiency, and although we know we must insure the ultimate incentive it remains to us to decide what is the best way of delivering the care that is best for the patient.

The perplexing problem in reforming Medicare physician payments is what to do about identifying services that are growing inappropriately. Clearly, the current system or global cap is not working. A variety of factors can cause appropriate service growth. For example, payment may not be aligned with the actual cost of

providing service. Providers may not be clear of which treatments are most appropriate for the service to be provided. This indicates that there is a problem that will have to be addressed delicately but not with a hatchet or a sledge hammer. One possibility that we hear about today is comparing doctor practice patterns with their peers and identifying and working collaboratively with those who when adjusting for the relative health status of their patients have practice patterns that fall outside the norm.

Again, there are ways to do things like this correctly and ways to do them in ways that would cause harm to the patient. Clearly, the latter must be avoided. This is what we must flush out in today's hearings and in future hearings in discussions on the matter. Changes to the Medicare physician payment system are long overdue. We will work hand-in-hand with the provider community and beneficiary representatives to protect Medicare fee for service for generations to come.

I look forward, Mr. Chairman, to working closely with you as well as Mr. Barton and Mr. Deal to craft a successful conclusion to this problem. I want to again commend you for what you are doing in holding these hearings today. I want to point out that this is an enormously important question that simply must be addressed not just in the interest of the doctors or the Medicare system but also in the needs and the concerns of the patients who after all the reason that this system has been set up. Thank you, Mr. Chairman. I yield back the balance of my time.

Mr. PALLONE. Thank you, Chairman Dingell, and I know that you have introduced legislation and have been trying to address this for several years so thank you again. I would recognize the gentleman from Pennsylvania, Mr. Pitts.

Mr. PITTS. No statement.

Mr. PALLONE. OK. Mr. Allen is recognized.

OPENING STATEMENT OF HON. TOM ALLEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MAINE

Mr. ALLEN. Thank you, Mr. Chairman, for convening this hearing to take a serious look at the Medicare physician payment system and the effect future reductions will have on patients access to care. Although Congress was able to block the scheduled 5.1 percent Medicare payment cut this year physicians are facing a 10 percent reimbursement cut next year if we don't act. I am disappointed that the President's fiscal 2008 budget does not provide any funds to deal with this problem. Maine and other rural States face unique challenges in attracting and retaining qualified physicians and insuring access to specialists. Insufficient payment by both Medicare and Medicaid is a major disincentive to providers in our State who are caring for a disproportionate share of elderly citizens.

Seventeen percent of Maine's population is on Medicare, and we have 17 practicing physicians per 1,000 beneficiaries. This is a below average ratio of physicians to Medicare beneficiaries. In addition, our physician population is older than the national average. Forty-six percent of our doctors are over 50, and many have chosen to reduce their patient case loads. Congress must evaluate the current reimbursement system and create a more sound financial

foundation for physician payment rates. Only by doing so will we avoid what has become an annual race to avert a financial crisis. Our goal must be to replace the current funding formula with one that accurately reflects physicians practice costs, new technology, and the age and health of the patient population being served. I look forward to hearing from our distinguished panel and yield back the balance of my time.

Mr. PALLONE. Thank you. I recognize Mr. Matheson of Utah.

OPENING STATEMENT OF HON. JIM MATHESON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF UTAH

Mr. MATHESON. Thank you, Mr. Chairman. While I am a new member of the Health Subcommittee, I have long argued that the current formula used for determining physician payment rates is flawed and should be reformed. During my first 6 years in Congress, I have heard from hundreds of Utah physicians regarding this issue. They provided me with many examples of the disconnect that exists between the formula and the actual cost of providing services. They have raised compelling concerns about reduced access to health care if the formula is allowed to be implemented, and many of them have also provided suggestions regarding ways to fix the problems associated with the current payment calculation.

As a result, I co-sponsored legislation at the last Congress that would reform the formula to more accurately reflect the cost of practicing medicine. Unfortunately, these reforms were not enacted prior to the end of last year's Congress. In fact, during my tenure in office Congress has always waited until the very last minute to pass a temporary fix to the problem. This creates uncertainty in the marketplace and is simply a case of avoiding the fundamental issue. I would also like to highlight the fact that last year's fix did include language allowing physicians who voluntarily report certain qualify measures to receive bonus payments of 1½ percent beginning July 1, 2007. I think that this was a good step forward and I am pleased to see that MedPAC is also interested in working with the Congress and with CMS on this aspect of reform.

Mr. Chairman, I hope the committee will be able to tackle the issue this year because I believe the physicians need to be able to provide seniors the access to care that is so desperately needed. Thank you. I yield back the balance of my time.

Mr. PALLONE. Thank you. I recognize Ms. Solis of California.

OPENING STATEMENT OF HON. HILDA L. SOLIS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Ms. SOLIS. Thank you, Mr. Chairman, and good morning. Thank you for holding this very important hearing. Medicare was enacted to provide affordable health insurance to older Americans and is important to address the sky rocketing cost of health care and access especially to quality affordable health care and especially in critical communities, minority communities, communities of color since these populations often encounter greater burdens of disease. Seniors in California, as you know, are struggling, and I have heard from my constituents that some California physicians have stopped taking new Medicare patients because of inadequate reim-

bursements. We find this in areas in east Los Angeles where I have heard from many of our medical providers and doctors and physicians who are already losing a lot of money by being there but continue to do so but have continuously told me, "Congresswoman, we need to do more to help provide for a greater rate of reimbursement".

So they stay in our communities because there are a low number of these physicians that are actually continuing to provide services in our much needed area. And earlier MedPAC reports stated that the percentage of physicians taking new Medicare patients has decreased. More than 62,000 seniors live in my district, and I wonder where those seniors are going to go if these doctors aren't receiving adequate payment. Sixteen percent of Medicare beneficiaries in California, by the way, happen to be Latino. Latinos already face many barriers in accessing medically necessary health services, and a MedPAC report published in 2006 stated that 7.1 of Latino Medicare beneficiaries delayed getting care due to cost.

Less access to care in my opinion will result in further health care disparities in our communities. I believe that Medicare beneficiaries should receive equal access to physicians who provide quality care. The rapidly increasing costs of health care are problems for residents in my district. The current payment system has not solved the problem of higher Medicare spending and out-of-pocket costs for our seniors as well. Instead, some seniors are receiving unnecessary and expensive services that do not provide additional health benefits, and I am concerned about safety net providers, our clinics, who are already struggling to care for their patients.

We need to insure that our physicians continue to care for our seniors and a physician payment system should emphasize prevention, primary care, and especially since today's seniors are living longer suffering from serious and costly chronic diseases such as diabetes and heart disease. I hope that any proposed physician payment system reimburses our doctors fairly for the vital services they provide and keeps health care affordable for the millions of seniors whom we represent, and we know they rely very heavily on Medicare. I look forward to hearing your recommendations and working with you to protect our seniors health care system. Thank you.

Mr. PALLONE. Thank you. And that, I believe, concludes our opening statements by the members of the subcommittee.

Any other statements for the record will be accepted at this time.

[The prepared statement of Mrs. Cubin follows:]

PREPARED STATEMENT OF HON. BARBARA CUBIN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WYOMING

Thank you Mr. Chairman. On January 1, 2007, America's physicians were scheduled to receive a 5 percent cut in Medicare reimbursement if Congress did not step in to provide a one-time bonus payment in the Tax Relief and Healthcare Act of 2006.

I was pleased to support this important intervention on behalf of Wyoming's 70,000 Medicare beneficiaries. The negative physician fee schedule, based on the flawed sustainable growth rate, most certainly presents an unacceptable situation not just for Wyoming's beneficiaries, but for the physicians they rely on.

These doctors are also small businesses. They are saddled with high malpractice premiums. They practice in rural areas, and in some cases are the only providers

in their communities. If just one Medicare provider shuts his or her doors in Wyoming, a whole community could be affected. But every time we act to stave off the cuts mandated by the sustainable growth rate, we are not only delaying the inevitable, we are making it worse.

In 2006, we faced an eventual 5 percent cut in 2008. We may have stopped the 2007 cuts, but now we face a nearly 10 percent cut in 2008, with more to follow several years thereafter. Facing cuts of this magnitude, we cannot simply rely on physicians' generosity to treat Medicare patients regardless of the reimbursement rate.

The sustainable growth rate formula was enacted to reduce the overutilization of Medicare services and control the growth of the Medicare program. While it has by many indications failed in respect to these goals, we cannot lose sight of them. The Centers for Medicare and Medicaid Services Office of the Actuary estimates that national health expenditures will double to $4 trillion over 6 years. Like the ever-present threat of physician payment cuts, this is a harsh realization we need to face head on.

The Republican-led Congress faced this realization when it directed the Medicare Payment Advisory Commission, or MedPac, to look at alternatives to the sustainable growth rate in the Deficit Reduction Act of 2005.

Today we have the opportunity to explore MedPac's long-term recommendations, with the goal of minimizing the cost of a long-term physician payment fix. I hope today's panelists will shed light on how this can be accomplished while at the same time taking steps to ensure quality and appropriate care to our Nation's Medicare beneficiaries.

I thank our panelists for joining us and look forward to their testimony.

Mr. PALLONE. We will now turn to Mr. Hackbarth. Let me say that Mr. Hackbarth is the chairman of the Medicare Payment Advisory Commission. Your statement becomes part of the hearing record, and of course at the discretion of the committee you can submit additional brief and pertinent statements in writing for inclusion in the record. And I would now recognize you for a 5-minute opening statement. Thank you for being here.

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

Mr. HACKBARTH. Thank you, Chairman Pallone, and Ranking Member Deal. I appreciate this opportunity to talk about MedPAC's recommendations on alternatives to Medicare sustainable growth rate system. As requested in the congressional mandate, MedPAC has analyzed the pros and cons of expenditure targets in general as well as the five options specifically included in the mandate. We present two alternatives paths for your consideration, one that includes continuation of an expenditure target and one that does not.

As you know, MedPAC is a 17-member commission with diverse participation including clinicians and health care executives and academics and former government officials. Despite the diversity of the commission, we generally are able to reach consensus on even complicated issues as has been discussed. That has not been possible on all dimensions of the SGR problem. To help you understand where the commissioners do agree and where we disagree, I have divided the SGR problem into four dimensions which are here on the screen. The first of those encourage efficiency in the delivery of health care. Let me begin with a quick definition of efficiency.

Improving efficiency is not just about reducing cost. Efficiency is about maximizing the benefit for the patient for any given level of expenditure. There is unanimous agreement within MedPAC that expenditure targets like the SGR do not themselves establish ap-

propriate incentives for efficiency. Indeed, by only constraining the amount paid for each individual physician service and expenditure target may actually increase, induce an appropriate or cost increasing behavior. Moreover, payments that become too low relative to the cost of delivering care may ultimately impede access to care.

To establish proper incentives for efficiency, Congress must pursue the agenda briefly described on the second slide. There are a lot of very complicated stuff included under these broad headings so I won't take time in my opening statement but I would be happy to go back and talk about the specific ideas within each of these categories. So there is unanimous agreement that these sorts of policy changes are what are needed to in fact improve the efficiency of the Medicare program. The commission is also unanimous in believing that this agenda for increasing value and efficiency in Medicare is urgent and requires a much larger investment in CMS in order to speed its ability to develop, implement, and refine payment systems.

Some progress to be sure is being made but that progress is far too slow. The second bullet here, as you can see, is encouraging fiscal discipline in policy making. Its expenditure targets like SGR don't by themselves establish proper incentives for efficiency. What might they be good for? And it is here that the commissioners disagree. Some commissioners believe that expenditure targets are useful for encouraging fiscal discipline in the policy-making process. To be clear, they don't establish appropriate incentives for providers but they may alter the dynamics of the policy-making process and result in more constraints, lower updates for providers.

Some commissioners think that is a good thing. In addition, expenditure targets may create the political leverage to force providers to accept reforms they might otherwise resist. Other commissioners, while acknowledging these potential benefits, agree that they come at far too high a price, and hence the disagreement within the commission. The third bullet, increasing equity among regions and providers. Here is another point on which there is substantial although not complete consensus within MedPAC. The existing SGR system is highly inequitable in important respects. If the target is exceeded all physicians are punished equally regardless of their individual behavior.

In addition, all regions of the country are treated equally even though there is abundant evidence that health care delivery is more efficient in some places than in others. And finally the SGR system as it exists currently targets only physicians when in fact Medicare has a total cost problem, not just a physician cost problem. Thus, if Congress elects to retain an expenditure target in some form it would be fairer and more effective to apply that target to total Medicare cost, not just physicians, to apply greater pressure in high cost regions than low cost regions and allow an opportunity for groups of providers to band together in what we refer to as accountable care organizations to receive their own performance assessment against the targets established by Congress.

Making expenditure targets more equitable will not be an easy task. Time, patience, determination, and investment would be required and without these the risk of failure and unintended consequences will increase dramatically. Now let me turn finally to the

last bullet here, minimizing or offsetting the budget score of fixing the SGR system. As you know all too well, proposals to repeal or modify SGR often carry a very large budget score as a result of the difference between the assumed payment rates and the base line and what are realistic rates to assure access to care. MedPAC nor anyone else for that matter has a simple magic solution to fill that gap. We do believe, however, that MedPAC's proposals can make a very, very substantial contribution to filling that budget gap. CBO has estimated that the 10-year cost of repealing SGR and replacing it with an alternative system is somewhere over $200 billion.

According to CBO going to financial neutrality for Medicare Advantage plans as MedPAC has proposed would save about $160 billion. Couple that with restraints on updates for other providers which MedPAC recommends. Couple that with the value and efficiency agenda that I alluded to earlier and you have a very substantial contribution towards filling that $200 billion plus budget gap. With that, Mr. Chairman, I will conclude my opening comment, and I look forward to questions.

[The prepared statement of Mr. Hackbarth follows:]

MEDPAC Medicare Payment Advisory Commission

TESTIMONY

Assessing Alternatives to the Sustainable Growth Rate System

March 6, 2007

Statement of
Glenn M. Hackbarth, J.D.

Chairman
Medicare Payment Advisory Commission

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

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Chairman Pallone, Ranking Member Deal, 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 alternatives to the sustainable growth rate (SGR) system used in Medicare's physician payment system.

Medicare pays for physician services on a fee-for-service basis using a resource-based relative value scale. Each service is assigned a weight reflecting the resources needed to furnish it. Payment is determined by multiplying a service's weight by a national physician payment rate, called the conversion factor.

Currently, as specified in statute, the annual update to the conversion factor is determined under the SGR, based on an expenditure target that is tied to growth in the gross domestic product (GDP). The SGR is widely considered to be flawed; it neither rewards physicians who restrain volume growth nor punishes those who prescribe unnecessary services. Some critics contend the SGR may actually stimulate volume growth. Other observers believe that, despite its flaws, the SGR has helped curb the increase in Medicare spending for physician services by alerting policymakers that spending is rising more rapidly than anticipated and constraining the ability of policymakers to increase fees.

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 to place a significant burden on taxpayers. Rapid growth in expenditures also directly affects beneficiary out-of-pocket costs through higher Part B and supplemental insurance premiums as well as higher copayments.

The Deficit Reduction Act of 2005 (DRA) requires MedPAC to examine alternative mechanisms for establishing expenditure targets. We also considered ways to reconfigure the existing SGR to improve its performance. We have reviewed the pros and cons of the different alternatives and outlined two possible paths for the Congress to follow. Significant disagreement exists within the Commission about the utility of expenditure

targets. Moreover, the complexity of the issues makes it difficult to recommend any option with confidence. Absent careful development and significant investment, the risk that a formulaic expenditure target will fail and have unintended consequences is substantial.

Despite disagreement about expenditure targets, the Commission is united on this: Whether or not the Congress elects to retain some form of expenditure target, a major investment should be made in Medicare's capability to develop, implement, and refine payment systems to change the inherent incentives in the fee-for-service system to reward quality and efficient use of resources while improving payment equity. Examples of such reforms include pay-for-performance programs for quality, improving payment accuracy, developing incentives to coordinate care, using comparative-effectiveness information, and bundling payments to reduce overutilization.

An expenditure target, however designed, cannot substitute for improvements to Medicare's payment systems; at best, it may be a useful complement. An expenditure target alone will not create the proper incentives for individual physicians or other providers; indeed, there is a risk that—in the absence of other changes—constraint on physician fees will stimulate inappropriate behavior, including the very increases in volume and intensity that the target system purports to control. It is better to think of an expenditure target as a tool for altering the dynamic of the policy process than as a tool for directly improving how providers deliver services. An expenditure target alerts policymakers that spending is rising more rapidly than anticipated and leads to an annual debate over the update to the physician payment rate. That debate may also influence the behavior of providers: To avoid rate decreases, they could be compelled to support payment reforms that they might otherwise find objectionable.

The Congress, then, must decide between two paths. One path would repeal the SGR and not replace it with a new expenditure target. Instead, the Congress would accelerate development and adoption of approaches for improving incentives for physicians and

other providers to furnish higher quality care at a lower cost. If it pursues this path, the Congress would need to make explicit decisions about how to update physician payments. Alternatively, the Congress could replace the SGR with a new expenditure target system. A new expenditure target would not reduce the need, however, for a major investment in payment reform. Regardless of the path chosen, Medicare should develop measures of practice styles and report the information to individual physicians. Medicare should also create opportunities for providers to collaborate to deliver high quality care while restraining resource use.

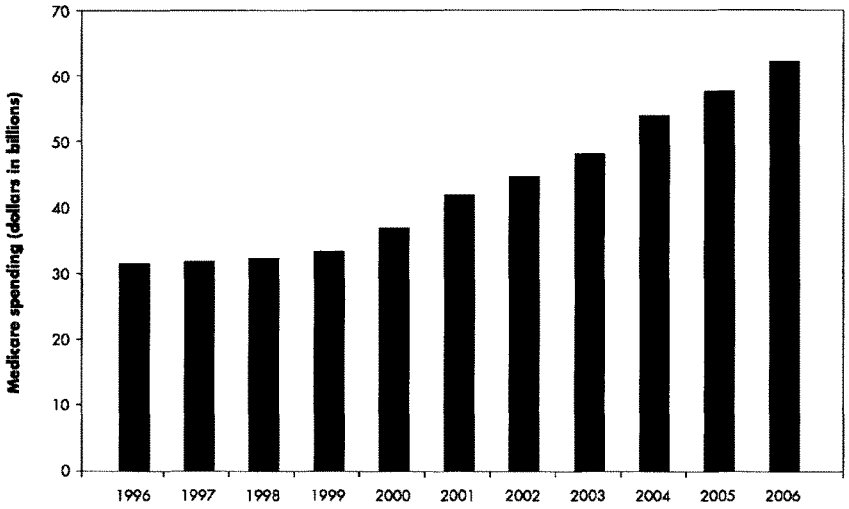
If the Congress chooses to use expenditure targets, the Commission has concluded that such targets should not apply solely to physicians. Rather, they should ultimately apply to all providers. Medicare has a total cost problem, not just a physician cost problem. Moreover, producing the optimal mix of services requires that all types of providers work together, not at cross purposes. For example, physicians and hospitals must collaborate to reduce unnecessary admissions and readmissions. If used, an expenditure target should be designed to encourage all types of providers to work together to keep costs as low as possible while increasing quality. The Congress may also wish to apply targets on a regional basis, since different parts of the country contribute differentially to volume and expenditure growth. Moreover, high-spending areas have not demonstrated higher quality of care.

The sustainable growth rate system

Each year, CMS follows the statutory formula to determine how to update fees for physician services to help align spending with the SGR's expenditure target. The SGR allows growth in spending due to factors that one would expect to affect the volume of physician services: inflation in physicians' practice costs, changes in enrollment in fee-for-service Medicare, and changes in spending due to laws and regulations. In addition, the SGR includes an allowance for growth above these factors based on growth in real GDP per capita. Growth in GDP—the measure of goods and services produced in the

United States—is used as a benchmark of how much additional expenditure growth society can afford.

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.

The SGR system has been widely criticized. In recent years expenditures for physician services have grown substantially, suggesting that the SGR does not provide a strong check on spending (Figure 1). It does little to counter the inherently inflationary nature of fee-for-service payment. In addition, the SGR is inequitable, treating all providers—regardless of their behavior—and all regions of the country alike.

The SGR also fails to distinguish between desirable increases in volume and those that are not. Some volume growth may be desirable. For example, growth arising from technology or changes in medical protocols that produce meaningful improvements to patients, or growth in services that are currently underutilized, is beneficial. But research

suggests that some portion of volume growth does not advance the health and well-being of beneficiaries. In geographic areas with more providers and more specialists, research has found that beneficiaries receive more services but do not experience better quality of care or better outcomes, nor do they report greater satisfaction with their care.

Table 1. Cumulative actual expenditures for SGR-related services exceeded SGR-allowed expenditures starting in 2002

Year	Cumulative expenditures (in billions) Allowed	Actual	Difference (in billions)
1996	$36.6	$36.6	N/A
1997	86.6	85.9	$0.7
1998	138.7	135.8	2.9
1999	194.1	188.4	5.7
2000	253.4	246.4	7.0
2001	315.4	312.7	2.7
2002	382.5	383.6	–1.1
2003	454.5	461.8	–7.3
2004	531.2	548.9	–17.7
2005	611.3	640.0	–28.7
2006	693.0*	734.9*	–41.9*

Note: SGR (sustainable growth rate), N/A (not applicable). Cumulative allowed and actual expenditures are as of calendar year end. Pursuant to the Balanced Budget Refinement Act of 1999, the SGRs for 2000 and all subsequent years are estimated and then revised twice by CMS, based on later data.
* Estimated.

Source: CMS 2006. Estimated sustainable growth rate and conversion factor, for Medicare payments to physicians in 2007. November. http://www.cms.hhs.gov/SustainableGRatesConFact/Downloads/sgr2007f.pdf.

Medicare spending for physician services has exceeded targeted spending for several years, resulting in the SGR calling for cuts in physician payment rates (Table 1). The Congress has repeatedly prevented these cuts from being implemented without changing the SGR formula or the target. As a result, the cumulative SGR formula calls for larger fee cuts in multiple years. The Medicare trustees project that the SGR will call for annual cuts of about 5 percent well into the next decade. The trustees characterize this projected series of negative updates to physician fees as "unrealistic" because the Congress is unlikely to allow them. But the federal budget's baseline includes the large fee cuts,

making it costly from a budgeting perspective to give zero updates, much less increase fees. If they were implemented, large cumulative cuts would likely compromise access to care. They might also have the unintended consequence of spurring volume growth as physicians attempt to maintain their income.

Using Medicare's physician and other payment systems to improve value

Medicare should institute policies that improve the value of the program to beneficiaries and taxpayers (see text box, p.17). Those policies should reward providers for efficient use of resources and create incentives to increase quality and coordinate care. Policies such as pay for performance that link payment to the quality of care physicians furnish should be implemented. At the same time, Medicare should encourage coordination of care and provision of primary care, allow gainsharing arrangements, bundle and package services where appropriate to reduce overuse, ensure that its prices are accurate, and rethink the program's benefit design and the effects of supplemental coverage. To reduce unwarranted variation in volume and expenditures, Medicare should collect and distribute information about how providers' practice styles and use of resources compare with those of their peers. Ultimately, this information could be used to adjust payments to physicians. Findings from comparative-effectiveness research should be used to inform payment policy and furnished to beneficiaries and providers to inform decisions about medical care. Finally, concerted efforts should be made to identify and prevent misuse, fraud, and abuse by strengthening provider standards, ensuring that services are furnished by qualified providers to eligible recipients, and verifying that services are appropriate and billed accurately and that payments for those services are correct.

The Congress needs to provide CMS with the necessary time, financial resources, and administrative flexibility to make these improvements. CMS will need to invest in information systems; develop, update, and improve quality and resource use measures; and contract for specialized services. In the long run, failure to invest in CMS will result in higher program costs and lower quality of care.

DRA-mandated alternatives to the SGR

The DRA requires that we examine the potential for volume controls using five alternative types of sub-national targets—geographic area, type of service, group practice, hospital medical staff, and physician outliers—and consider the feasibility of each. Policymakers should recognize that, by their very nature, these alternatives can only attempt to control total expenditures, not volume. Each alternative has advantages and disadvantages, but without accompanying payment policies that change the inherent incentives of fee-for-service payment, the ability to influence the behavior of individual physicians will be limited.

The Commission has not provided budgetary scores for the alternatives. MedPAC does not produce official scoring estimates. Further, many of the alternatives' administrative implications are unknown. For any of the alternatives, details of the formula—including where the target is set, how to deal with the existing difference between the target and spending, and whether the target is applied only to physician services or is extended more broadly—are the important determinants of projected total spending. Efforts to relax the current SGR (e.g., softening or eliminating the cumulative formula) will be costly under current baseline assumptions. However, the Congress may be able to maintain some expenditure control by retaining the expenditure target in some form.

Geographic area alternative

The geographic area alternative would apply targets to subnational geographic areas. Setting different fee update amounts by region acknowledges that regional practice patterns vary and contribute differentially to overall volume and expenditure growth. Use of different regional updates would improve equity across the country and over time could help reduce geographic variation. However, it is not clear what the optimum geographic unit would be. Choosing the unit involves tradeoffs between physician accountability, year-to-year volatility, and administrative feasibility. Using smaller units, such as hospital referral regions, might increase physician accountability but would also increase year-to-year volatility and be difficult to administer. Large units, such as states

or Part D regions, are more stable and are easier to administer but include too many physicians to encourage accountability.

Using different regional updates would not entirely address the inequities of the current system; for example, a physician who practices conservatively in a high-volume region would still be penalized. Using different regional updates could also create wide disparities in payment rates by area. Beneficiaries crossing the boundaries of geographic areas to seek care also would be an issue that would have to be resolved.

Type-of-service alternative

A type-of-service alternative would set expenditure targets for different types of services, as was done under the volume performance standard (VPS), which preceded the SGR. (Under the VPS, three targets were established—for evaluation and management services, surgical procedures, and all other services.) A type-of-service expenditure target recognizes that expenditure growth differs widely across types of services. Some might prefer this type of target because it would differentiate between services with the greatest growth in volume and expenditures and those with the smallest. This alternative also could be designed to boost payments for primary care services, which some believe are undervalued.

But service-specific targets present a number of difficulties. One problem is that, under such targets, inequities across services and specialties could arise. In addition, setting service-specific targets would implicitly require Medicare to know the optimal mix of services. This would be difficult, since the optimal mix of services will evolve with changes in the population served, patterns of illness, and medical knowledge and technology.

Multispecialty group practice alternative

The Congress asked MedPAC to analyze an alternative to the SGR that might adjust payment based on physicians' participation in group practices, since some studies suggest

that physicians in multispecialty group practices may be more likely to use care management processes and information technology and to have lower overall resource use. But considering the small share of physicians in multispecialty groups (20 percent), and that not all group practices engage in activities that improve quality and manage resource use, payment policies focusing solely on group status may not effectively elicit the desired behavior. Further, using separate targets for group and nongroup physicians could be viewed as inequitable, since efficient physicians in smaller nongroup practices would be ineligible for the payment updates that physicians in multispecialty groups would receive. In addition, rural physicians may have few, if any, opportunities to join group practices. Such small groups of physicians would also increase year-to-year volatility and could be difficult to administer. Establishing payment incentives for performing specific activities associated with better care and lower resource use would likely be more effective than using separate targets based on group practice status.

While the Commission has not recommended a multispecialty group alternative for an expenditure target, such groups may still be an important locus for many of the policy changes that MedPAC believes are important. For example, these groups could serve as accountable care organizations (ACOs), together with independent practice associations (IPAs), hospital medical staffs, and other organized groups of physicians. The Commission's preliminary research has found that beneficiaries who regularly see physicians in multispecialty groups appear to use fewer resources than other beneficiaries. Multispecialty groups may be more likely to incorporate incentives to control resource use and monitor and influence practice styles, which may encourage providers to better coordinate care and ensure that patients are appropriately monitored and receive necessary follow-up care.

Hospital medical staff alternative

A hospital medical staff target system would use Medicare claims to assign physicians and beneficiaries to one type of ACO based on the hospitals they use most. Even if some physicians have little or no direct interaction with a hospital, they can be assigned to the

group based on the hospital most of their patients use. This option creates a virtual physician group using the extended hospital staff as the organizational focal point. Initially, Medicare could collect and distribute information about the practice patterns of different groups. Ultimately, that information could be used to adjust payments for differences in resource use and quality.

Using hospital medical staffs as ACOs could better align incentives to control expenditures. The hospital could provide an organizational locus for physicians in the area to come together to monitor and influence practice styles. Although the size of the groups would vary substantially, each of them would be much smaller than the current national pool. Individual physicians could therefore more readily see a link between their own actions and their group meeting its target. Over time, this alternative is intended to induce physicians and other providers to practice more as a system, optimizing care delivery and reducing overall expenditures.

There are significant barriers to this alternative. Some argue that hospitals and physicians are competitors who will not easily collaborate with one another, making this type of ACO an unlikely vehicle for change. Such small groups of physicians would increase year-to-year volatility and could be difficult to administer. Physicians may resist having Medicare assign them to an entity to which they may feel little or no affinity. Physicians who rarely refer patients for hospital care may be particularly resistant. Finally, there may be additional legislative changes to allow sharing of funds that would be required to implement this alternative.

Outlier alternative

Medicare could identify physicians with very high resource use relative to their peers. CMS could first provide confidential feedback to physicians. Then, once greater experience and confidence in resource-use measurement tools were gained, policymakers could use the results for additional interventions such as public reporting, targeting fraud and abuse, pay for performance, or differential updates based on relative performance.

The major advantage of this alternative is that it would promote individual accountability and would enable physicians to more readily see a link between their actions and their payment. However, a number of technical issues would need to be resolved. Implementation of an outlier system based on episode groupers may prove difficult if physicians cannot be convinced of the validity of episode grouping tools. Physicians will need to be confident that their scores reflect the relative complexity of their patient mix and that they are being compared to an appropriate set of peers. There would likely be considerable controversy around initial physician scores as some physicians realized that their practice patterns were not in line with those of their peers.

Reconfiguring the national target system

We also considered a reconfiguration of the current national target. For example, the current system could be changed to moderate or eliminate the cumulative aspect of the spending targets. Another option is to implement an additional allowance corridor around the allowed spending target line. Both options would relieve some of the budget pressure and result in more favorable updates but also would increase total expenditures and would not change the inflationary incentives inherent in fee-for-service payment.

Other changes could be made to the physician payment system to address services that are growing quickly. Such growth may signal that relative prices for those services do not reflect the time and complexity of furnishing them. In examining such services, the Secretary would need to take into account changes in both the number of physicians furnishing the services to Medicare beneficiaries and the number of hours physicians worked. CMS could use the results from these analyses to flag services for closer examination of their relative work values. Alternatively, the Secretary could automatically correct such mispriced services and the Relative Value Scale Update Committee could then evaluate these changes during its regular five-year review.

Choices for the Congress on expenditure targets

There are two paths the Congress could take. The Commission did not reach a consensus on which path is best. The issues surrounding the use of expenditure targets are complex, the information requirements are many, and the full effects are almost unknowable; in addition, the risk of failure and unintended consequences is high. Nevertheless, some Commissioners believe it is prudent to retain an expenditure target to limit rate increases and to provide leverage with providers to encourage them to embrace reforms they might otherwise oppose. At the same time, other Commissioners fear that undue restraint on rates may impede access to care in the long run. Moreover, across-the board restraint that fails to distinguish between good performers and poor performers may encourage providers to engage in undesirable behavior to maintain their profitability—for example, ordering services of marginal value or seeking to furnish services with payments that are high relative to costs.

Despite disagreement about the utility of expenditure targets, the Commission is united on this key point: Whether or not the Congress elects to retain some form of expenditure target, a major new investment should be made in Medicare's capability to develop, implement, and refine fee-for-service payment systems to reward quality and efficient use of resources while improving payment equity, as discussed below. An expenditure target, however designed, is not a substitute for improving Medicare's payment systems; at best, it may be a useful complement. An expenditure target by itself cannot create the proper incentives for individual physicians or other providers. A target is a tool for improving the dynamics of policymaking, not health care delivery.

Following are two alternative paths for the Congress to consider.

Path 1

The first path would repeal the SGR. No new system of expenditure targets would be implemented. Instead, the Congress would accelerate development and adoption of approaches for improving incentives for physicians and other providers to furnish lower

cost and higher quality care (see text box, p. 17). Increasing the value of Medicare in this way will require:

- ***Changing the payment incentives.*** Policies must be implemented that link payment to the quality of care physicians and other providers furnish. MedPAC's pay-for-performance recommendations would move toward correcting the problem of lack of incentives for quality care. At the same time, Medicare needs to encourage coordination of care and provision of primary care, ensure that its prices are accurate, allow gainsharing arrangements, and bundle and package services where appropriate to reduce overuse. ACOs like physician groups and other combinations of providers can be encouraged as a means to improve quality and reduce inappropriate use of resources. Medicare should also rethink the program's benefit design and the effects of supplemental coverage.

- ***Collecting and disseminating information.*** Variation in practice patterns may reflect geographic differences in what physicians and other providers believe is appropriate care. To reduce this variation, providers need information about how their practice styles compare with those of their peers. Ultimately, such information could be used to adjust payments to physicians. In addition, findings from comparative-effectiveness research should be used to inform payment policy and furnished to beneficiaries and providers to inform decisions about medical care. Both of these are activities in which collaborating with the private sector could lead to wider adoption and greater impact.

- ***Redoubling efforts to identify and prevent misuse, fraud, and abuse.*** This effort includes supporting quality through the use of standards, ensuring that services are furnished by qualified providers to eligible recipients, and verifying that services are appropriate and billed accurately and that payments for those services are correct.

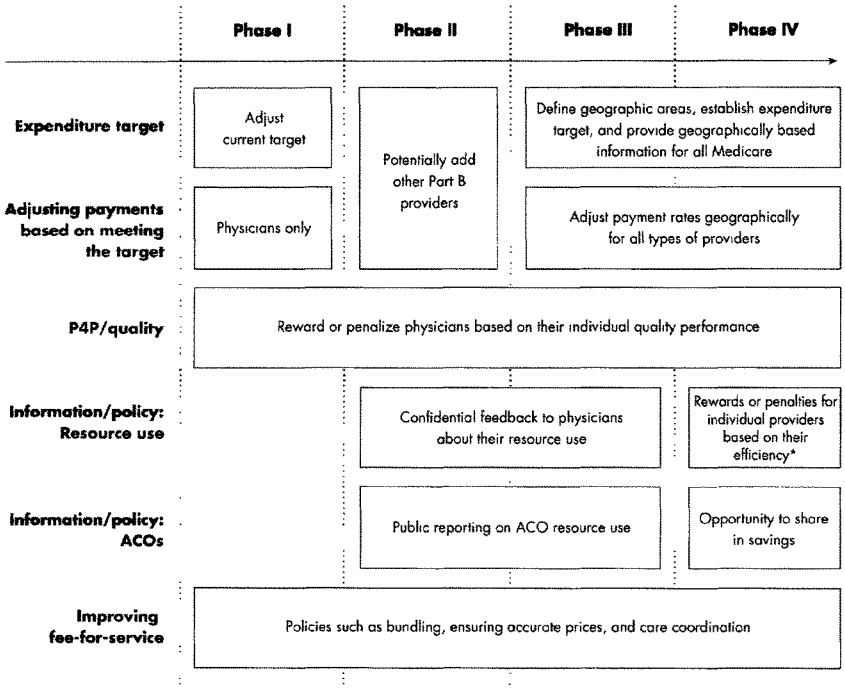
Path 2

The second path would pursue the approaches outlined in path 1 but would also include a new system of expenditure targets (Figure 2). As policymakers grapple with the budgetary consequences of volume and expenditure growth, the presence of an expenditure target may prompt more rapid adoption of the approaches in path 1, since it will put financial pressure on providers to change. If the Congress determines that a target is necessary to ensure restraint on fee increases, the Commission has concluded that such a target should embody the following core principles:

- encompass all of fee-for-service Medicare,
- apply the most pressure in the parts of the country where service use is highest,
- establish opportunities for providers to share savings from improved efficiency,
- reward efficient care in all forms of physician practice organization, and
- provide feedback with the best tools available and in collaboration with private payers.

In keeping with these principles, the expenditure target should not be borne solely by physicians. Rather, it should ultimately be applied to all providers to encourage different providers to work together to keep costs as low as possible while increasing quality. The Congress should also consider applying any expenditure target on a geographic basis, since different parts of the country contribute differentially to volume and expenditure growth. If an expenditure target reflects the limits of what society wants to pay, the greatest pressure should be applied to those areas of the country with the highest per beneficiary costs and the greatest contribution to Medicare expenditure growth.

Figure 2. Timeline for path 2



Note: P4P (pay for performance), ACO (accountable care organization).
* Providers receive rewards or penalties if they are not part of ACOs.

Geographically adjusted targets, even if applied at the level of metropolitan statistical areas, are still too distant from individual providers to create appropriate incentives for efficiency. Creating proper incentives for improved performance—whether for physicians or other providers—will require much more targeted incentives. Rewards and penalties must be based on the performance of provider groupings that are small enough for the providers to be able to work together to improve. Therefore, within each geographic area, measurement of resource use would show how physicians compare with their peers and would reveal outliers. The comparisons could show the resource use of

individual physicians and of groups of physicians belonging to ACOs, such as integrated delivery systems, multispecialty physician groups, and collaborations of hospitals and physicians. ACOs, in turn, would have to meet eligibility criteria but would then be able to share savings with the program if they furnish care more efficiently than the trend in their area. Episode groupers and per capita measures are tools for measuring resource use, and they could become tools that define payment adjustments for physicians who remain committed to solo or small practice outside the confines of larger organizations.

This expenditure target system would address three goals simultaneously. First, it would address geographic disparities in spending and the volume of services. Second, by departing from the existing national SGR and allowing providers to organize into ACOs, it would improve equity and encourage improvements in the organization of care. Third, providers would receive actionable information to change their practice style.

Improving Medicare's value

Medicare should change payment incentives by:

- *Linking payment to quality by basing a portion of provider payment on performance.* The Commission has found that two types of physician measures are ready to be collected: structural measures associated with information technology (such as whether a physician's office tracks patients' follow-up care) and claims-based process measures, which are available for a broad set of conditions. To implement pay-for-performance, CMS must be given the authority to pay providers differentially based on performance. Such a program should be budget neutral, with monies set aside redistributed to providers who performed as required.
- *Encouraging coordination of care and use of care management processes, especially for chronic care patients.* There are a number of care coordination and care management models Medicare could implement. For example, beneficiaries with chronic conditions could volunteer to see a specific physician or care provider for the complex condition that qualifies them to receive care coordination/care management. That physician would serve as a sort of medical home for the patient. Payment for services to coordinate care would be contingent on negotiated levels of performance in cost savings and quality improvements.
- *Ensuring accurate prices by identifying and correcting mispriced services.* CMS should reduce its reliance on physician specialty societies to identify misvalued services so that overvalued services are not overlooked in the process of revising the physician fee schedule's relative weights. CMS should also update the assumptions it uses to estimate the practice expenses associated with physician services. Further, CMS should initiate reviews of services that have experienced substantial changes in volume, length of stay, site of services, practice expense, or other factors that may indicate changes in physician work.
- *Allowing shared accountability arrangements, including gainsharing, between physicians and hospitals.* Such arrangements might increase the willingness of physicians to collaborate with hospitals to lower costs and improve care.
- *Bundling services.* Bundling puts providers at greater financial risk for the services provided and thus gives them an incentive to furnish and order services judiciously. Candidates for bundling include services typically provided during the same episode of care. Bundling the hospital payment and the physician payment for given DRGs could also increase efficiency and improve coordination of care.
- *Promoting primary care, which can lower costs without compromising quality.* Medicare should create better incentives for providers to furnish primary care (e.g., by ensuring accurate prices for primary care services) and for beneficiaries to seek it (e.g., by changing Medicare's cost sharing structure).
- *Rethinking Medicare's cost-sharing structure and its ability to steer beneficiaries to lower cost and more effective treatment options.*

(continued next page)

Improving Medicare's value (continued)

Medicare should collect and disseminate information by:

- *Measuring physicians' resource use over time and sharing 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 available evidence-based research recommends), and revise their practice styles as appropriate. Once greater confidence with the measurement tool was gained, Medicare could use the results for payments—for example, as a component of a pay-for-performance program that rewards both quality and efficiency. CMS could also use the measurement tool to flag unusual patterns of care that might indicate misuse, fraud, and abuse.
- *Encouraging the development and use of comparative-effectiveness information to help providers and patients determine what constitutes good quality, cost-effective care.* Comparative-effectiveness information could also be used to prioritize pay-for-performance measures, target screening programs, and prioritize disease management initiatives. Given the potential utility of this information to Medicare, and given concerns about the variability in methods and the potential bias of researchers conducting clinical- and cost-effectiveness research, a public-private partnership may be warranted. For example, the federal government could help set priorities for research, while funding could come in part from drug manufacturers, health plans, and pharmacy benefit managers.

Medicare should improve program integrity and provider standards by:

- *Using standards, where appropriate, in physician offices to ensure quality.* MedPAC has recommended that CMS impose quality standards as conditions of payment for imaging services. Other types of services may be candidates for standards as well.
- *Continuing to improve program integrity, capitalizing on the opportunity presented by administrative contractor reform.* Contractor reform may also provide an opportunity for Medicare to enhance its ability to measure performance, improve quality of care, and encourage coordination of care.

Mr. PALLONE. Thank you, Mr. Hackbarth. I am just going to recognize myself for 5 minutes initially. You mentioned a much larger investment in CMS to achieve the goals and you obviously talked about the role of CMS so that is my first question. It seems likely that the key to any change in physician payments is CMS' ability to implement the change. And so my question really two fold, can CMS implement any of your recommendations without legislation, and, second, what kind of resources and time are they going to need?

Mr. HACKBARTH. If you could put up the second of the two slides. Let me just quickly go through this agenda and talk about where the various pieces stand. Beginning with pricing accuracy, what this refers to is trying to establish prices that reflect the cost of providing high quality efficient care. It is an issue not just with the physician payment system but with all of Medicare's payment systems for hospitals and post acute providers as well as physicians. MedPAC in recent years has made numerous recommendations about how those systems can be refined and made more accurate. There is a lot of work underway in CMS currently. No new legislative authority is generally required. The issue is really the speed at which that refinement work occurs and that is often affected by available resources.

Mr. PALLONE. What do you think we need in terms of resources and then what would the time line be depending if they were available?

Mr. HACKBARTH. Making a specific recommendation about how much of the resources should be increased is beyond where MedPAC has gone at this point, and frankly a little beyond our expertise. Those are operational questions and require very detailed knowledge of CMS operations. What we are reflecting is that we talk to them about these issues and often they agree in principle with what we are recommending but the pace at which they can churn out the refinements is slower than it needs to be.

Mr. PALLONE. If you can't be more specific then I think I am going to move on. OK. I also wanted to ask about the HMOs because you mentioned how you can save a significant amount of money by looking at this differential in payment with the HMOs. In your update on the Medicare private plans you report that Medicare HMOs are paid 112 percent of traditional Medicare on average. In other words, for every beneficiary who chooses to enroll in a Medicare HMO the Medicare program pays 12 percent more than if they were to remain in traditional Medicare. So if you could just comment briefly on the commission's recommendations related to Medicare private plan payments. I know you did.

Mr. HACKBARTH. Yes.

Mr. PALLONE. But do you believe that they pose a threat to the traditional Medicare program, and if you want to go into a little more detail about how we are going to save money in terms of that overall. I know you mentioned 160 versus 200.

Mr. HACKBARTH. MedPAC has often stated that we believe having private plans as an option for beneficiaries is a good thing. We believe that many private plans may be able to offer something of value to Medicare beneficiaries through their efficiency, through their ability to deal with providers in ways that Medicare itself

finds difficult to do. So having that option is very important. However, we think that that option ought to be on a financially neutral basis so if private plans can achieve efficiency and as a result of that efficiency have savings to share with Medicare beneficiaries in the form of added benefits and the like that is a terrific thing and we are all in favor of it.

Mr. PALLONE. Are you concerned that if we don't achieve that neutrality that they are going to be a threat to the traditional Medicare program?

Mr. HACKBARTH. Our concern is that if you pay more than Medicare's cost what you start to do is attract plans into Medicare that aren't adding value, that aren't more efficient than traditional Medicare and are only driving up the cost of the program. And we have particular concern about the private fee for service plans, which are in fact the most expensive of the plan types offered under Medicare Advantage. They offer relatively little value but they become very attractive to Medicare beneficiaries for obvious reasons, more benefits, no restrictions of any type on free choice, and so there is very rapid growth under the private fee for service plans, and they are much more expensive so that has put us on a path that could be dangerous for the program.

Mr. PALLONE. Thank you. Thank you very much. Mr. Deal.

Mr. DEAL. Thank you. Mr. Hackbarth, in your testimony and in your report, you outline two basic paths. I want to talk to you about the second path. In your testimony just a few minutes ago you said that if we retain the overall spending targets that one of the ways we could make it more effective is to apply it across all providers. Let me ask you just a very simple question to begin with and then I am going to ask you to explain it. Now by that, I would assume you are talking about including hospitals within the overall provider group.

Mr. HACKBARTH. Yes.

Mr. DEAL. Now obviously we have part A and part B of Medicare funded differently. Would you explain to me how if we were to adopt that approach how do we reconcile the different part A and part B components, and is that a problem or is it not a problem? Would you explain how you would envision that incorporation?

Mr. HACKBARTH. Well, the basic idea is to say this is our target for total expenditures for Medicare beneficiaries, and then to the extent that we miss that target it would affect the updates provided not just to physicians but to hospitals and all the providers. As to how that would interact with the different financing of the various trust funds, we have not looked at that in detail but rather focused on the basic idea of constraining updates across the board and not just for physicians. And one of the reasons we think, some commissioners, think that that would be a better thing to do is that we don't have just a physician cost problem. We have a total cost problem.

And as some of the members of the committee have pointed out, if you focus just on physician cost and constrain only that when in fact there is potential substitution of services, growth in physician services to avoid hospital costs, a system that focuses only on physicians is really unfair.

Mr. DEAL. That is part of the complaint the physician community has had for a long time is that actions that they have taken to restrain overall costs have inured to the benefit of hospitals and their reimbursement formula but has penalized the physician community.

Mr. HACKBARTH. We want growth some places. Some types of services we want more in order to reduce other places, hopefully more expensive services. And so a total expenditure target in that sense would be fairer and more effective.

Mr. DEAL. You mentioned the regional discrepancies of costs and quality of care. Could you rather quickly sort of outline some examples of that?

Mr. HACKBARTH. I would be happy to do so. We have got the expert on that on the next panel, Dr. Fisher, and he could do it far better than I. But briefly what we see is at the State level more than two fold variation in Medicare expenditures per beneficiary after adjusting for differences in the populations, differences in the risk characteristics and the like. If you go to smaller geographic areas and States then the variation is even higher than two fold variation. We also have found that higher expenditures per beneficiary does not necessarily mean a better quality. In fact, many of the lower cost States fare very well in terms of their quality measures.

So the idea behind regionalizing the expenditure target is to say if Congress decides we have got a Medicare cost problem it doesn't make any sense to apply the pressure equally to all States. Some States are demonstrably contributing more to that problem than others so if we got a cost problem we ought to apply the pressure differentially, apply the greatest pressure to the areas of the country that contribute most to the problem and less correspondingly to the lower cost areas, and in that sense it would be more equitable than the current SGR.

Mr. DEAL. In my closing seconds, I want to thank you for in your report addressing the specific issues that the DRA asked you to do. I think you have done a pretty good job of addressing those, and there are some areas such as the outliers that I think we have to explore in much greater detail, but thank you for being here.

Mr. PALLONE. Thank you. The gentlewoman from California, Ms. Eshoo.

Ms. ESHOO. Thank you, Mr. Chairman. Thank you, Dr. Hackbarth. I have a lot of questions. Let me see how I can summarize them. The Deficit Reduction Act required MedPAC to look at alternatives and targets and other ways of reconfiguring the existing SGR and improving on the performance. And I appreciate the work that has gone into your report but I don't find that you have provided Congress with any recommendation to remedy the situation. Now maybe I missed it somewhere but I don't see any clear recommendation. Do you agree with that description?

Mr. HACKBARTH. No.

Ms. ESHOO. All right. Well, in 2001 MedPAC concluded that the SGR should be eliminated, physicians should be subject to the inflation-based update system that the commission uses for other provider groups. Now has your position changed since then or is it the same?

Mr. HACKBARTH. Our position has changed somewhat for two reasons.

Ms. ESHOO. And tell us why you abandoned it. Would you tell us the new recommendations?

Mr. HACKBARTH. Our positions changed somewhat for two reasons. One is, as you know, the composition of the commission changes over time, and so we have a different set of commissioners than we had in 2001 with a somewhat different perspective. The second thing that has changed is, and I think this applies to all commissioners, a growing sense of urgency about Medicare's cost problem and the health care system in general, its problem with costs. We are 5, 6 years further along on a path that the commissioners believe is ultimately unsustainable——

Ms. ESHOO. So just succinctly what is your new recommendation? I have to tell you that looking at this is—well, I think it is one of the skimpiest things I have ever seen. This is increasing value and efficiency in Medicare, pricing accuracy, coordination of care, accountability. The one that I love the most at the bottom is information. This is a commission that was put together by the Congress, instructed that it should be put together, and I know I am being a little hard but that is hardly any meat on the bones, I have to tell you. If this is what MedPAC is coming up with, I think you got to go back to the drawing boards. I mean this is really sophomoric what is up on the board.

Mr. HACKBARTH. We literally have hundreds of pages explaining those proposals in detail, and I would be happy to spend as much time as you would like——

Ms. ESHOO. But when you are here, you need to summarize it but I think that you need to summarize and have some meat on the bones. I really have had trouble understanding what you have recommended to us in these key areas.

Mr. HACKBARTH. Well, the point that I hope the committee will understand is that we don't think that there is a single solution to this problem, that in fact there is unanimous agreement within the commission that a long series of changes need to be made to encourage efficiency in the Medicare program and follow——

Ms. ESHOO. Now did MedPAC take a look at the geographic payment locality issue?

Mr. HACKBARTH. Not in this particular report, no, but we have previously.

Ms. ESHOO. And when did you last take a look at that?

Mr. HACKBARTH. I think it was 2 years ago.

Ms. ESHOO. Well, that was developed more than 40 years ago, and many areas in the country have changed and changed dramatically, and it seems to me that a commission that looks at or is responsible for reviewing how Medicare is delivered and to whom and by whom, I think this really cries out for review but maybe you have so much work to do that you can't take a look at it. Do you have a work plan that says that you are going to review this and make a recommendation to the Congress?

Mr. HACKBARTH. As I said, we looked at the issue 2 years ago and, no, we don't have any immediate plan to take——

Ms. ESHOO. Does MedPAC think that Congress has done something it and that is why you are not reviewing it?

Mr. HACKBARTH. No. What we have said is that we think that there needs to be a system of geographic adjustment, that there are some problems, isolated problems, with the existing system, that the lines can be redrawn, should be redrawn in some States, including California, that those changes ought to be done on a budget neutral basis within the State, and that CMS ought to respect the fact that at least some States have elected to have a single area for the whole State. We don't run the Medicare program.

Ms. ESHOO. I didn't suggest that you did, but you have the clear responsibility in terms of making I think clear and concise recommendations to Congress. I am having a hard time drawing them. I think my time is up. Thank you, Mr. Chairman.

Mr. PALLONE. Thank you. Dr. Burgess.

Mr. BURGESS. Thanks, Mr. Chairman. One of the issues that I think we have to most seriously address is the issue of quality reporting and I have always felt very strongly that there actually ought to be a platform of several quality reporting mechanisms available to doctors and that they not be punitive, that they be additive. And yet when we heard some of the other opening statements people talked about how grateful they were we were able to add an update in the bill that we passed right before the end of last year. But I have some data from Scott and White Hospital, from Dr. Rohack, who is the cardiologist there on the clinical faculty, on the medical school faculty, also I think a board member from the AMA, and they did a calculation for the last 6 months of 2006, their clinic part B allowables. Running that calculation it actually cost them $298 per physician to do the paperwork in order to capture the monies that are going to be made available to them, I believe at the end of this year if CMS does indeed come up with those recommendations in June, and they jump through all of the hoops that they are required to jump through.

So that hardly seems like an additive benefit. In fact, most physicians will look at that and simply shrug their shoulders and throw that into the file. They are not going to participate in a quality measure that in fact doesn't bring them additional revenue but ends up costing them revenue just to calculate what they are owed under the new formula. How do you see us getting around that type of problem because to me the critical aspect of quality reporting is that it has to be an additional payment in addition to what is available, whether it be under MEI or SGR, what is your feeling on that?

Mr. HACKBARTH. As you know, we favor the concept of not just quality reporting but also pay for performance, but we have also said that doing it for physicians presents some unique challenges for a couple of reasons. One is that there is a much higher degree of specialization among physicians than hospitals, for example. The infrastructure, the informational infrastructure, is less in small physician practices than it is in hospitals. And so there is some concern within the commission about just indiscriminately saying more quality reporting is better for physicians and the more measures the better.

Mr. BURGESS. Yes, I would just point out that Scott and White Hospital does enjoy already a good reputation for quality. I think they are number ranked No. 14 in the Nation, and they are not a

small organization. They have 320 physicians in their central unit and another 180 physicians in their outlying areas. So a significant problem that we have created for them in our efforts to help them, and it just underscores how difficult and sometimes how awkward this process can be. With that in mind, what you described in your report with the ACO is a virtual care organization of some type. How do we insure that that does what it is intended to do and is not just simply a virtual organization to absorb dollars and not deliver any benefit?

Mr. HACKBARTH. The basis for supporting the idea of accountable care organization is that patients can benefit from more organization, systematic organization.

Mr. BURGESS. We have already seen the application at least in Dr. Rohack's case ended up being a detriment to their rather sizable quality practice in central Texas.

Mr. HACKBARTH. But I am not familiar with what is happening at that clinic right now. Are they in the group practice demonstration?

Mr. BURGESS. I am not sure whether they are in——

Mr. HACKBARTH. I don't know if they are or not. I don't think that they are.

Mr. BURGESS. But the figures that were given by CMS is what they anticipate the bonus to be so it was back of the envelope calculation to be sure but I wanted to get an idea, did we help Dr. Rohack when we passed this bill at the end of the year, and it looks at least at first blush we didn't help a bit. In fact, we cost them money if they put their actuaries to work on trying to collect the bonus to which they would be entitled by doing their quality reporting. Let me just point out to you additionally probably one of the worse days of my life as a practicing physician was when RVRBS came on the scene. Is there a better way to calculate the cost of differing services and differing practices and differing areas.

Mr. HACKBARTH. If I could, Mr. Burgess, I would just like to go back to the previous question for a second. When we are talking about accountable care organizations what we are talking about is a model whereby you would look at the total cost for beneficiaries within, for example, this clinic, and then share with the clinic the savings to the extent that they are able to hold costs below the target levels, so it is very different than the quality pay for performance model that was in the Tax Act. This is the model that is being tested now in the group practice demo. That is what we are referring to as accountable care organizations, and there the benefit might be much larger.

Mr. BURGESS. When will you be able to make this data available to us?

Mr. HACKBARTH. Well, the group practice demo is underway as we speak at 13 different locations across the country.

Mr. BURGESS. So when will we have the data available?

Mr. HACKBARTH. It is a 3-year demo, and we are like at the second year now.

Mr. BURGESS. Obviously that is a long time in this trajectory where we are catching up every year and trying to do something to prevent the total collapse.

Mr. PALLONE. We got to move on. You were over a minute. Thanks. I recognize Ms. DeGette.

Ms. DEGETTE. Thank you, Mr. Chairman. Mr. Hackbarth, we are all kind of concerned over here about the MedPAC recommendations because Congress has been looking for a long time at how we can find a long-term fix for the physician reimbursement problem, and in reading your written testimony and listening today it is virtually impossible for us sitting up here to figure out what your recommendations are, and in fact in your written testimony you say that Congress must decide between two paths. One path repeals the SGR and doesn't replace it with the new expenditure target. Congress accelerates development and adoption of approaches for improving incentives. Alternatively, the Congress could replace the SGR with a new expenditure target system. And it seems to me, No. one, these two alternatives are both a little bit nebulous. The second, it is two alternatives that we thought we created you to make a recommendation, so my question to you following up on what Ms. Eshoo said is if you were us and you had to pick one of the two alternatives, what would you do?

Mr. HACKBARTH. The commission is split on it. You can ask people who have expertise on these issues what they think. What they think is there is a disagreement. The commission is split down the middle on whether expenditure targets are useful in Medicare.

Ms. DEGETTE. So if the commission, who are the experts, are split on what to do how do you think Congress should go about trying to figure out a solution, a long-term solution?

Mr. HACKBARTH. Again, you can ask people what they think and you can't generate agreement where it doesn't exist. There is agreement on a very broad agenda and a very detailed agenda that falls under these broad headings.

Ms. DEGETTE. Right. As Ms. Eshoo points out to me just now, we can get information. I don't mean to belittle your efforts but what we are struggling to try to do is come up with solutions which we have been doing for some years and why we created you guys.

Mr. HACKBARTH. I would be happy to come and meet with you individually to talk about the specifics under these items and what it means by information in that bullet.

Ms. DEGETTE. I respect you, and I know that there are many pages of information that support those four points, but the bottom line is there are still two recommendations, neither of which are flushed out in detail, somehow leaving it up to us to try to pick and choose, and for us as Mr. Green said, it just kicks the can down the road a little bit more.

Mr. HACKBARTH. Well, let us talk about the two paths and the difference in thinking between them. As I said in my initial comments the people who believe that expenditure targets should be preserved in some form believe they feel a great sense of urgency about the cost growth in the Medicare program and they believe that it is appropriate to take some risk, frankly, to maintain expenditure targets in order to establish fiscal discipline in the program. Ultimately, the Congress is the judge of how urgent that problem is and how concerned you are about the drain on resources for other important programs.

Ms. DEGETTE. So would you say then that that is the approach that Congress should take only if we think that the fiscal pressures are great but that the other approach would be preferable?

Mr. HACKBARTH. The other approach focuses on trying to change payment systems at a very detailed level to improve the fairness of those systems and to encourage greater efficiency in the delivery of care. It is a complicated agenda. It is not an easy agenda. But in the long run if you want to improve fairness and efficiency these are the things that you need to do and there are literally dozens of steps under this agenda and all the commissioners agree on that.

Ms. DEGETTE. This agenda could also be cost effective if implemented correctly.

Mr. HACKBARTH. Absolutely. And the commission is unanimous on that. There is no disagreement about that.

Ms. DEGETTE. Mr. Chairman, with all due respect, I think that we should either disband this commission and get a new one that will give us clear recommendations or we should send the existing commission back to come up with a clear choice for us so that we can actually use this information. And I do appreciate Mr. Hackbarth coming today to talk to us but I think that the work product is unfinished and that we need much more information. Thank you for your indulgence, Mr. Chairman.

Mr. PALLONE. Thank you, Ms. DeGette. I would just point out again though that a lot has to do with what you were tasked to accomplish. I mean obviously we can ask you to do certain things and we can be more specific too in what we task you to do. And I think part of the concern is what exactly you were tasked to do. I am not going to get into that now but that is always the question is how specific we get in what we ask you to do. I would like to now move to recognize Mr. Murphy from Pennsylvania.

Mr. MURPHY. Thank you, Mr. Chairman. I thought I was further down the list. I just want to focus on some of the questions about waste and get some sense from you and some more details of how much do you think is currently within the Medicare system, the payment system, in terms of the waste that is taking place. Do you have some concrete assessments of that?

Mr. HACKBARTH. No. That is a very difficult question to answer including what you mean by waste.

Mr. MURPHY. Some of that would be just the efficiency of the system, health care system.

Mr. HACKBARTH. The problem in U.S. health care is not necessarily lots and lots of zero benefit care being provided but rather care being provided that adds only a little bit to better outcomes for patients at a very high cost. So there is some pure waste, no benefit care. In fact, there is some care provided that is actually harmful to patients but the big problem in U.S. health care is a lack of efficiency, care provided of only marginal benefit at great expense.

Mr. MURPHY. Well, one of the points that you may have heard me making in my opening statement had to do with the infection rate in hospitals in America. I know to their credit many hospitals are working diligently on this and many have provided significant or seen significant decreases in, for example, post-operative infection rates through many things including giving antibiotics at the

right time before and after surgery but in some of them the low tech high turnout of outcome so even washing their hands, sterilizing or cleaning up before and after procedures, et cetera, and yet Medicare still pays for infections people get in hospitals. As I mentioned, I introduced a bill that would require hospitals to publicly state their infection rates.

And what I would also like to see us do is actually take some of the cost savings from that and use it as grants to hospitals that are able to lower the infection rates to zero. Are these things that you think are doable, that we can really use the clout of Medicare's payment system to say this is something we ought to really be looking at and not continue to pay for that?

Mr. HACKBARTH. Yes. We do think that substantial progress can be made both through public reporting and pay for performance, and there is just no reason why we should have the level of infection rates that we have. We agree with that and there are steps that can be taken.

Mr. MURPHY. Let me ask another area, and that is with preventative care. Do you believe that Medicare should be reimbursing doctors for some preventative care services? And another area is patient care management. Let me explain a little bit about that. You probably are aware of this but I know that a couple studies done in Pittsburgh hospitals, one was following diabetics, and we recognize about 80 percent or so of health care costs of those were chronically ill. And a substantial portion of those are folks who we used to call it hospital non-compliant patients, we realize better now that a lot of that was from chronically ill patients who have very complicated cases. It is nearly impossible for them to monitor and do all the right things from their diet, their medication, their insulin, their exercise, their mental health, all those things that are so very, very important.

One hospital found that just by monitoring the care of these patients and calling them on a weekly basis to ask them a few simple questions actually with diabetic patients reduced re-hospitalization rates by 75 percent. Another hospital reduced hospitalizations of those with heart disease by 50 percent. These are massive savings. And yet my understanding is the Medicare system for diabetics will reimburse or pay the hospitals for providing hospital care or amputations, et cetera, but do not pay for a nurse to make a 5-minute call or for a doctor to set up an e-mail system. What kind of changes do you think realistically we can make there?

Mr. HACKBARTH. So what you are doing, Mr. Murphy, is actually going through the items on this list, and what you are talking about falls under the heading of coordination of care. And Medicare does not properly pay for coordination of care by primary care physicians, and MedPAC has recommended a number of ways that that might be altered. In addition to that, CMS is now testing different models for encouraging coordination of care. There is the health support pilot project that is looking at patients with chronic illness including diabetes, and we think potentially that is a very helpful model.

In addition to that, there is a medical home demonstration that is now in the process of being established which basically increases payments for physicians for that ongoing relationship, counseling,

education of patients, following up on their care, following up on specialist visits and the like. We think there is huge opportunity there.

Mr. MURPHY. I appreciate it. Mr. Chairman, I hope this is an area we can look further at because the cost savings on this are pretty massive so I thank you for dealing with this issue. Thank you, sir.

Mr. PALLONE. I understand. Thanks. Mrs. Capps.

Mrs. CAPPS. Thank you, Dr. Hackbarth. And I have two different topics I would like to get into so keep in mind that this question I am about to address having to do with the geographic price cost index is but the first half. I am deeply concerned as you might know about the current GPCI, if we can call it that, formula currently in place. And I think it is interesting that you in your recommendations have highlighted the need to revisit. You have a proposal to establish expenditure targets based on geographic regions but I am wondering how you can do this. You said the last time the commission discussed GPCI was 2 years ago, but doesn't this proposal to deal with geographic regions highlight the need to revisit how we reimburse physicians based on their location because of the inequities in the current system and those inequities have become a huge barrier to access, and so many of counties across the country in my district.

So I am asking you about how we update the current classification of geographic localities even as we devise a new system for Medicare physician reimbursements. I am worried that if we adopted the model of establishing expenditure targets without first revisiting GPCI classifications we would only be further compounding the existing problem. After all as I mentioned in my opening statement the bottom line is insuring access for all beneficiaries. The failure to account for these fatal flaws in the current price cost index is going to further exacerbate any kind of proposal you are going to make, and I am just asking you now have you taken into account these current inequities as you have formulated suggestions for updating the overall payment system?

Mr. HACKBARTH. As I said in my response earlier on the specific issues of GPCIs in California, we have said that we think there are some problems, and we do think that there are ways to correct them but that it ought to be done on a budget neutral basis within California.

Mrs. CAPPS. Well, it is actually among 135 or so counties across the country, this inequity exists, so it is not just our region although I am certainly going to acknowledge that.

Mr. HACKBARTH. I wouldn't say that it exists only in California. I am not sure I would agree with 135 either. I don't know how that is calculated.

Mrs. CAPPS. We can give you that information and maybe you can correct it if it is wrong.

Mr. HACKBARTH. Yes, but it is on a national basis a relatively isolated problem that we think can be corrected.

Mrs. CAPPS. OK. I am just suggesting before I move on that in order to carry out the recommendations you are making now that we can't do it on the back of a very flawed system. We have to do more than one thing at the same time if we are going to make any

progress. Maybe we need to revisit the actual mandate that you were given to deal with on this whole fix. But let me talk about another topic because it also is very relevant to the Deficit Reduction Act, and that has to do with imaging procedures. We have discussed this many times last year but I am still concerned about how these cuts have been proposed.

MedPAC continues to cite the volume of imaging services as growing at a faster rate than all fee schedule services. But I don't believe you are taking into account the fact that over the last few years many imaging services have moved from hospitals to physician offices as a cost saving to health care both to the patients and to the providers of health care. It is less expensive if you do this in an outpatient or an office-based setting. That should be a good thing also for the sake of preventive health services. Preventive health care is by far the least expensive way to provide health care with the best outcomes. I would hope you would agree with that.

So I am wondering if you have done any further analysis of the growth and imaging services since our hearing in July, 2006 to take into account the shifts in the site of service. I think it is safe to argue that early diagnosis of disease can be identified by imaging procedures. Early diagnosis produces much more savings in the long run but if we continue on the current path of this disparate discrepancy in reimbursement for office-based services we are going to see physicians stopping to do this and it is going to end up increasing the cost again.

Mr. HACKBARTH. As we discussed last time, imaging is——

Mrs. CAPPS. Well, let me ask you, have you discussed this further since that time?

Mr. HACKBARTH. MedPAC has not taken up imaging since our last conversation on this. Let me just review some points because I think we agree on some of this. Imaging is tricky because there are important technological advances. We can do great things for patients.

Mrs. CAPPS. Yes.

Mr. HACKBARTH. And we are all in favor of that. In some cases potentially growth in imaging can avoid the need for other more costly services.

Mrs. CAPPS. We all agree with that.

Mr. HACKBARTH. In some cases moving things from a hospital base to a physician base can be a good thing, and so I think we agree on that. We don't think that from hospital base to a physician base explains all of the growth in imaging. We have looked at that, and we think it is just a substitution effect.

Mrs. CAPPS. I have to finish by saying that you are throwing the baby out with the bath water by hesitating to allow physicians to or giving them some guidelines showing the ways that they can do this that will be cost savings. And I would strongly urge that this needs to be dealt with in the earliest possible time frame——

Mr. PALLONE. We need to move on.

Mrs. CAPPS. Thank you.

Mr. PALLONE. OK. Next we have Mr. Pitts of Pennsylvania is recognized for 8 minutes.

Mr. PITTS. Thank you, Mr. Chairman. A couple of questions for you, Mr. Hackbarth, to continue this line of questioning on the im-

aging. I think that we can all support the need within Medicare to reward providers for an efficient use of resources. In this report, MedPAC continues to cite the growth in imaging as being a problem, yet ultrasound-guided breast biopsies save Medicare $1,000 per patient, and decrease the risk of infection, speed the time to diagnosis, and have better cosmetic results. However, ultrasound guided breast biopsies mean that two ultrasound are performed that would not be performed if the surgeon performed an open surgical biopsy.

My first question, would MedPAC not consider this an efficient use of services, ultrasound services, where comparative effectiveness information has played a role in increasing ultrasound services related to breast biopsies while providing a better outcome for all parties? Second, is it clear from MedPAC's examination of the SGR by type of service included, that is, imaging lab services, et cetera, that the growth within the physician's fee schedule is not appropriate? I would assume that with Medicare beneficiaries living longer, increased incidents of disease change and clinical practice guidelines, shift in site of service and the screening benefits that Congress has enacted over the last several years that the growth found by MedPAC could be a result of the health care system being more efficient with the care going to the site of service with the lowest overhead and greatest beneficiary access.

Mr. HACKBARTH. We think that some of the growth is imaging is appropriate and to the benefit of patients and may even reduce other Medicare costs. We don't believe that applies to all of the growth in imaging. We think that part of the growth in imaging may in fact be driven by distortions in the Medicare payment system where we overpay for some types of services. Providers know that we over pay. They know they are profitable and so they increase the volume of those services. So it is a mixture, and I know that is frustrating to the committee but rarely these things have black and white answers. MedPAC has never recommended that we try to cut imaging across the board.

The thrust of our recommendations has been for much more targeted, sophisticated approach than that because we recognize that there are benefits from some imaging.

Mr. PITTS. And perhaps demographics of the Medicare population, the migration from invasive to non-invasive diagnostic tool.

Mr. HACKBARTH. Those are part of the reason for the rapid growth but we don't think that they explain all of it.

Mr. PITTS. Well, MedPAC continues in this report to cite the volume of imaging services as growing at a faster rate than all fee schedule services over the last few years. Many imaging services have moved from hospitals to physician's offices. Has MedPAC done any further analysis of the growth and imaging services to take into account the shifts in site of service since our hearing in July 2006 and was MedPAC able to look at both the hospital outpatient fee schedule data and the physician fee schedule data combined over time to account for this site in service shift or are we again without real data regarding what is the true new growth in each of these types of services?

Mr. HACKBARTH. We have not looked as a commission at the issue since the last hearing but at that hearing the numbers that

we talked about, we did look at the substitution issue and whether the growth in fee schedule expenditure and imaging was solely due to substitution, and we did not find that to be the case. We don't think that substitution of physician services for hospital services explains all the growth and imaging. There are a lot of different factors that go into it.

Mr. PITTS. Your analysis only used Medicare physician fee schedule database, is that correct, therefore, the MedPAC has not adjusted the growth rate to count for that shift in the site of service?

Mr. HACKBARTH. We have tried to look at whether movement from hospital-based imaging to physician-based imaging explains the growth and we don't think it explains all the growth, no.

Mr. PITTS. And what about my first question, the efficient use of services?

Mr. HACKBARTH. Well, as I said earlier there are new types of imaging that can be more efficient. They can improve patient outcomes and reduce the need for other services that are higher cost. And that is good. We want to preserve that. We don't believe that is all that is happening in the growth imaging. We think some of the growth is for care of marginal benefit to patients at a high cost. We think some of the growth is due to inaccurate pricing and unusual profit opportunities. You go to physician conferences and you can see the imaging manufacturers selling their wares, talking about what a great profit opportunity this is, so that is a factor in this complicated picture as well.

Mr. PITTS. Thank you, Mr. Chairman.

Mr. PALLONE. Thank you. I recognize Ms. Hooley of Oregon.

Ms. HOOLEY. Thank you, Mr. Chairman. I have three questions. I am going to ask you all three of them, and then we will have a chance to discuss them. MedPAC concluded in its report to Congress that Medicare beneficiaries do not suffer from a lack of access to physicians. However, that is not what Medicare beneficiaries tell me in Oregon. That is not what they say. It is not what the doctors say. And I used to jokingly say to my friends that are about ready to retire if your doctor is older you better find a younger doctor, otherwise, you are not going to be able to get a doctor if you are retired and are on Medicare.

I used to say it jokingly. I now am dead serious when I say that. You are from Oregon. I want to know if you have heard the same problems in Oregon or what is happening in Oregon that may be unusual in terms of the rest of the country. The second question is Oregon provided health care at a very reasonable cost. We were very efficient. We had a high penetration of managed care. And because of that we had been penalized over and over again for low reimbursement rates. And in rural areas where you have a high percentage of Medicare beneficiaries than in other parts of the country you combine that with a high number of beneficiaries and a low reimbursement rate, and frankly you can't find doctors to serve in the rural areas because they simply can't make a living doing it, and the question is has that been taken into account.

And then the third question is MedPAC noted in its report that adjusting payments based on physicians participating in a group practice would be difficult to implement in rural communities because few if any rural providers can join multi-specialty practices.

I was very pleased to see that you recognized that. However, that is the only thing in your report that you really pay attention to the impact of MedPAC on rural providers. And my question is why doesn't MedPAC's report give more attention to highlighting the differences and how various proposals would impact rural communities versus other communities?

Mr. HACKBARTH. OK.

Ms. HOOLEY. Are we different in Oregon?

Mr. HACKBARTH. I don't know about different in Oregon in general but there are places within Oregon where there might be unusual access issues. Let me just start with the big picture. When we ask both beneficiaries and physicians about access to care in the case of physicians willingness to accept new patients, in the case of beneficiaries their satisfaction with access on a national basis things look pretty good on both beneficiaries and physician front. Access compares pretty well to what exists for privately insured, non-Medicare patients.

Ms. HOOLEY. They may be fine nationwide but I am telling you it is a problem.

Mr. HACKBARTH. Now having said that, obviously the picture can differ in particular communities. Take mine of Bend.

I think that there are somewhat greater access issues for Medicare beneficiaries in Bend than in most other parts of the country. Are those the result of Medicare payment rates and Medicare payment rates alone? I don't think so. One of the issues that fast-growing communities face is that there can be an imbalance between the number of patients and the supply of physicians. I think that is true in Bend. We have had very rapid growth in a retiree population and that has grown faster than the supply of physicians. That is not just a matter of Medicare payment rates. There are broader issues involved there.

Ms. HOOLEY. But Salem, an area, capital city, there are literally no doctors taking Medicare patients.

Mr. HACKBARTH. I don't know what the data are in Salem in particular but we do know on a national basis the access continues to be pretty good. It wouldn't necessarily stay that way as Chairman Pallone mentioned in his statement if we had successive years of cuts in rates. We do believe that would affect access but we are not seeing that in the national picture right now. As for the second question about low cost states being penalized to some extent, let us put it this way, they are not rewarded under Medicare for their efficiency and systems like SGR that cut across the board, hurt the low cost states maybe more than others. That is why some commissioners think that we ought to go to a geographically-based system of targets that applies the greatest pressure in the high cost states, not the low cost states like Oregon.

Ms. HOOLEY. I am talking about Oregon in general, not just my district, you have places in rural communities because of the high number of beneficiaries there, and the low reimbursement doctor's offices are closing. There is one doctor's office in the area. I mean they just simply can't afford to take another Medicare patient, and it is interesting because if you look at the rest of Oregon it is amazing, and that is why I tell my friends you better get a young doctor is if they have other insurance they seem to be able to get accepted

into that doctor's practice but if they have Medicare they don't get accepted into the doctor's practice.

Mr. PALLONE. I am going to have to stop you guys. I know you only got into the second of the three questions but I will just ask you to respond to complete the second and get to the third in the record because we are just over, that is all.

Mr. HACKBARTH. On this issue of access in rural areas, I think it is a critical question.

Mr. PALLONE. OK. Just if you could summarize because we already went over almost 2 minutes.

Mr. HACKBARTH. What doctors tell us is that almost 60 percent of rural physicians say they accept all new Medicare patients. That is what physicians tell us.

Mr. PALLONE. And, Mr. Hackbarth, if you could just finish the rest of it in a written response, I would appreciate it. Thank you.

Ms. HOOLEY. Thank you.

Mr. PALLONE. Next we have our ranking member, Mr. Barton, of Texas.

Mr. BARTON. Thank you, Mr. Chairman. We are going to disagree a number of times this year on solutions but I think we have bipartisan agreement that this particular issue is a huge problem trying to find a way to adequately reimburse our physicians while at the same time not bankrupting the Medicare trust fund and the part B premium payers. The recipients, our Medicare beneficiaries, is an ongoing problem. I wrestled with it. Mr. Tauzin wrestled with it. Now you and Mr. Dingell are wrestling with it. So some time this year when we get to the solution stage, we are certainly going to be vigorous probably in debating solutions but we don't disagree that this is a problem.

Did your group prepare the table that lists all the costs of the proposed solutions or is that something that CBO has done? It has 15 different alternatives from a freeze payment rate in 2008 and hold future updates at current law levels. That cost $4.2 billion. And then No. 15 is an automatic MEI update that replaces the SGR and holds the premium payers harmless, and that is $330 billion. Is that your table?

Mr. HACKBARTH. That is CBO's. It is not ours. My guess is it is a CBO table.

Mr. BARTON. OK. Have you seen that table?

Mr. HACKBARTH. The $330 billion figure is not the one that I have seen. The one I have seen is I think $260 billion, $270 billion for repeal and replaced with MEI.

Mr. BARTON. Do you have a cost estimate for whatever MedPAC has said is the solution?

Mr. HACKBARTH. We don't do cost estimates, Mr. Barton. That is——

Mr. BARTON. That is convenient.

Mr. HACKBARTH. Well, that is CBO's institutional responsibility. We are both congressional support agencies and that is their responsibility, not ours.

Mr. BARTON. Well, what is your policy recommendation or recommendations then?

Mr. HACKBARTH. Well, what we have recommended is not just in this report but in previous reports a long series of recommenda-

tions to improve pricing accuracy and to encourage efficiency in Medicare, and I would be happy to go through it but I have a feeling that I am not going to have a chance to.

Mr. BARTON. So you don't have a recommendation on this chart that CBO has put out about a specific recommendation like the 1 percent update in 2008 and 2009 or an MEI update in 2008?

Mr. HACKBARTH. On this specific issue, Mr. Barton, of what the annual increase should be for physicians what we recommend is that that not be set in legislation but that the Congress look at it year by year to determine what the appropriate increase is so——

Mr. BARTON. Do you advocate abolishing the SGR?

Mr. HACKBARTH. That is the issue on which the commission is divided, Mr. Barton.

Mr. BARTON. So there are some that say it should be and some that say it shouldn't be?

Mr. HACKBARTH. Yes. Roughly half the commission would like to see a system of expenditure targets retained although not applied only to physicians but rather to all providers.

Mr. BARTON. Now what we did last year was put some quality measures and put some bonus payments and we just did a very—not a permanent change but created a small incentive program for the next year or so. Does MedPAC support that?

Mr. HACKBARTH. We support the general idea of quality reporting and of rewarding that.

Mr. BARTON. But on the issue of the cost your group doesn't try to cost any of these alternatives out?

Mr. HACKBARTH. No. CBO does the cost estimate.

Mr. BARTON. Mr. Chairman, I am going to yield back and look forward to working with you and Mr. Deal and Mr. Dingell to try to find a way out of this mess.

Mr. PALLONE. I appreciate that. Thank you.

Mr. Green of Texas.

Mr. GREEN. Thank you, Mr. Chairman, and following our former chairman of the committee, I know last year he told me many times he wanted to have a permanent fix to it, and we are in the same situation, and even in the odd numbered years like I said earlier as well as in the even numbered years. Mr. Hackbarth, we often hear from physicians who describe their payment situation under Medicare when they are comparing it to hospitals, specifically we hear that hospitals get annual updates with no global target or automatic cuts if the volume grows too much. Can you speak to the differences in the payment systems for the physicians and the hospitals?

Mr. HACKBARTH. Well, again this is the issue that I referred to earlier. There are some commissioners who believe that treating hospitals and physicians differently in this regard is inequitable, and Medicare has a total cost problem, not just a physician cost problem. And so if there is an expenditure targeted it ought to be applied equally to hospitals and physicians.

Mr. GREEN. OK. Physicians get paid for each service they provide while hospitals get paid on the episode or group of services, and could Medicare group those services together and pay physicians for a whole episode rather than a service by service fee, and in your opinion would this payment practice encourage care coordination?

Mr. HACKBARTH. We have recommended that Medicare begin looking at physician resource use on an episode basis so how much does it cost to care for a patient with say diabetes as opposed to just looking at office visits and imaging, everything separate. Our recommendation is that in the first instance we provide that information to physicians on how their patterns and practice compare to their peers and do it on a confidential basis. As we develop the tools and experience with them then the analysis might be used with payment rates and higher updates, for example, for physicians that are consistently efficient in their episodes, so that is a direction that we think we ought to go.

Mr. GREEN. Thank you. Mr. Chairman, I would hope that we can look at, for example, whether diabetes patients or something else instead of one treating each visit, it is actually the episode of visits similar with the hospitals. Since my co-sponsor on the bill on imaging, Congressman Pitts, asked a question about—highlighted MedPAC's comments about the importance of imaging in primary care and care coordination, and Ms. Capps mentioned how nowadays there is lots of imaging being done in doctor's offices compared to hospitals, let me ask you a different question. Two-thirds of Medicare spending goes for individuals with more chronic conditions, and I agree with your recommendation that we should encourage care coordination and more emphasis on primary care.

However, the Medicare system is designed both in delivery and financing health care to address acute condition specific problems. Can you discuss how this element of the Medicare system serves as a barrier to effective primary care and care coordination, and would it take a fundamental change in the system either through CMS or through statute to insure that proper delivery of primary care and the care coordination, again this fits in with the first question, but do we need the structural change to do that?

Mr. HACKBARTH. Yes. There is going to need to be a structural change in all likelihood. A big part of it is going to require legislation to do. There are some things that can be done without legislation but, for example, the medical home idea where we pay a primary care physician to work with a patient over time, particularly a patient with chronic illness, that requires a new payment method that will have to be legislated. We are looking at different models for how best to do that and have demonstration projects underway that will hopefully give us guidance.

Mr. GREEN. Does MedPAC have a time frame for that study and those models?

Mr. HACKBARTH. Well, the demos of course are being run by CMS, and each has its own schedule. The one that is most advanced at this point is the Medicare health support pilot that was initiated I guess under MMA. Some of the other demonstrations are still in the developmental stage.

Mr. GREEN. Thank you, Mr. Chairman. I yield back my time but again I would urge—hopefully our committee would look at that because again I think it might end up hopefully saving money but it also makes sure that physicians know that patient is with him and the whole episode of their illnesses particularly the chronic, the numbers that we saw. Thank you, Mr. Chairman.

Mr. PALLONE. Thank you. And you raise some very important questions that we have to look into, so thanks again. Mr. Shadegg of Arizona.

Mr. SHADEGG. Thank you, Mr. Chairman, and I appreciate your holding this hearing. It is yet one more in a series that I have participated in what continues to puzzle me. I must begin by saying, Mr. Hackbarth, that I sympathize with you. As I hear my colleagues complain about not liking your product, it seems to me that the next thing we need to do, and I want to make sure this is understood to be tongue in cheek, is create a commission to study your commission. I think you have been given an impossible task. In my tenure in Congress, I have watched Medicare funding. I have watched the SGR system fail year in and year out. I have watched the Congress do what I think I just heard you recommend which is look at each year and try to figure out the appropriate level of funding.

What I think you are charged with doing is price fixing or setting prices appropriately for the entire health care industry and I quite frankly think that is an impossible task. I also think, and I have said it here before but I want to say it again, that it is a scandal that the United States Congress creates a program, promises health care to a category of people, then discovers that it doesn't have enough money to pay the providers to deliver that health care and so it says, well, we won't scale back the promised benefits, what we will do is, quite frankly, cheat or under pay the providers. I guess that gives me some sense of understanding why the providers then naturally gain where some portions of the SGR have overcompensated some categories of work and others under compensate, and so providers are drawn to the areas where they overcompensate.

Let me ask you first, as I understand your testimony what you have been able to come up with is two different alternatives, I gather in part because the commission is partially divided. One is to repeal the SGR, not replace it, but go to some form of alternative which I gather would be pay for performance, is that the so-called path one?

Mr. HACKBARTH. Pay for performance would be part of it but not the whole thing. Care coordination would be part of it as we just discussed with Mr. Green. Resource measurement episode based analysis would be part of it. There are many different pieces to it.

Mr. SHADEGG. The second piece of it as I understand it would be to actually replace the SGR with a new price setting mechanism that would apply to all care providers in the hope that that would reduce the untoward incentives in the current system which has the SGR just setting position rates, is that correct?

Mr. HACKBARTH. Generally speaking, right.

Mr. SHADEGG. To the extent that pay for performance were to be a part of the first path, who would decide which physicians had performed or not performed? How do you envision that decision being made?

Mr. HACKBARTH. One of the things that we have looked and will come back to is how to institutionalize the process of developing performance measurements. I think physicians and all providers for that matter have a right to expect that there be some consist-

ency in that process and that it be done in accordance with the best available evidence as opposed to be done in a bureaucratic process.

Mr. SHADEGG. That is the available evidence. Are you envisioning that it would then be—or maybe you haven't gotten to this point. My bottom line question is, is physician performance going to predominantly be measured by patient satisfaction, patients saying we were satisfied, or by external measures other than the expression of patient satisfaction?

Mr. HACKBARTH. I think it needs to be both. It needs to be incorporated in the framework with patient satisfaction and technical measurements of quality based on best available evidence.

Mr. SHADEGG. I have deep concerns about any system which is not predominantly driven by patient satisfaction, and I would encourage you if you are going to look at this to look at making—while I understand there are professional evaluations my cardiologist in whose hands I have put my life knows the other good cardiologists in town and knows the good practices. At the same time I believe that patient evaluation as it should be, must be a huge component of this. Let me ask you another question. With regard to an alternative to SGR you have been asked to look at its failure and to recommend alternatives. Have you considered or could you consider in the future a big picture evaluation, that is to say perhaps doing away with government price setting in Medicare altogether, and instead providing people with essentially a stipend or a fixed amount of money, a tax credit, if you will, and allowing the consumers of Medicare services to spend that for Medicare services the way they deem appropriate so that you wouldn't need a top down government price setting mechanism but you could use a Medicare patient driven system because I personally believe that in all of health care where we have gone wrong is by taking patients out of the driver's seat, and I don't see patients being put back into the driver's seat. Is that an issue you could look at?

Mr. HACKBARTH. What we have said is that Medicare needs some of each, that we believe that there should continue to be the traditional Medicare program but that private options ought to be available to Medicare beneficiaries and that there ought to be a financially neutral choice between the two so private plans can do it more efficiently and if beneficiaries want to choose them they ought to have that opportunity to do so. What we object to is paying private plans more than traditional Medicare.

Mr. SHADEGG. My time has expired. But let me just conclude by saying I am not suggesting necessarily private plans. I am suggesting that—and I would accept this as one portion, one alternative, putting the money in the hands of the patients and letting them spend it where they thought it was appropriate so that you use them to set prices even as a demonstration project. I thank you, Mr. Chairman.

Mr. PALLONE. Thank you. Ms. Baldwin.

Ms. BALDWIN. Thank you, Mr. Chairman. I have two sort of directions for my questions. Both have been touched on already, but I hope that you can perhaps explore these a little bit more deeply with me. The first relates to reimbursement practices in primary care, and the second goes back to this area of the concept of the geographical disparities. So first on primary care, I have had the

opportunity, as I am sure many of my colleagues have, to meet with physicians engaged in primary care practices and also to talk a little bit about the number of medical students who are choosing to specialize rather than go into primary care practices, and the trend is of concern certainly away from primary care, family practice or internal medicine studies.

I visited a clinic in my district during our last recess where the Medicare payment trends were of great concern. It is a physician group that is only primary care, and the percentage of Medicaid and Medicare patients that they have and the low reimbursement rates are such that they have unsustainable losses that they are experiencing that are increasing in each year. They don't have any specialty doctors in their practice with which they could do some sort of cross subsidy or cost shifting, and in fact they even broke down in charts that they provided to me the per physician per year cost to subsidize basically the Medicaid and Medicare services that they are providing.

And it was very distressing to me to wonder how long they can sustain such a practice. And so I would ask you how can our payment policies as we look at this, look at a long-term fix, what sort of hope can I give these primary care physicians, and also with regard to students entering medical school, how can our payment policies impact this very problematic trend that we are seeing with regard to the number of students going into primary care.

Mr. HACKBARTH. Improving payment for primary care involves work on three paths. One is we think there are problems in how the relative values are set for different physician services that lead to underpayment of some primary care services, and we have made some recommendations on that. We think that Medicare might also look at adding some new codes to the system specifically directed at rewarding time spent in educating counseling patients, basic primary care activities. Finally, as we discussed already, there are demonstrations underway that look at rewarding care coordination specifically through an added payment, a per patient payment, to cover the cost of care coordination, especially for those with serious chronic illness, so there are multiple different approaches to improving primary care payment.

As for the supply issue certainly the low income potential for primary care relative to other specialties is a deterrent for some medical students. People who are deeply involved in that process and medical education, working with medical students, tell me though that income isn't the only factor, that other factors that discourage people from going into primary care are the lifestyle compared to some of the specialties. It is a harder lifestyle. And finally it seems as having less intellectual challenge than some of the sophisticated sub-specialties. So in short we favor increasing payment for primary care in various ways. We shouldn't have any illusions though about how easily it will change the supply of primary care physicians.

Ms. BALDWIN. I would love to explore that more deeply. I am going to not do so because I want to quickly get in a question about the geographic disparities. We talked a bit about this and I guess two questions. One is the extent to which MedPAC and CMS has measured the differences in volume of services provided in different

localities so how much of that data exists. And, second, in your report you discuss the option of reimbursing physicians based on sub-national geographic areas. I wonder what you mean by that is what is the most feasible unit of measurement, states, portions of states or groups of states.

Mr. HACKBARTH. Yes. On the first piece the available evidence on variation, Dr. Fisher, who is on the next panel, is the expert on that question so maybe I will let him address it in detail for you. As opposed to the appropriate geographic unit, roughly half the commission likes the idea, first of all. We didn't talk about what the right geographic unit would be. There is a trade off. As you go to smaller units you get more precision in the targeting but with smaller units you get some problems like variability with small numbers, instability in the numbers from year to year, a risk that people will start to cross borders to receive their care or physicians will change location of practices.

And so there is not a clear right answer that I can offer you as to the right geographic unit, but we can go into that more at another time if you wish.

Mr. PALLONE. We are running out of time. Thank you. OK. I recognize Ms. Wilson of New Mexico.

Ms. WILSON. Thank you, Mr. Chairman. I think I join my colleagues on both sides of the aisle here in agreeing that this sustainable growth formula is unsustainable, and it should be permanently fixed. But I also don't think it is reasonable to try to mandate consensus among experts if a consensus isn't really there. I recognize it is a very difficult problem that thoughtful people and thoughtful people can disagree. So I appreciate your input. Really two areas of questions that I wanted to focus on. And the first has to do with incentives. You highlight a number of areas of possible incentives or ways to change the system so there are incentives for providing high quality care and so forth.

Do you think there are any savings inherent in those approaches or is the recommendation of the commission to put those incentives in place and allow or indeed encourage those funds to be kept in patient care?

Mr. HACKBARTH. We do believe that there are savings. We do believe that the better incentives will change patterns of care and make care more efficient. They are not the sort of savings that are readily scored by CBO though because they involve behavioral change over a long period of time.

Ms. WILSON. I also, like some of my colleagues from other rural states, I am always concerned when people talk about changing the formulas and making different formulas for sub-national geographical areas, and we saw in the managed care formulas, for examples, significantly disadvantaged rural areas, and a lot of the formulas the way they are set up pay much less in rural areas, and I can understand where the cost of space or the cost of energy may be different in different regions of the country but the cost of a physician's time should not depend on where they live. And the value and the increasing value of their time should not depend on where they live.

When you talk about sub-national geographic areas, if we were to do this, have you all done any modeling on which areas or type

of areas of the country would be winners and which would be losers?

Mr. HACKBARTH. We have not. Again, the commission has not agreed on that issue of doing sub-national geographic targets, and we have not made a recommendation to do that, and as a result we haven't tried to figure out all of the variations within that category.

Ms. WILSON. So you haven't gone back and looked at data and done modeling and said if we had done this what would have happened?

Mr. HACKBARTH. In response to previous requests from Congress looked at variation by state and how Medicare expenditures vary by state. Dr. Fisher has looked at it based on hospital service areas and I couldn't characterize simply who the winners are and who the losers are. We can provide a list of the states and who has low cost and who has high cost. I would be happy to do that.

Ms. WILSON. I appreciate that. I worry that when we start doing that you immediately start to put pressure on rural areas, and I have seen it happen in other formulas here, and I also know the reality is that concentrated population centers in America have more votes in the House of Representatives, and that is a reality but it is something I am very concerned about.

Mr. HACKBARTH. The proponents of geographically based expenditure targets believe that that system would be fairer to the low cost states, many of which have large rural components. Many of the states that are highest cost have very large urban areas and so the intent certainly is not to disadvantage rural areas, and in fact it may benefit many rural areas, many rural states.

Ms. WILSON. If you have any further data on that that you are able to share or information on it that would help us to expand our understanding on what that might mean, I would very much appreciate it. Thank you, Mr. Chairman.

Mr. PALLONE. Thank you. Ms. Solis.

Ms. SOLIS. Thank you, Mr. Chairman. I know we don't have a lot of time. I did want to touch base regarding the geographic payment locality issue as well. I am not sure what statistics or information you have about Los Angeles County in southern California, but I am very concerned because as I said earlier in my opening statement we are losing the ability to attract doctors to come in to low income underserved areas. And the county of Los Angeles if we use say a median income or a median formula to pay for reimbursements could actually end up penalizing communities that are unincorporated, which are part of Los Angeles County, as an example, but have the highest number of seniors that really require and would be eligible for this type of assistance. So I am anxious to hear at some point, if not now, to get that information from you.

And then also you mentioned earlier that there might be some type of attempt to try to compensate physicians that have to do a little bit more counseling. One of the things that has come up in the course of my being here on the hill is trying to figure out how we can help provide for incentives for doctors who do have to spend more time translating information to immigrant populations to seniors from diverse backgrounds and the notion that they should be given some additional pay because they are spending more time to

technically go through and actually explain and interpret every little detail as to the care for that patient.

And then lastly how do we bridge the gap for disparities because we have so many underserved African-American, Asian and Latino communities where they typically are not being, for example, given the same kinds of testing or examinations or vaccinations like influenza. And I have a real concern with that because our communities are being overlooked so if you could please touch on those three items.

Mr. HACKBARTH. On the issue of the geographic adjusters in California maybe the most efficient way to deal with that would be to have a follow-up conversation and provide a letter for you about Los Angeles County. I don't know the facts off the top of my head so we would have to do some research on that. On the issue of the cost of translation that is not an issue that we have looked at specifically one way or the other.

Ms. SOLIS. It has never come up?

Mr. HACKBARTH. Translation specifically, no, it has not.

Ms. SOLIS. Even the demographic challenges and the case load that is increasing in the Hispanic population? I find that rather surprising. I would urge the commission to strongly consider that.

Mr. HACKBARTH. Yes, that is fair enough.

Ms. SOLIS. Disparities, and how do we have kind of a across the board health examination for communities that typically don't get, for example, influenza vaccinations as readily as say the traditional population.

Mr. HACKBARTH. Yes. Certainly there are disparities in access. Our focus has been on trying to assure fair payment for all types of providers. How to change that issue is not something that we specifically talked about the disparities.

Ms. SOLIS. That is a big issue in our district.

Mr. HACKBARTH. We may come back to that.

Ms. SOLIS. And maybe I could just mention quickly that we have a tri-caucus that exists in the House; Black Caucus, Asian Caucus, and Hispanic Caucus, and we are going to be introducing legislation on health care disparities of which many of our seniors are impacted heavily with respect to how to tackle chronic illnesses particularly in the area of diabetes treatment, stroke, cancers, things of that nature, and would love to share with you that information.

And then something that one of my colleagues brought up that I have to also touch on is the fact that it is hard to attract physicians and incoming interns, medical interns, into low income service areas. And I understand the need to have more available in rural areas, particularly on Indian reservations and other low income areas. But in the areas that I represent it is very hard to attract young students and beginning that process early on, not at their senior year and not at the college level, and what incentives might we be able to look at since we see this increasing changing demographic population in the senior community that is going to live longer, that is going to look a lot different than what we normally have provided treatment to in the last 40 years, and if maybe there is an incentive or there is initiatives that we could put forward through the Congress to help you in that manner to help promote that.

Mr. PALLONE. Did you want to comment? Do you agree?

Mr. HACKBARTH. In principle but we just have not studied it so I don't have anything to offer on behalf of the commission.

Ms. SOLIS. Thank you.

Mr. PALLONE. Thank you. And last but not least is the gentleman from Texas, Mr. Hall.

Mr. HALL. Mr. Chairman, thank you. As you know, I have two Energy and Commerce subcommittees working, the Energy Subcommittee on the third floor, and I have been there and not knowing the questions that have been asked, I won't take his time. I am sure that the chairman is going to allow us to submit questions and they will give us answers, and we will do that. But I thank Chairman Hackbarth for his time and the time of preparation and the time in appearing here, and the good services you render this country. I appreciate it, and I am sure this committee and this chairman appreciates it. I yield back my time.

Mr. PALLONE. Thank you, Mr. Hall. Let me reiterate that we do appreciate what the commission has done, and I thought it was a very thorough analysis today. You have taken a lot of questions here for the last couple hours or so, so thank you so much for all that you do. And, you know, again I always say we can only expect you to do what we task you to do. That is always the issue here. So thanks again.

I would ask the next panel to come forward.

I will start by introducing Mr. Bruce Steinwald, who is Director of Health Care for the Government Accountability Office, and then we have Dr. Elliott Fisher, who is a professor of Medicine and of Community and Family Medicine at Dartmouth Medical School, and I know that your mom has been ill so I did want to thank you for coming down here to testify today even despite that situation with her. I hope that she is getting better and that everything works out. Thank you.

Dr. Thames, we have seen you many times. Thank you for coming back again. He is Dr. Byron Thames, member of the Board of Directors of the American Association of Retired Persons. I guess we will begin with Mr. Steinwald.

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

Mr. STEINWALD. Thank you, Mr. Chairman, Mr. Deal, and members of the subcommittee. Thank you for having me here today. I am going to briefly summarize the findings of a recently completed GAO study, but before I do I wanted to speak directly into the microphone and give you a little pictorial summary of how we got into the situation we face today. Very briefly, these are the years covered by the SGR on that exhibit. The bars that are up there now show the annual increases in the Medicare economic index, which is about 2½ percent per year, not a great deal.

The next chart shows the annual updates in physician fees under the SGR system. You can see the updates in the early years of the SGR were in excess of inflation and the cost of running a medical practice until 2002 when there was the 1-year decline, and subsequent to that modest updates by result of an act of Congress overriding the scheduled negative updates that the SGR called for. All

of that was related to increases in Medicare spending for part B services per beneficiary. You can see in the years 2000 and 2001, those spending amount increases per beneficiary far exceeded the updates in the MEI. It is those spending increases that led to the decrease in 2002, and you can see subsequent to then the spending increases have far exceeded either the MEI or the update.

And let me point out and emphasize those spending increases that have occurred in the first half of this decade have both yielded additional revenue to doctors above the update factor and yielded additional co-payments on the part of beneficiaries. So with that as a back drop, let me go on to the current study. We have done two studies in response to mandates in the Medicare Modernization Act. The first was a study on the sustainable growth rate itself. The second was a study that directed us to look at physician compensation generally, and when we consulted with Hill staff and others about how we might make best use of this direction, we decided to address what are the principle criticisms of the SGR, ones that we share.

It is a very blunt instrument. It treats all doctors the same. It doesn't discriminate between efficient and inefficient medical practices, and it doesn't provide incentives that operate at the individual physician level. And so we embark on a study that would try to get out those deficiencies of the SGR. These are generally what we did up there on the screen. The first thing we did was we looked at what some health care purchasers, not Medicare, but outside of Medicare are doing to encourage efficiency in medical practice. We looked at a wide range of purchasers. Some of them are private insurance companies, some of them were provider organizations, and some were government directed including one Canadian province.

They all do several things, one of which is they look at the spending of the physicians' patients, not just for physicians' own services but for a full range of services. They create bench marks for efficiency to try to gauge and identify the doctors who appear to be practicing medicine inefficiently. They all measure quality as well as efficiency and have performance measures that combine quality with efficiency, and they all try very hard to bring their physicians on board and explain to them what they are trying to accomplish. And what is listed on the chart are some of the things that these purchasers do with that profiling information once they collect it.

They range from simply educating physicians, providing information on how they stack up compared to their peers all the way to more stringent arrangements including directing patients to receive care from the doctors who score high on performance measures up to and sometimes excluding inefficient physicians from provider networks. By having seen what some provider organizations do, we then embarked on an examination of Medicare claims data to see if we could devise a methodology that could identify efficiency in Medicare and could we do what some of these providers do, and we selected 12 metropolitan areas in which to conduct this study. First, we identified patients who appear to be overly expensive given their health status. It is very important to correct for health

status because obviously expect patients who have multiple illnesses to consume more services.

Second, we measured not just what these patients were spending for doctor services but a full range of services and then we drew a threshold, we tried to see whether these overly expensive patients tended to cluster among certain doctors or were they randomly distributed. In all of the 12 areas that we studied, we found that there was some clustering of these overly expensive patients among a relatively few doctors. There was more clustering in some areas than others. In the Miami metropolitan area, for example, there was a great deal of clustering over the overly expensive patients.

And then finally having gone through this exercise, we asked ourselves, well, what is the applicability of the kinds of things that the other purchasers are doing to Medicare, and we find that there are some important strengths and differences. Medicare has tools available to do this kind of identification of efficient practices. They have a comprehensive claims database on patient consumption of health care services. They are several hundred thousand physicians that participate in Medicare so that in almost every community you can form meaningful comparisons among doctors, and they have experience in using methods to account for differences in patient health status.

Mr. PALLONE. I just want you to wrap up because we are going over.

Mr. STEINWALD. I am wrapping up right now. We are sending a report to CMS later this week for their review. We don't think that this approach is a panacea and it is not going to be the solution to the SGR problem, but the primary virtue of this kind of approach is that it does get at the problem of SGR being such a blunt instrument and so inequitable. We hope that CMS will work with you and others to see if this is one approach that could be included in a package of reforms to help reform Medicare payment for physicians. Thank you very much.

[The prepared statement of Mr. Steinwald follows:]

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MEDICARE SPENDING

Preliminary Findings Regarding an Approach Focusing on Physician Practice Patterns to Foster Program Efficiency

Statement of A. Bruce Steinwald
Director, Health Care

GAO-07-567T

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today as you discuss options for improving how Medicare pays physicians. Your task is not simple, as you seek reforms that can help moderate spending growth while ensuring that beneficiaries have appropriate access to high-quality physician services and physicians receive fair compensation for providing those services. Medicare's current system of spending targets used to moderate spending growth and annually update physician fees is 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. From 1999—the first year that the SGR system was used to update physician fees—through 2001, physicians received fee increases annually. Since 2002, actual Medicare spending on physician services has exceeded SGR targets, and the SGR systems has called for fee cuts to offset the excess spending. In 2002 the SGR system reduced physician fees by nearly 5 percent. Fee declines in subsequent years were averted only by administrative and legislative actions that modified or temporarily overrode the SGR system.[1] In the absence of additional administrative or legislative action, the SGR system will likely reduce fees by about 5 percent a year for the next several years.

The potential for a sustained period of declining fees has raised policymakers' concerns about the appropriateness of the SGR system for updating physician fees and about physicians' continued participation in the Medicare program. A particular concern is that the SGR system acts as a blunt instrument in that all physicians are subject to the consequences of excess spending—namely, downward fee adjustments—that may stem from the excessive use of resources by only some physicians. However, as we have discussed in our prior work, the SGR system serves an important role in

[1]For example, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) specified a minimum update of 1.5 percent for both 2004 and 2005. Pub. L. No. 108-173, § 601(a)(1), 117 Stat. 2066, 2300.

alerting policymakers to the need for fiscal discipline.[2] Specifically, fee cuts under the SGR system signal to physicians collectively and to the Congress that spending due to volume and intensity has increased more than allowed.

Some of the higher volume and intensity that drives spending growth may not be medically necessary. 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.[3] 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 these physicians.

With these circumstances in mind, and in fulfillment of a 2003 mandate to examine aspects of physician compensation in Medicare,[4] we conducted a study focusing on efficiency with respect to physician practices. In our study, we use 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. My remarks today will address (1) physician-focused approaches taken by other health care purchasers to address inefficient medical practices, (2) our efforts to estimate the prevalence of inefficient physicians in Medicare, and (3) the methodological tools available to the Centers for Medicare & Medicaid Services (CMS) to identify inefficient physician practice patterns programwide. My remarks today are based on our study's preliminary findings.

[2]GAO, *Medicare Physician Payments: Trends in Service Utilization, Spending, and Fees Prompt Consideration of Alternative Payment Approaches*, GAO-06-1008T (Washington, D.C.: July 25, 2006) and *Medicare Physician Payments: Concerns about Spending Target System Prompt Interest in Considering Reforms*, GAO-05-85 (Washington, D.C.: Oct. 8, 2004).

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

[4]MMA, Pub. L. No. 108-173, § 953, 117 Stat. 2066, 2428.

In conducting our study, we interviewed representatives of 10 health care purchasers,[5] including 5 commercial health plans, 1 provider network, 1 trust fund jointly managed by employers and a union, and 3 government agencies—2 in U.S. states and 1 in a Canadian province. We selected these purchasers because their programs that examine physician practices explicitly assess efficiency—unlike many such programs that assess quality only. We also estimated the prevalence in Medicare of physicians likely to practice inefficiently. To do this work, we examined 2003 Medicare claims data from 12 metropolitan areas. We ensured the reliability of the claims data used in this report by performing appropriate electronic data checks and by interviewing officials at CMS who were knowledgeable about the data. In addition, we discussed the facts contained in this statement with CMS officials. The study on which these remarks are based has been conducted beginning September 2005 in accordance with generally accepted government auditing standards.

In summary, the health care purchasers we studied examined the practice patterns of physicians in their networks and used the results to promote efficiency. They adopted a range of incentives—from steering patients toward the most efficient providers to excluding a physician from the network—to encourage physicians to provide care efficiently; some reported savings as a result of these efforts. Using our own methodology to analyze the practice patterns of physicians in Medicare, we found that physicians who were likely to be practicing medicine inefficiently were present in all 12 of the metropolitan areas studied. CMS also has the tools to identify physicians in Medicare who are likely to practice medicine inefficiently, including comprehensive claims information, sufficient numbers of physicians in most areas to construct adequate sample sizes, and methods to adjust for differences in beneficiary health status.

[5]In our study, we use "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.

Some Health Care Purchasers Use Physician Profiling Results to Encourage Efficient Medical Practice

Consistent with the premise that physicians play a central role in the generation of most health care expenditures, some health care purchasers employ physician profiling to promote efficiency. 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. 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.[6] 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.

Health Care Purchasers Profiled Physicians across Several Dimensions to Evaluate Physician Performance

The 10 health care purchasers we examined used two basic profiling approaches to identify physicians whose medical practices were inefficient. One approach focused on the costs associated with treating a specific episode of illness—such as a stroke or heart attack. The other approach focused on costs, within a specific period, associated with the patients in a physician's practice. Both approaches used information from medical claims data to measure resource use and account for differences in patients' health status. In addition, both approaches assessed physicians (or physician groups) based on the costs associated with services that they may not have provided directly, such as costs associated with a hospitalization or services provided by a different physician.

Although the methods used by purchasers to predict patient spending varied, all used patient demographics and diagnoses. The methods they used generally computed efficiency measures as the ratio of actual to expected spending for patients of similar health status. In addition, all of the purchasers we interviewed profiled specialists and all but one also profiled primary care physicians. Several purchasers said they would only profile physicians who treated an adequate number of cases, since such analyses typically require a minimum sample size to be valid.

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

Health Care Purchasers Linked Physician Profiling Results to a Range of Incentives Encouraging Efficiency

The health care purchasers we examined directly tied the results of their profiling methods to incentives that encourage physicians in their networks to practice efficiently. The incentives varied widely in design, application, and severity of consequences. Purchasers used incentives that included

- educating physicians to encourage more efficient care,
- designating in their physician directories those physicians who met efficiency and quality standards,
- dividing physicians into tiers based on efficiency and giving enrollees financial incentives to see physicians in particular tiers,
- providing bonuses or imposing penalties based on efficiency and quality standards, and
- excluding inefficient physicians from the network.

Physician Profiling Has Potential for Savings

Evidence from our interviews with the health care purchasers suggests that physician profiling programs may have the potential to generate savings for health care purchasers. Three of the 10 purchasers reported that the profiling programs produced savings and provided us with estimates of savings attributable to their physician-focused efficiency efforts. For example, 1 of those purchasers reported that growth in spending fell from 12 percent to about 1 percent in the first year after it restructured its network as part of its efficiency program, and an actuarial firm hired by the purchaser estimated that about three quarters of the reduction in expenditure growth was most likely a result of the efficiency program. Three other purchasers suggested their programs might have achieved savings but did not provide savings estimates, while four said they had not attempted to measure savings at the time of our interviews.

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

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 focused our analysis on generalists—physicians who described their specialty as general practice, internal medicine, or family practice. We did not include specialists in our analysis. We selected areas that were diverse geographically and in terms of Medicare spending per beneficiary.

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 locations according to their health status, using diagnosis and demographic information. Patients whose total Medicare expenditures—for services provided by all health providers, not just physicians—far exceeded those of other patients in their same health status grouping were classified as overly expensive. 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. We concluded that these outlier physicians were likely to be practicing medicine inefficiently.[7]

Based on 2003 Medicare claims data, our analysis found outlier generalist physicians in all 12 metropolitan areas we studied. In two of the areas, outlier generalists accounted for more than 10 percent of the area's generalist physician population. In the remaining areas, the proportion of outlier generalists ranged from 2 percent to about 6 percent of the area's generalist population.

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

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 fee-for-service 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.

- *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. Specifically, CMS has used increasingly sophisticated risk adjustment methodologies over the past decade to set payment rates for beneficiaries enrolled in managed care plans.

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 identify inefficient practice patterns.

Concluding Observations

Our experience in examining what health care purchasers other than Medicare are doing to improve physician efficiency and in analyzing Medicare claims has enabled us to gain some insights into the potential of physician profiling to improve Medicare program efficiency. 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 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 James Cosgrove and Phyllis Thorburn, Assistant Directors; Todd Anderson; Alex Dworkowitz; Hannah Fein; Gregory Giusto; Richard Lipinski; and Eric Wedum.

Mr. PALLONE. Thank you, Mr. Steinwald. Dr. Fisher.

STATEMENT OF ELLIOTT S. FISHER, M.D., M.P.H., PROFESSOR, MEDICINE AND COMMUNITY AND FAMILY MEDICINE, DARTMOUTH MEDICAL SCHOOL

Dr. FISHER. First I would like to thank you for your expression of concern about my mother. I think she will be fine. It is a wonderful example of the challenges of care coordination that are faced by Medicare beneficiaries and their children. Mr. Chairman, Congressman Deal, and remaining members of the committee, the recently released report assessing alternatives to the sustainable growth rate system provides an outstanding analysis of the key issues and challenges confronting Congress as it considers both how to reform payment approaches in a period of serious budget constraints.

The report outlines a broad array of policy approaches that Congress and CMS could and probably should pursue to improve the quality and cost of Medicare beneficiaries. I agree with almost all of their principles and many of the specific recommendations. I am going to focus on the relevance of my own research to the implications for reform and what I believe are some of the principles that you should pursue. Two full differences in Medicare spending exist across U.S. regions and across the populations cared for by hospitals and major academic medical centers. These aren't due to differences in patient needs or the prices of services. Rather they are due to the volume of care, differences in the amount of care provided to similar patients.

The differences are largely due to what Jack Wennberg and I have now termed supply sensitive services, things like the frequency of physician visits, use of specialists in lieu of primary care physicians, use of the acute care hospital as a site of care for patients who might otherwise be cared for elsewhere, and the frequency of diagnostic tests and imaging. Our work has shown convincingly that higher spending regions, higher spending hospitals, those with higher volume do not provide better care. On the contrary the evidence suggests that higher spending is associated with lower quality, and more recently that U.S. regions that grew fastest fell further behind in their quality and outcomes.

The research highlights the magnitude of the opportunity to improve the value of Medicare services. It said a little bit with tongue in cheek recognizing that it would be hard to do but if all U.S. regions could safely adopt the practice patterns of the most conservative regions Medicare spending would fall by 30 percent. The research also provides support for several key payment reform principles that are imbedded in the commission's pathway two. First, insuring that incentives to control spending growth apply to all providers whether through expenditure targets or other means.

Second, striving to reduce regional disparities in spending by applying greater pressure on currently high spending regions. And finally our research provides strong support for the importance of fostering what the commission refers to as accountable care organizations. These are locally integrated delivery systems that would have the following key attributes. First, they are large enough to support comprehensive and effective performance measurement.

Second, they can provide or manage with others the full continuum of care, patient care, provided to Medicare beneficiaries. And, third, they could participate in shared savings approaches to payment reform as an interim step toward fundamental reform of the Medicare payment system.

Accountable care organizations should be a key element of payment reform for the following four reasons. First, most physicians actually already practice within the context of an existing virtual multi-specialty group practice. Most physicians make their referrals to other physicians within a local network. Most physicians admit their patients to a single hospital and work within the context of that hospital and the local physicians who are practicing with them. Therefore, modest incentives that could prompt physicians to come together around either the hospital or medical groups would neither disrupt the physician's current practice patterns nor disrupt their patients' experience of care.

These virtual multi-specialty group practices are described in the commission's report and currently exist in almost all communities of the United States. ACOs could be given incentives to control total Medicare payments allowing budgetary savings with smaller relative impact on individual provider incomes. Third, performance measurement at the level of an accountable care organization would be much more trackable in the near term than any other efforts to measure performance. I have served on the Institute of Medicine performance measurement committee that reported to Congress a year ago. We have in the testimony that I submitted examples of the kinds of performance measurement that could be readily implemented at the level of an accountable care organization or local entity.

Finally, most physicians continue to practice in one or two physician practices, in small group practices. Accountable care organizations, whether it is large physician groups or built around hospitals, would have the capacity to invest in electronic health records, improve care management protocols, coordination of care, the issues that are highlighted as the major problems that we face in U.S. health care today. We have found that growth in spending on physician services varies dramatically across these virtual medical specialty groups, and data that is included in the written testimony we have shown that within these groups within the United States growth rates over the last 4 years ranged between 2.4 percent per year in the slowest growing fifth of current physician practices, so almost 10 percent per year in the highest growing fifth of physician practices.

We can therefore now identify the ACOs that are most responsible for growth in spending and they should be held accountable for their contribution to growth in spending but we can also offer to identify those groups, those who are growing at 2.4 percent per year or less that offer us a path toward improved value for Medicare. Thank you very much for the opportunity to testify.

[The prepared statement of Dr. Fisher follows:]

The Implications of Regional and Provider-specific Variations in Medicare Spending for Medicare Payment Reform

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

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The Implications of Regional and Provider-specific Variations in Medicare Spending for Medicare Payment Reform

Summary of Major Points

The Medicare Payment Advisory Commission Report *Assessing Alternatives to the Sustainable Growth Rates System* provides an outstanding analysis of the key issues and challenges confronting Congress as it considers how to reform current Medicare approaches to provider payment during a period of serious budget constraints.

Nearly two-fold differences in Medicare spending exist across U.S. regions and across the populations cared for by major academic medical centers. These cannot be explained on the basis of differences in patients' needs for care or to differences in prices. Rather they are due largely to differences in the volume -- or overall intensity of care -- and are largely explained by greater tuse of what we call "supply-sensitive services" -- discretionary services such as the frequency of physician visits, use of specialists as opposed to primary care physicians, the use of the acute care hospital as a site of care, and the frequency of diagnostic tests and imaging.

Higher spending regions, academic medical centers and hospitals do not provide better care. On the contrary, the evidence suggests that higher spending is associated with lower quality; and U.S. regions that grew fastest fell somewhat further behind in their quality and outcomes.

This research highlights the magnitude of the opportunity to improve the value of Medicare services and provides further support for several key payment reform principles that are embedded in the Commission's Pathway Two: ensuring that incentives to control spending growth apply to all providers, whether through expenditure targets or other means and striving to reduce regional disparities in spending by applying greater pressure on currently high-spending regions.

Our research also provides strong support for the importance of fostering the

development of Accountable Care Organizations -- local integrated delivery systems that (1) are large enough to support comprehensive performance measurement, (2) can provide or effectively manage the full continuum of patient care; (3) could participate in shared-savings approaches to payment reform as an interim step toward fundamental payment reform.

Accountable Care Organizations should be a key element of payment reform for the following reasons: (1) Most physicians already practice within "virtual" multi-specialty group practices; modest incentives might prompt physicians to establish formal organizations that would neither disrupt their current practice patterns or their patients' care; (2) ACOs could be given incentives to control total Medicare payments, allowing budgetary savings with smaller relative impact on provider revenues; (3) Performance measurement at the level of an ACO would be much more tractable in the near term. (4) ACOs are more likely to have the capacity to invest in the infrastructure required to improve care, such as electronic health records and care management protocols.

We have shown that growth in spending on physician services varies dramatically across empirically defined "virtual" multi-specialty group practices, ranging from a low of 2.4% per year in the slowest growing fifth to almost 10% per year in the highest growing groups. We can therefore identify the ACOs who are most responsible for the growth in spending -- and those that offer a path toward improved value for Medicare.

Thank you Mr. Chairman, Congressman Deal, and distinguished members of the Committee for your invitation to address you today.

There is broad agreement on the scope of the challenges facing the U.S. health care system. The quality of care is remarkably uneven. Costs are rising at rates that threaten the affordability of care. And there is broad agreement that our current approach to paying for medical care is part of the problem.

The recently released Medicare Payment Advisory Commission report *Assessing Alternatives to the Sustainable Growth Rates System* provides an outstanding analysis of the key issues and challenges confronting Congress as it considers how to reform current Medicare approaches to provider payment during a period of serious budget constraints. The report also outlines a broad array of policy approaches that Congress and CMS could pursue to improve the quality and costs of care for Medicare beneficiaries. I find that I agree with almost all of their recommendations.

In particular I endorse their central recommendation: Congress should make a substantial investment in Medicare's capability to develop, implement, and refine payment systems that will reward higher quality care and efficient use of resources. I am also in general agreement with their analysis of the underlying causes of poor quality and rising costs and their general prescriptions: improved performance measures, reform of payment policies toward a system that rewards both improved quality and lower costs.

My research with colleagues at Dartmouth most relevant, however, to three key payment reform principles that are embedded in the Commission's Pathway Two: (1) Ensuring that incentives to control spending growth apply to all providers, whether through expenditure targets or other means; (2) Striving to reduce regional disparities in spending by applying greater pressure on currently high-spending regions; (3) Fostering the development of Accountable Care Organizations.

In the remainder of my testimony, I will briefly summarize the key findings of our research on variations in Medicare spending, what we have learned about the likely causes of these differences, and then discuss why a focus on fostering organizational accountability should be a key part of any payment reform strategy.

Variations in Medicare Spending

Over thirty years ago, John Wennberg published his seminal article documenting the remarkable variations in practice and spending across small areas of Vermont.[1] With core support from the Robert Wood Johnson Foundation, and more recently from the National Institutes of Aging, we applied these methods to the Medicare population and found variations of a similar magnitude (Figure 1).[2] Per-capita spending on Medicare beneficiaries residing in regions such as Miami, Los Angeles and Manhattan is more than 60% greater than for those residing in Minneapolis, Sacramento, or Rochester, NY. We have now repeated these studies focusing on the chronically ill populations served by hospitals and their medical staffs.[3, 4] Even among the top 15 "Honor Roll" academic medical centers (based upon US News and World Reports rankings), we find two fold

differences in per-beneficiary spending on severely ill patients. (Figure 2). Most of the variation in spending across these institutions is due to differences in the volume (or intensity) of services, not to differences in price.

Two critical questions are raised by these studies. What are the benefits, if any, of higher spending across US regions and hospitals? And, what are the causes of the differences we observe?

What are the benefits of higher spending?

Over the past ten years, we have completed a series of studies examining the implications of these differences in spending for the quality and outcomes of care received by Medicare beneficiaries (Figure 3). Overall, the technical quality of care, such as whether patients receive appropriate initial treatment for their heart attacks or timely preventive services, is somewhat worse in higher spending regions and hospitals.[2, 5] Those in higher spending regions don't receive more elective surgery.[2] Rather, the differences in spending are almost entirely due to differences in what we call "supply-sensitive services": the frequency of visits to physicians, how much time similar patients spending in the hospital, and differences in other discretionary services such as imaging, diagnostic tests and minor procedures.[2, 6]

Beneficiary satisfaction with care was no better in high spending regions and their perceptions of the accessibility of care were somewhat worse in high spending regions.[7] In terms of health outcomes, we found that mortality rates in higher spending regions and hospitals were either no better or slightly worse than in lower spending delivery systems.[7] Perhaps most worrisome was our finding that spending growth was greatest in higher spending regions (on average) and that in regions where spending growth was greatest, survival following heart attacks improved more slowly over recent years than in regions where spending growth was slowest.[8]

Studies comparing physicians' perceptions of their ability to provide high quality care present a similar picture. Physicians in higher spending regions are more likely to report that the continuity of their relationships with patients and their communication with other physicians is inadequate to support high quality care. On average, physicians in higher spending regions are more likely to report difficulty providing high quality care.[9]

These findings point to a troubling paradox: within the context of the U.S. health care delivery system higher spending is associated with lower quality of care and, on average, slightly worse outcomes.

What are the causes of higher spending?

Our more recent work has focused on trying to disentangle the underlying causes of the differences in spending and spending growth across regions. At this stage it is important to distinguish what we know, based on completed research, from what we think we know, our current best theory of what explains the findings.

The evidence

Patients' preferences for care vary slightly across regions, but not enough to explain the magnitude of spending differences we see. (For example, Medicare beneficiaries in high spending regions are no more likely to prefer aggressive end-of-life care than those in low spending regions[10, 11]). And differences in the malpractice environment explain only about 10% of state level differences in spending.[12] On the other hand, the local capacity of the health care delivery system varies dramatically across regions of differing spending levels. (Figure 4) High spending regions have 32% more hospital beds per-capita, 65% more medical specialists, and 75% more general internists (data not shown). [2] Moreover, it is well known that the current payment system tends to reward high margin services (such as invasive cardiovascular procedures) and ensures that any new capacity will remain fully utilized. (Lower two panels of Figure 4). Elyria, Ohio, for example, has for many years had the highest rates of angioplasty in the United States. A New York Times article described how the high financial rewards for performing this procedure led to the rapid growth of the cardiology group in Elyria.[13]

More recently, we have found that physicians' clinical judgment also varies across regions of differing spending levels.(Figure 5) In a study using clinical vignettes, primary care physicians in higher spending regions were much more likely to recommend discretionary treatments (such as more frequent visits or imaging) than those in low spending regions.[14] Where clinical evidence is stronger (as in referral to a cardiologist for chest pain and a markedly abnormal stress test), we found no association between physicians' decisions and local spending levels.

The theory: capacity, payment and clinical judgment in the "gray" areas

These findings suggest a likely explanation for the dramatic differences in spending across regions and the paradoxical finding that higher spending seems to lead to worse quality and worse outcomes (Figure 6). Current clinical evidence and principles of professionalism are an important, but limited, influence on clinical decision-making. Most physicians practice within a local organizational context and policy environment that profoundly influences their decision-making, especially in discretionary settings. Hospitals and physicians each face incentives that will in general reward expansion of capacity (especially for highly reimbursed services) and recruitment of additional procedure-oriented specialists. When there are more physicians, relative to the size of the population they serve, physicians will see their patients more frequently. When there are more specialists or hospital beds available, primary care physicians and other specialists will learn to rely upon those specialists and use those beds. (It is more efficient from the primary care physician's perspective to refer a difficult problem to a specialist or admit them to the hospital than to try to manage them themselves in the context of an office visit for which payments have become relatively constrained).

The consequence is that what appear to be reasonable individual clinical and policy decisions (given the current payment system) lead in aggregate to higher utilization rates, greater costs and, inadvertently, worse quality and worse outcomes. The key element of this theory is that because so many clinical decisions are in the "gray areas" (how often to see a patient, when to refer to a specialist, when to admit to the hospital), any expansion of capacity will result in a subtle shift in clinical judgment toward greater intensity.

Harm could occur through several mechanisms.[15] Greater use of diagnostic tests could find more abnormalities that would never have caused the patient any problem (a condition referred to as "pseudodisease"). Because most treatments have some risks, providing those treatments to patients who don't need them could cause harm. And as care becomes more complex and more physicians are involved, it will be less and less clear who is responsible for each aspect of a patients' care. Miscommunication -- and errors -- become more likely.

Implications: accountable care, performance measurement and payment reform

Although there are a broad array of policy levers that could be brought to bear (see Figure 7 and the excellent discussion in Chapter 3 of the Commission's report), this causal model suggests that reform efforts should include a focus on fostering local organizational accountability for quality and total-per beneficiary costs (through comprehensive performance measurement) and eventual payment reform. The model also suggests that a critical element of any successful strategy will be to control the future growth of capacity -- whether within a local integrated delivery system or at the state or national levels. [1]

There are a number of current organizations that could serve as "Accountable Care Organizations" (Figure 8) -- local delivery systems that are large enough to support comprehensive performance measurement, can provide or effectively manage the continuum of care as a real or virtually integrated delivery system, and are capable of prospective budgeting and planning their resource and workforce needs. These include large multi-specialty group practices that own their own hospitals, physician-hospital organizations or other large integrated physician practice networks, hospitals that own their own physician groups, and, perhaps, the Extended Hospital Medical Staff (EHMS).[17]

The EHMS is an empirically defined (i.e. "virtual") multi-specialty group practice directly or indirectly affiliated with a single hospital. Our analyses of Medicare claims data found the following.[17]

- Almost all physicians can be empirically assigned to a single hospital, based upon where they provide inpatient care or where their patients are admitted.
- Medicare beneficiaries cared for by these physicians tend to receive most of their care from within the group, from their affiliated hospital, or from a single other hospital and its physicians (often an obvious referral hospital).

Although there are a number of barriers to the universal implementation of ACOs through either the EHMS or other models[18], the advantages of a payment reform strategy that included fostering ACOs include at least the following (Figure 9).

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[1] The evidence reviewed above is also relevant to debates about the physician workforce. If low-spending regions can achieve equal or better outcomes and quality than high spending regions, we may be able to meet future workforce needs without growing the workforce further.16. Goodman DC. The physician workforce crisis: where is the evidence? Health Aff (Millwood) 2005;Suppl Web Exclusives:W5-108-W5-10.

(1) Most physicians already practice within relatively coherent real or virtual ACOs. Because most physicians already practice within informal practice networks that are more or less tightly affiliated with one or more hospitals (as discussed above), modest incentives and removal of current legal barriers could encourage them to establish formal relationships for the purpose of performance measurement, pay-for-performance rewards, shared savings or other gainsharing arrangements that would require little disruption of their current referral patterns.

(2) Effective performance measurement would be more tractable. Current performance measurement efforts focused on individual physicians confront numerous difficulties, including the narrow scope of quality measures available, potential limitations of episode groupers as measures of costs, the difficulty of attributing care to a single physician, the lack of performance measures for many specialties, and the relatively small number of patients that may be specifically attributable to any single physician. An even more important concern is the broader scope of measures that become possible at the level of an ACO. The Institute of Medicine's recent reports on performance measurement and pay-for-performance both call for the development of measures that focus on the longitudinal experience of Medicare beneficiaries (including measures of total costs and health outcomes), as well as measures that directly address the current fragmentation of patient care. Measuring at the ACO level increases the number of physicians whose care can be assessed (at some level) and the number of patients who contribute to measures (Figure 9) as well as the breadth of measures that are feasible. Figure 10 provides several examples based upon existing Medicare claims-based measures. But with appropriate risk adjustment, measures of health outcomes (such as surgical mortality rates or outcomes following acute myocardial infarction) would also be possible. [19] Finally, there are important practical advantages: the administrative complexity of data collection methods and auditing procedures for 5000 hospitals would be much less daunting than those required to collect and audit data on the more than 500,000 individual physicians practicing in the United States.

(3) Measures and incentives could encompass total Medicare program payments. A focus on Accountable Care Organizations could (as Figure 11 demonstrates) include a broader array of spending measures beyond physician services. This particular example includes utilization by Medicare beneficiaries cared for within EHMS-defined ACOs. Measures include not only spending on physician services, but also hospital spending and SNF utilization. Work is currently underway by the Dartmouth Atlas project to add the remaining categories (long-stay hospitals, outpatient services, home health and hospice) so that these may be presented at the ACO (hospital or EHMS) levels. An advantage of focusing expenditure targets on total program payments is that the real problem confronting Congress is Medicare spending growth (not just physician spending) and that including all Medicare providers under a revised expenditure target would allow Congress to achieve a given budgetary savings with lower relative reductions in any specific providers' incomes.

(4) ACOs would have the capacity to invest in system improvement and are the right level for efforts to control costs. Evidence is growing that health plans and hospitals have responded to current public reporting and pay-for-performance initiatives. Large-

multispecialty medical groups have also been found to be more likely to invest in electronic health records and care management systems.

The most important reason, however, to focus on ACOs is to establish accountability for local decisions about capacity and thus costs. As was discussed above, local decisions that influence capacity -- capital investments, recruitment, and individual physicians' choices about practice location -- are likely to be the first step in the causal chain leading physicians to adopt more intensive practice patterns, and to the overuse of supply-sensitive services. Figure 12 shows how ACOs defined using the Extended Hospital Medical Staff method differed in terms of growth in per-beneficiary spending between 1999 and 2003. The lowest spending two fifths of these ACOs grew at less than 5% per year, while the highest growth groups had annual increases in per-beneficiary spending on physician services of almost 10 percent. Although further analyses are under way to explore the causes of these differences, it is likely that the more rapid increases are a function not only of increased volume per physician, but also of increases in the numbers of physicians providing services or the addition of new diagnostic, imaging or inpatient services. Comprehensive measures of longitudinal quality and costs at the ACO level would bring the impact of such decisions to light.

Challenges facing the development of ACOs

While the potential advantages of fostering the development of ACOs are substantial, serious barriers to moving in this direction must be acknowledged.

The current market. Under a payment system that now largely focuses on controlling the prices of individual services, but continues to disproportionately reward high technology procedures and those providers who own their facilities or increase their volume of services, physician entrepreneurial activity has increased dramatically. The consequence has been an increase in direct competition between physicians and hospitals. Reversing these trends may be difficult.

Cultural barriers. Physician practice and professional identity in the United States has long been characterized by a high degree of professional autonomy and a culture of individual responsibility -- both of which are reinforced by current medical training, professional malpractice liability programs and payment systems. Although there are numerous examples of physicians deeply engaged in collaborating with hospital administrators and nurses to improve the delivery of care, these remain relatively isolated examples. The notion of accepting a degree of responsibility for the care of all of the patients within their local delivery system will be resisted by many physicians.

Legal obstacles. Legal obstacles to physician-hospital collaboration are substantial, especially with regard to sharing the potential financial gains of more efficient care.[i]

Variability in the degree of alignment. Our data reveal substantial variability across hospitals in the degree to which physicians and patients are already aligned with a single hospital and a relatively coherent medical staff.

Moving forward

It is exactly these practical barriers, however, that make pursuing the notion of the Accountable Care Organizations worthy of further discussion and cautious efforts to test the ideas more fully. The alternative -- a narrow focus on provider performance assessment and pay-for-performance incentives aimed at individual physicians and institutional providers -- will require overcoming many of the same political and practical challenges. But it would also risk reinforcing the fragmentation and lack of coordination that characterizes the current delivery system. And any effort that fails to foster accountability for future capacity growth will be unlikely to rein in the growth of Medicare spending.

The remarkable differences in spending growth observed across existing empirically defined multi-specialty groups reveals that some are already growing at a rate that would not imperil the future health of the Medicare Trust Funds. Payment reform should include efforts to provide support and incentives that would allow all Medicare beneficiaries to receive care from local integrated delivery systems that achieve both high quality and a truly sustainable rate of growth.

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Figure 3. What does higher spending "buy"?

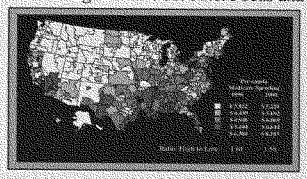
Compared to the lowest spending regions, what do residents of higher spending regions get for the additional $3000 per beneficiary (in 2000)?

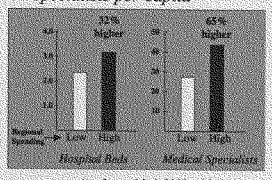
Resource levels[1]	*More hospital beds per capita (32%)* *More medical specialists (65%) and internists (75%)*
Content / Quality of Care[1,2]	*Technical quality worse* *No more major elective surgery*
Supply-sensitive services →	***More hospital stays, visits, specialist use, tests, procedures***
Health Outcomes[1,2]	*Slightly higher mortality* *No better function*
Physician-reported quality[5]	*Worse communication among physicians* *Greater difficulty ensuring continuity of care* *Greater difficulty providing high quality care*
Patient-reported quality[1,3]	*Lower satisfaction with hospital care* *Worse access to primary care*
Trends over time[4]	*Lower gains in survival (following AMI)*
Supply-sensitive services →	*Greater growth in per-capita resource use*

(1) Ann Intern Med: 2003; 138: 273-298
(2) Health Affairs web exclusives, October 7, 2004
(3) Health Affairs, web exclusives, Nov 16, 2005
(4) Health Affairs web exclusives, Feb 7, 2006
(5) Ann Intern Med: 2006; 144: 641-649

Figure 4. The role of supply and current payment systems

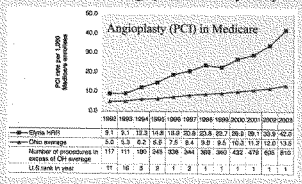
Compared to the lowest spending regions (tan) the highest spending regions have 32% more beds and 65% more specialists per-capita





Ann Intern Med: 2003; 138: 273-298

Current payment systems reward high margin services (e.g. angioplasty) and ensure that physicians stay busy: more cardiologists per capita --> more visits



Dartmouth Atlas of Health Care: www.dartmouthatlas.org

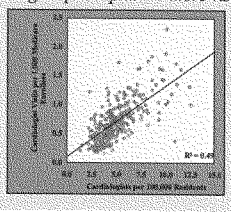


Figure 5. The role of judgment in discretionary settings

For clinical services where judgment is required and no clear guidelines existt physicians in high spending regions are more likely to intervene.

Percent of patients for whom physicians would recommend the intervention in low and high spending regions in each scenario:	**Low Spending Regions**	**High Spending Regions**	**Trend significant**
Cardiology referral for chest pain and abnormal stress test	91	93	no
Drug treatment of high cholesterol with no other risk factors	44	53	yes
Urology referral for mild symptoms of prostatic enlargement	23	32	yes
MRI for back pain and mildly abnormal nerve function	69	82	yes
Prostate cancer screening test for 60 year old white male	68	78	yes
Visit for patient with isolated high blood pressure in 3 months or less	22	49	yes

Sirovich *Archives of Internal Medicine*. 165(19):2252-6, 2005 Oct 24
Sirovich, *Journal of General Internal Medicine;*

Figure 6. Why is spending higher? Why might harm occur?

Clinical evidence (e.g. RCTs, guidelines) and principles of professionalism are a critically important -- but limited -- influence on clinical decision-making.

Physicians practice within a local organizational context and policy environment that profoundly influences their decision-making. Payment system ensures that existing (and new capacity) is fully utilized.

Consequence: *reasonable* individual clinical and local decisions lead, in aggregate, to higher utilization rates, greater costs -- *and inadvertently* -- worse outcomes

The more complicated care becomes, the more likely mistakes are to occur.

Hospitals are dangerous places if you don't need to be there.

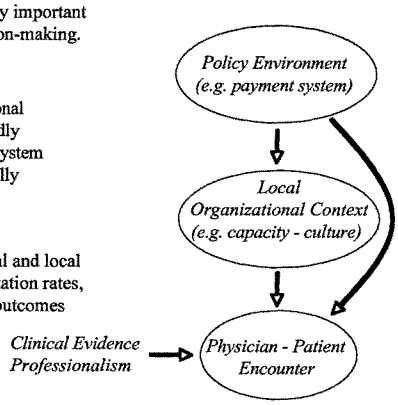


Figure 7. Potential policy levers

Research priorities (biology vs clinical practice)
Coverage policy
Performance measurement / Public reporting
Payment system reform
Workforce policy (medical schools, GME)

Recruitment / practice location decisions
Capital investment (hospital, outpatient)
Organizational structure (hospital, MD group)
Process management (QI, IT adoption)

Specialty certification
Graduate Medical Education
Continuing Medical Education
HIT for care and decision-support
Patient / public education and incentives

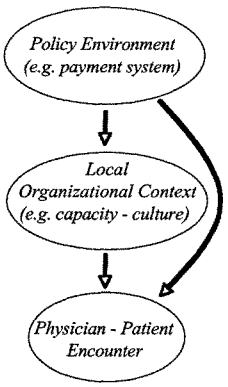


Figure 8. Fostering organizational accountability

Essential attributes of an Accountable Care Organization

- Sufficient size to support comprehensive performance measurement
- Provides (or can effectively manage) continuum of care as a real or virtually integrated local delivery system
- Capable of prospectively planning budgets, capacity and resource needs

Potential Accountable Care Organizations

- Large multi-specialty group practices that own their own hospitals
  (Mayo, Virginia Mason, Scott White, Cleveland Clinic, Partners)
- Physician-Hospital Organizations / Practice Networks
  (Middlesex Health System)
- Hospitals that own physician groups
  (Intermountain Healthcare, many rural hospitals)
- Extended Hospital Medical Staff

Figure 9. Why focus on developing ACO's?

Most physicians already practice within "virtual" ACOs

- Virtually all MDs (95%) and Medicare beneficiaries (93%) can be assigned based on claims data to their local hospital and its medical staff
- Most care is already delivered within these virtual multi-specialty groups
- Modest incentives might prompt physicians to establish formal organizations that would not have to disrupt their current practices or patient care.

Performance measurement is more tractable in the near term

- All physicians could be included in measurement with adequate sample sizes, less difficulty in attribution (see Figure 9).
- Diverse and important measures are feasible (see Figure 10).

Spending measures can include total Medicare payments

- Either SGR or shared savings models to have broader impact
- Could achieve comparable budgetary savings with smaller *relative* effect on providers' revenues

ACOs more likely to have capacity to invest in improvement: electronic health records, care management, etc

Fisher et al. *Creating Accountable Care Organizations: The Extended Hospital Medical Staff*
Health Affairs; Published online, 12/05/06

Figure 10. Attributing care to individual physicians

If one assigns Medicare beneficiaries to the physician they see most often, many physicians will have no patients assigned. Sample sizes are too small to use for many important measures.

	Assessed as Individual Physicians		*Assessed as members of hospital extended staff*
	Among MDs with 1+ patient assigned (n = 254,250)	*Among all MDs (n = 572,637)*	*Among all MDs (n = 572,637)*
No patients	0	56	0
1 to 24	36	16	0.3
25-99	30	13	0.7
100-499	32	15	1.3
500 and over	1	1	97.7
	100%	100%	100%

Fisher et al. *Creating Accountable Care Organizations: The Extended Hospital Medical Staff*
Health Affairs; Published online, 12/05/06

Figure 11. Diverse performance measures possible

Among ACOs defined by extended hospital medical staff method and stratified by physician spending levels in 2003, average performance varies little in technical quality, but substantially in terms of utilization rates, care transitions, and spending (in standardized prices)*

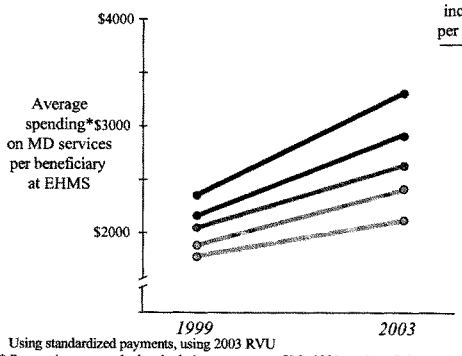
	Low Spending	*Middle*	*High Spending*	***Ratio High to Low***
Mammography 65-69	47.8	48.6	47.2	**0.99**
Eye exams, diabetes	39.0	40.5	41.5	**1.06**
HBA1c, diabetes	54.9	56.5	54.5	**0.99**
Hospital Discharges§	330	367	390	**1.18**
SNF stays §	74.3	75.7	81.7	**1.10**
Care transitions	0.86	0.92	0.97	**1.13**
*Physician services***	$2,085	$2,560	$3,295	**1.58**
Acute care hospital	$2,086	$2,432	$2,649	**1.27**

* Defined using 2003 standardized payments based upon RVUs
** Physician and hospital spending calculated using standardized national prices (spending and utilization data are age-sex-race adjusted)
§ per 1000 beneficiaries

Fisher et al. *Creating Accountable Care Organizations: The Extended Hospital Medical Staff* Health Affairs; Published online, 12/05/06

Figure 12. Relative growth in spending varies

Growth in per-beneficiary spending on physician services across ACOs defined by Extended Hospital Medical Staff method (n = 4772) stratified into quintiles by magnitude of per-beneficiary growth (1999-2003)



Absolute increase per benef.	Percent increase 99-03**	Average Annual Rate
$936	46%	9.9%
$675	33%	7.3%
$551	27%	6.1%
$431	21%	4.8%
$198	10%	2.4%

* Using standardized payments, using 2003 RVU
** Percent increase calculated relative to *average* U.S. 1999 per-beneficiary spending in order to assess relative contribution to aggregate growth.

Source: Fisher and Gottlieb, MedPAC analyses, December 2006

Mr. PALLONE. Thank you, Dr. Fisher. Dr. Thames.

STATEMENT OF T. BYRON THAMES, M.D., MEMBER, BOARD OF DIRECTORS, AMERICAN ASSOCIATION OF RETIRED PERSONS

Dr. THAMES. Mr. Chairman, Mr. Deal, thank you very much for inviting AARP to testify today. AARP believes that the Medicare physician payment system should be changed from one that rewards quality to one that rewards quality. AARP recently conducted a survey of our members, current and future Medicare beneficiaries, about their experience with physicians. The vast majority report good access to and high levels of satisfaction with their physicians but for many the cost of care remains a concern. These AARP members represent the nearly 43 million Americans who rely on Medicare for their health care coverage.

Physicians are central to delivery of that care. While we believe physicians who treat Medicare beneficiaries should be paid fairly. Our members tell us the program must be kept affordable as well. Determining how to balance these two needs is a complex yet critical policy problem that must be solved for the Medicare program to remain strong for future generations. The sustainable growth rate system which has been widely recognized as flawed does not distinguish between doctors who provide Medicare beneficiaries with high quality care and those who provide unnecessary or inappropriate services. Moreover, the SGR has not been effective at controlling the volume or intensity of services leading to higher Medicare spending and greater out of pocket cost for beneficiaries.

The monthly Medicare part B premium set at 25 percent of part B spending has doubled since 2000. Beneficiaries also face increased cost sharing obligations and higher deductibles when part B expenditures rise. There doesn't seem to be an end in sight for these out-of-pocket increases. Using existing SGR methodology physician fees are expected to be reduced each year at least until 2012. Under this scenario, we can expect to continue the now annual cycle of physician groups lobbying Congress to avoid payment cuts, doctors threatening to stop taking Medicare patients, and Congress overriding the SGR at the last minute.

We must find a better approach. AARP believes that ultimately the SGR should be replaced with a system that encourages physicians to provide beneficiaries of the Medicare program with greater value for the health care dollar. Medicare beneficiaries need and expect their doctors to provide respective treatment. Payment incentives should encourage high quality, not unnecessary quantity. A truly sustainable payment system will be built on a foundation that emphasizes four key elements; one, information technology; two, greater use of comparative effectiveness research; three, performance measurement including physician resource use; and, four, enhanced care coordination.

My written statement details each of these but before any changes to the SGR are made there are a number of factors to consider. First, ultimately repealing the SGR will be quite costly. A transition to a value-based purchasing framework must not be financed at beneficiary expense. Second, we need to make sure beneficiaries are protected from extraordinary out-of-pocket expenses as the system is reformed. One such protection would be a cap on part

B premium increases. Another potential option is to limit the total part B out-of-pocket costs. Third, elimination of the SGR cannot be viewed as carte blanche for physicians to maximize revenues through uncontrolled volume.

Rather, a new payment system should be designed to encourage appropriate care. Congress cannot continue to avoid the current problem in the part B payment system. Each year we wait the problem only gets worse. AARP stands ready to work with Congress and the physician community to develop a workable solution. Thank you, Mr. Chairman.

[The prepared statement of Dr. Thames follows:]

TESTIMONY BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

HOUSE COMMITTEE ON ENERGY AND COMMERCE

ON

EXPLORING OPTIONS FOR IMPROVING THE MEDICARE

PHYSICIAN PAYMENT SYSTEM

March 6, 2007

WASHINGTON, D.C.

WITNESS: BYRON THAMES, MD
AARP BOARD MEMBER

For further information, contact:
Nora Super/Kirsten Sloan
Federal Affairs Department
(202) 434-3770

Chairman Pallone, Ranking Member Deal, and distinguished members of the committee, my name is Byron Thames. I am a member of AARP's Board of Directors and a physician. Thank you for inviting AARP to testify on options for improving the Medicare physician payment system.

AARP believes that physicians are central to the delivery of health care, and that Medicare's payment system should encourage quality and affordable care. Today's hearing focuses on Medicare's physician payment system. Medicare's current system does not distinguish between those doctors who provide Medicare beneficiaries with high quality care and those who provide unnecessary or inappropriate services. Moreover, the sustainable growth rate (SGR) system has not been effective at controlling the volume or intensity of services, which has led to higher Medicare spending and greater out-of-pocket costs for beneficiaries.

Payment incentives should encourage high quality, not unnecessary quantity. AARP supports higher Medicare payments for physicians who provide efficient, high quality, patient-centered care. A truly sustainable payment system will be built on a foundation that emphasizes four key elements: information technology; greater use of comparative effectiveness research; performance measurement including physician resource use; and enhanced care coordination.

The Doctor-Patient Relationship: What AARP Members Say

AARP recently conducted a survey asking older Americans – current and future Medicare beneficiaries – about their experience with physicians. The vast majority of those surveyed report good access to and high levels of satisfaction with their physicians, but the cost of care remains a concern.

Medicare beneficiaries are beginning to feel the impact of the large Part B premium increases caused, in part, by the many legislative changes that have overridden the SGR. Of those surveyed, fourteen percent of beneficiaries said that they had to give up something to pay for an increase in their Medicare premium. Twenty one percent said they had to cut back on groceries.

The AARP members surveyed are among the over 43 million Americans who rely on Medicare for their health care. Physicians are central to the delivery of that health care. AARP believes physicians who treat Medicare patients should be paid fairly. But as we have learned from our members, the program must be affordable for beneficiaries as well. Determining how to balance these two needs is a complex, yet critical, policy problem that must be solved for the Medicare program to remain strong for future generations.

AARP supports long-term reform of the physician payment system. Annual short-term fixes simply exacerbate spending growth and only delay needed

discussions about how to control rising expenditures. AARP believes the time has come to move toward a payment system that rewards physicians for providing greater value for health care spending. A recent Institute of Medicine report, *Rewarding Provider Performance: Aligning Incentives in Medicare*, concluded that "because the current basic payment systems reward overuse of services, use of high-cost complex procedures, and do not acknowledge the wide variations in quality across providers, . . . payment reforms are needed now to recognize care that is of high clinical quality, patient-centered, and efficient."

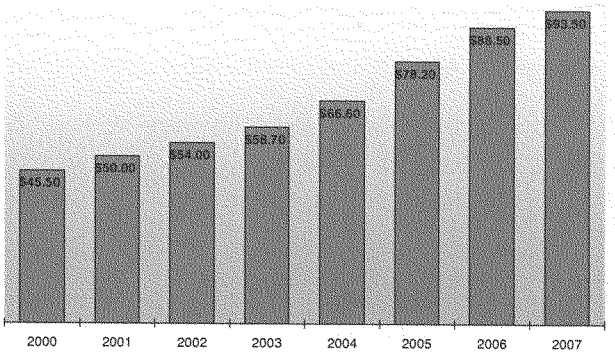
We couldn't agree more. All Medicare beneficiaries must have access to physicians who provide high quality care. At the same time, beneficiaries need to be protected from extraordinary out-of-pocket costs.

Overriding the SGR: Direct Financial Consequences for Beneficiaries

The SGR system, designed to keep spending in line with an overall target, was viewed as necessary to address unchecked increases in the volume of physician services. Since 2002, actual spending on physician services has exceeded the SGR target, thereby triggering reductions in physician updates. With the exception of 2002, however, Congress has consistently voted to override this mandated reduction in response to physician concerns.

Unfortunately, each time Congress overrides the SGR there is a direct cost for Medicare beneficiaries. That's because by law, the monthly Medicare Part B premium is set at 25 percent of Part B spending. The Part B premium has doubled since 2000 – due in part to the payment increases for physicians (see chart).

Part B Premiums More than Double Since 2000



Source: 2006 Medicare Trustees Report

AARP Federal Affairs
February 19, 2007

Beneficiaries again face large increases in their 2008 premiums due to a convergence of three factors. First, the congressional action taken late last year to avert a physician pay cut in 2007 will not affect the beneficiary Part B premium until next year because the 2007 premium had already been calculated. Second, other factors will put additional upward pressure on Part B premium cost growth for 2008 (e.g., growth in Medicare outpatient spending, expenditures for physician-administered drugs, and Medicare Advantage payments, which exceed

costs in traditional Medicare by approximately 12 percent, on average). Third, if Congress acts again this year to prevent a reduction in physician payments – estimated by the Congressional Budget Office at 10 percent – these additional costs could also be rolled into the 2008 beneficiary premium.

Increased costs to beneficiaries are not limited to premiums. Cost-sharing obligations – which usually reflect 20 percent of Medicare's payment – also jump each time provider reimbursement rates increase. For each increase of $10 billion in physician payments, beneficiary coinsurance amounts increase roughly $2 billion. In addition, the increased Part B spending also leads directly to a higher Part B deductible. Since 2005, the annual deductible has increased along with per capita Part B expenditures.

The Medicare program must be kept affordable to remain true to its intent. When it was created in 1965, more than half of older Americans were uninsured and they were the population most likely to be living in poverty. Today, about 50 percent of Medicare beneficiaries have incomes below $15,000, and the median income for an individual between the ages of 65 and 69 is less than $30,000. The average older person already spends about one quarter of his/her income on health care. This does not include the additional, and often substantial, costs of services that Medicare does not cover – including long-term home and nursing home care. If Part B premiums and cost-sharing continue to escalate, many more beneficiaries will find it increasingly difficult to pay for the care they need.

Each time the SGR is overridden, the price tag beneficiaries pay in the long run increases. Due to the cumulative nature of the targets, physician payment updates in future years must be lowered to offset the accumulated excess spending and to slow expected spending for the coming year. As a result, under the SGR methodology, physician fees are expected to be reduced each year at least until 2012. Under this scenario, we can expect to continue the now annual cycle of physician groups lobbying Congress to avoid these payment cuts, doctors threatening to stop taking Medicare patients, and Congress overriding the SGR at the last minute. We must find a better approach.

Alternatives to the SGR: MedPAC's Report to Congress

MedPAC released a new report on March 1 that examines alternatives to the current SGR. As requested by Congress, MedPAC studied the implications of moving from a single, national SGR to five potential sub-national target systems that would be based on: geography, type of service, group practice, hospital medical staff, and outliers. We commend MedPAC for providing a thorough examination of each alternative's advantages and disadvantages.

From the beneficiary perspective, we believe the outlier option holds the most promise for higher quality at a lower cost to the Medicare program. One of the major advantages of the outlier approach is that it would allow the Medicare program and others to learn from those physicians who use fewer resources

while maintaining a high level of quality. It is important to better understand the differences between inappropriate volume growth and appropriate growth (e.g., from technology changes that improve care for patients). This information could be used to identify best practices for the treatment of specified patients and conditions. An outlier policy could also promote individual physician accountability. It does not require a large scale restructuring of the existing physician marketplace and could be used to measure most physicians in the United States.

Similarly, as MedPAC notes, encouraging specific actions, such as care coordination or investment in information technology, may be more successful than varying reimbursement levels based on a physician's specialty, or region, or practice type.

MedPAC presents two alternative paths for Congress to consider for paying physicians in the Medicare program. The first path would be to repeal the SGR and pursue policy approaches for improving the value of the Medicare physician payment system. The second path would be to retain some type of expenditure target – applied to all Medicare providers, calculated at a geographic level.

Medicare's experience with the SGR has not proven to be successful and beneficiaries have borne the financial penalty in higher out-of-pocket-costs. As

MedPAC noted, it is a flawed system that inappropriately influences clinical decisions about where and how many services are provided.

Clearly, the SGR has not been effective at controlling the volume of physician services. According to the Government Accountability Office, from 2000-2005, while Medicare physician fees rose by 4.5 percent, program spending on physician services grew by nearly 60 percent. On a per beneficiary basis, spending for physician services grew by approximately 45 percent.

Many experts have concluded that one of the SGR system's fundamental flaws is its assumption that physicians would act collectively – on a national level – to control the volume of service. MedPAC concluded in 2002 that, "if anything, an individual physician has an incentive to increase volume under such a system."

The SGR does not distinguish between those doctors who provide high quality care to beneficiaries and those who provide unnecessary services. In fact, physicians providing the most efficient care are penalized under Medicare's current payment system while a physician who orders more tests or performs more procedures than are indicated is paid more.

The volume performance standard, which was used to set Medicare fee updates from 1992-1997, was eliminated because of concerns about how it distorted payments for one service relative to another. It is not clear that a new form of

expenditure target will be any better for beneficiaries or Medicare, and another administratively-complex formula could lead us down yet another time-consuming and failed path of unintended consequences. As MedPAC warns in its executive summary, "the risk that a formulaic expenditure target will fail and have unintended consequences is substantial."

For these reasons, the first path outlined by MedPAC may have more promise. AARP believes Congress and CMS should focus their efforts on redesigning the payment incentives to promote quality and encourage efficiency. Congress should not abandon its emphasis on controlling expenditures, but it should put its energy into finding strategies that encourage better, more efficient, and patient-centered care.

There are a number of factors to consider. First, ultimately repealing the SGR would be quite costly. A transition to a value purchasing framework must not be financed at beneficiary expense. Therefore, some kind of transition may be necessary. Second, we need to make sure beneficiaries are protected from extraordinary out-of-pocket expenses as the Part B payment system is reformed. One such protection would be a cap on Part B premium increases. Congress could stipulate that the Part B premium could only increase by a certain percentage, dollar amount, or a five-year average. While beneficiary premiums would still increase, the increases would be limited, and beneficiaries would be in a better position to plan their monthly expenses.

Another potential option is to limit total Part B out-of-pocket costs. Unlike many health insurance policies available to younger Americans, Medicare has no catastrophic limit for cost-sharing. Protecting sicker beneficiaries who are more vulnerable financially is critically important.

Third, elimination of the SGR cannot be viewed as carte blanche for physicians to maximize revenues through uncontrolled increases in the volume of services. The volume of unnecessary services in Medicare remains a problem – in terms of the quality of care provided, the added cost to beneficiaries, and the rate of growth in Medicare spending. A new physician payment system should be designed to encourage appropriate care and prevent unrestrained volume.

Congress cannot continue to avoid the current problem in the Part B payment system. The annual physician payment fixes Congress has enacted since 2003 have created an increasingly bigger hole which will become harder to climb out of as each year passes. We believe the time to act is now. AARP stands ready to work with Congress and the physician community to develop a workable solution.

Changing the Incentives to Promote High Quality

AARP also believes Congress needs to change the incentives in Medicare's physician payment system to promote quality and encourage efficiency. We

recommend Congress focus its efforts on four key areas: encouraging widespread adoption of health information technology; expanding the use of comparative effectiveness research; utilizing performance measurement including physician resource use; and enhancing care coordination.

Information Technology – AARP believes health information technology (HIT) has enormous potential to both improve quality and eventually lead to lower costs throughout our health care system. Yet the United States lags far behind most industrialized nations in maximizing its potential benefits. According to the Commonwealth Fund, only about one-fourth of U.S. primary care physicians report use of electronic medical records, compared with nine of ten primary care physicians in the Netherlands, New Zealand and the U.K.

Among the many advantages of HIT, it could: help providers coordinate care across settings, reduce errors and duplicative services, support clinical and patient decision making, improve communications between doctors and patients, and help to foster patient management of their health conditions through ready access to their personal information. Finally, HIT could create "virtual" integrated delivery systems without requiring formal mergers or affiliations.

Expand Comparative Effectiveness Studies and the Clinical Evidence Base – Consumers, providers, and purchasers need objective, credible, evidence-based information to help them make good health care decisions. Congress recognized

this need in section 1013 of the Medicare Modernization Act of 2003 by authorizing $50 million for head-to-head comparisons of treatment options. To date, the Agency for Healthcare Research and Quality (AHRQ) has received only $15 million for 2005 and $15 million for 2006 – far below the authorized amount. Congress should provide AHRQ, at a minimum, with $50 million in FY 2007 for comparative effectiveness research and begin to look at expanding the opportunities for both financing and using this research.

Comparative effectiveness research is a way to compare drugs within a therapeutic class, similar procedures, or drugs versus procedures to determine which treatments are most effective. In addition, as the MedPAC report notes, comparative effectiveness research could also be used to help "prioritize pay-for-performance measures, target screening programs, or prioritize disease management initiatives." This type of research could improve the overall quality of health care delivery and patient outcomes while reducing inappropriate, inefficient, and ineffective care. There is a clear need for a significant government role in paying for this important evidence, since Medicare and other federal programs stand to benefit (over 40 percent of health care is paid by the federal government) from having a stronger base of evidence on which to make payment and other decisions.

Performance Measurement – Physicians who report quality measures will receive bonus incentive payments in 2007 under the Tax Relief and Health Care

Act of 2006. These quality reporting efforts begin to move Medicare in the important direction of providing better quality and more value for beneficiaries.

Pay-for-reporting represents a first step and the initial Centers for Medicare and Medicaid Services (CMS) list of quality measures for the Physician Voluntary Reporting Program – now referred to as the Physician Quality Reporting Initiative – is a starting point for a discussion. However, there is still substantial work to be done on the quality measures themselves so that when we actually pay-for-performance there will be rigor in the process to justify spending Medicare resources on this initiative.

For pay-for-performance to be successful in improving care for beneficiaries, AARP believes Medicare should focus first on high cost, highly prevalent conditions for which valid, reliable measures exist (such as for diabetes and congestive heart failure) as well as on efficiency and resource use and care coordination. While it is important that all physicians participate in the program eventually, this should not be CMS's first priority. The top priority should be improving health care for Medicare beneficiaries and giving them value. Let's start with good measures that can effectively assess performance across the high priority areas that have been identified.

AARP believes that the federal government must financially support the development of performance measures. Improving health care should be

considered a public good and we will not be able to improve quality unless we have valid and reliable measures to assess what we are doing. Measures should be vetted through an open forum with meaningful consumer input (such as the National Quality Forum).

There are many gaps in our ability to assess health care quality. These gaps must be filled as quickly as possible. We need to improve risk adjustment methods to remove any incentives doctors may have to avoid patients with multiple chronic conditions, or inadvertently penalize providers in underserved communities.

Performance assessment must include resource use and efficiency. Researchers at the Dartmouth Medical School have found that regions of the United States with the highest health care spending do not appear to have sicker patients or better outcomes than regions with lower spending. They estimate that Medicare could reduce spending by at least 30 percent, while improving the outcomes of care, if the physicians whose practice styles are the most resource intensive (i.e., they order more diagnostic services and procedures) reduced the intensity of their practice. In its discussion of an outlier policy and measuring resources and providing feedback, MedPAC provides convincing arguments for why CMS should measure physicians' resource use over time and provide the results to physicians. AARP strongly recommends that CMS adopt this recommendation, especially if the SGR is eventually repealed. It is critically

important that the Medicare program continue to focus efforts on ways to help physicians practice most appropriately. We would hope that the information could eventually be used to help beneficiaries identify those physicians who deliver high quality care. It could also eventually be used to help design payment policies.

Enhancing Care Coordination – Finally, we should focus again on the doctor-patient relationship, a relationship of great importance to most AARP members. Under Medicare's current physician payment system, physicians who conduct procedures receive higher compensation than those who diagnose and manage complex problems. Doctors who spend time with their patients and their family members to discuss treatment options are reimbursed at much lower rates. For example, the national average Medicare reimbursement for placement of two coronary artery stents via cardiac catherization was $1,012 in 2002; a two-hour family meeting was reimbursed on average between $75 and $95. It should be noted that national comparisons conducted by Dartmouth researchers indicate that communities with more robust primary care provide lower cost, higher quality care. It is clear that the mix of physicians in a community has a direct impact on quality and cost. Moreover, patients report more care coordination problems the more specialists they see.

As the MedPAC report emphasizes, the Medicare program could improve the efficiency of health care delivery by increasing the use of primary care services

and encouraging coordination of care. Coordination of care is important for individuals with multiple chronic conditions and especially as individuals move across care settings. AARP believes that Medicare's payment methods should be changed to create incentives in the fee-for-service system to better coordinate care so that beneficiaries receive the best care possible. In addition, other practitioners, such as nurse practitioners, physician assistants, and advanced practice nurses, might help fill this growing gap of primary care and needed care coordination.

Treatment of chronic illnesses accounts for the majority of health care expenditures, including those of the Medicare program, yet the traditional Medicare system is not designed to prevent complications. For example, a 2003 study by Elizabeth McGlynn of the quality of care delivered to adults in the U.S. found that only 24 percent of people with diabetes had their blood sugar appropriately monitored, and 45 percent of people presenting with myocardial infarction received the proper medications known to reduce deaths among patients suffering from this condition. Medicare beneficiaries – whether they choose managed care or traditional Medicare – should have access to better chronic care management.

Recently enacted Medicare legislation has expanded the number and type of Medicare demonstration projects to examine the impact of various strategies for improving the coordination of care for beneficiaries with chronic conditions in

traditional Medicare, such as the Medicare Health Support demonstration, the Physician Group Practice demonstration, and the new Medical Home demonstration.

AARP supports developing comprehensive, coordinated approaches to financing and delivering a wide range of needed care to chronically ill people. We hope to see effective strategies of this kind applied to the broader Medicare beneficiary population soon.

Conclusion

In conclusion, millions of AARP members depend upon Medicare every day. They need access to the best quality care and the physicians who deliver it. And they need that care to be affordable. The SGR system has not successfully controlled physician spending. To help keep Medicare affordable for beneficiaries today and financially strong into the future, AARP believes the incentives in the current physician payment system need to be changed to promote quality and encourage efficiency. We look forward to working with you and your colleagues to address this challenge.

Mr. PALLONE. Thank you, Dr. Thames. I will start off recognizing myself for 5 minutes of questions, and I wanted to ask Mr. Steinwald a couple questions. You mentioned how in the GAO study you were judging doctors against their peers in the community, and obviously medicine traditionally follows that local standard of practice. In other words, doctors are judged against their peers in the community. But when you compare doctors in the community did you still find significant variations in the use of services for similar beneficiaries?

Mr. STEINWALD. Yes, we did, Mr. Chairman. We divided all beneficiaries into 31 different risk categories so we were really trying to hold their health status constant. And then within each one of those categories we took the top 20 percent of beneficiaries who were spending the most holding risk constant, and we do find variations within the community on how those patients are treated. As I said before, we found that there tends to be clustering of those expensive patients among a subset of doctors in the community. The amount of clustering varies from one metropolitan area to another.

Mr. PALLONE. Now what areas had the most of the outliers, the doctors that were providing extra care or whatever prescribing more services than is normal, what areas did you find had the most of those?

Mr. STEINWALD. Well, we selected 12 metropolitan areas so we don't have a survey of the entire country. Of the 12 Miami metropolitan area is what was by far the most extreme, and I think second was Baton Rouge. And then there are others. As I say, all had some of these doctors but others were less than those two.

Mr. PALLONE. Did you find that there were any characteristics that the outliers had in common across the 12 regions that you studied or those 12 metropolitan areas?

Mr. STEINWALD. I should have said that we were only looking at generalists, not specialists in that study.

Mr. PALLONE. OK.

Mr. STEINWALD. And we don't have measures of how they differ from one another. We do have some measures of how their patients differ though. And, for example, we found that the patients of these doctors tend to me more frequently hospitalized and especially more frequently hospitalized multiple times in a year.

Mr. PALLONE. OK. In your testimony you note that CMS has the tools to identify the outliers, but I mean if they have those tools why are they doing it? Is it a legislative barrier? Is it something that Congress has to do to help them move forward?

Mr. STEINWALD. CMS currently has tools that it uses principally in its program integrity efforts to detect fraud and abuse. What we are suggesting that they think about doing goes far beyond just detecting fraud and abuse, and if they were in fact to consider doing some of the things that the other payers I mentioned do, they would almost certainly need new legislative authority for that purpose.

Mr. PALLONE. OK. Thank you. Thank you, Mr. Steinwald. I want to ask Dr. Fisher, in your opinion what role does information play in insuring proper utilization and accurate payment rates? In other words, should we be alerting physicians who are outliers with re-

gard to the utilization use? Should that information be public or remain private? I know these are touchy issues but what is your opinion on it?

Dr. FISHER. The role of information is absolutely critical. I highlight two areas that you haven't mentioned, the need for comparative effective research and performance measurement, but focusing specifically on the kinds of individual provider profiling that are being discussed and were highlighted in the GAO report. I think the key question is around the validity, accuracy, and meaningfulness of the measures that are used to profile the physicians. When those measures are meaningful and can be fed back to physicians that provide useful information to physicians and there is good data from a variety of studies over the last 30 years then physician feedback and performance information is a useful way to help physicians move toward the middle.

It will not, however, address the problem of underlying increases in health care costs. It will help improve physician practice. It may bring physicians back toward the middle of the mean but the problems between Miami and Minneapolis is the mean is that they are different in the averages, and most of the clinical decisions that physicians are making are subject to substantial clinical judgment, cannot be specifically judged to be inappropriate, so the challenge is how to guide local delivery systems to improve the overall efficiency of care.

If there were one hypothesis I would have about why physicians or high cost physicians are clustered together is we know well from our work comparing academic medical centers across the country that the patients who were cared for by some academic medical centers within Los Angeles or within Miami are treated very differently by the physicians who work within that particular system, and what we believe is the driver of the differences in cost between a high cost hospital and Miami and the lower cost health system is Miami in terms of per beneficiary cost is the relative capacity of that system, how many hospital beds they have or beneficiaries they serve because physicians and hospital physicians will rely on the beds if they can get their hands on them because it is easier for us to manage our patients when we have access to a hospital bed.

Mr. PALLONE. So you wouldn't want to draw any broad conclusions about how or what information we should provide to physicians or whether we should make information public or remain private. You have to look at a lot of different situations.

Dr. FISHER. I think feedback to physicians with good measures is very important. I think public release of that information at the individual physician level is not likely to be helpful. Neither MedPAC nor the Institute of Medicine was willing to talk about release of information. It depends a lot on the information that you are releasing, information on how patient-centered care, how effective a physician is at providing patient-centered care. That may well be important to release at the individual physician level, who has got good manners, who listens to their patients.

Resource use measures are much more complicated than the technical issues around those, and measurement and attribution at

the individual physician level remain a controversial measurement issue that I think is not yet ready for public release.

Mr. PALLONE. OK. That is helpful. Thank you. Mr. Deal.

Mr. DEAL. Thank you. I am going to try to see if I can put together some pieces of what everybody has said here and see if we can come up with some general idea of where we can head if we have the courage to approach designing a new system. And I guess I would start with the four ingredients that Dr. Thames has outlined briefly, information technology, greater use of comparative effectiveness research, performance measurements including physician resource use, and enhanced care coordination. The other two gentlemen, do you both agree that those are essential ingredients of whatever we try to design?

Dr. FISHER. Sure.

Mr. STEINWALD. Yes.

Mr. DEAL. And I think that is also consistent with what we heard from MedPAC as to the general categories of that. Now when we go beyond that we have some real problems with how we design something, and let me focus in on that. Dr. Fisher, you said volume of services is one of the primary ingredients of driving costs up, and this is pretty self-explanatory, I think. If we go to a system like an accountable care organization, I presume the idea would be that if we are going to set spending targets that instead of it being a national spending target we would begin to segment that down into the minutia of even these accountable care organizations having a set target for themselves, would that be sort of the concept?

Dr. FISHER. MedPAC has talked about a concept that would have the target at a regional level with shared savings models for the accountable care organizations within those and others subject to the expenditure target.

Mr. DEAL. We would probably have to do it that way to start with anyway.

Dr. FISHER. Yes, but I think the fundamental notion of trying to have the incentives aligned so that accountable care organizations could benefit from doing all of those four things and reducing the cost of care that they would receive some of the savings when they achieved that. That is the fundamental notion.

Mr. DEAL. But it is this cohesiveness and coordination of care that we are trying to emphasize. Now in that regard if we return to looking at getting into health IT that we did not finalize last year one of the big sticking points was the grants and how big the grant program is going to be, et cetera. It would seem to me that if we want to do something here that implements that then maybe in the grants for health IT they ought to be centered in organizations such as this that would give you an overall arching information base rather than just piecemealing it out into pieces that are disjointed. Does that have some sense to it?

Dr. FISHER. I would certainly agree with that.

Mr. DEAL. Because that is one of the key ingredients that we sort of all agree to is information technology. OK. Obviously in whatever we set as goals, we have to balance the cost versus quality of care and the great irony as your study shows is that you don't reach the conclusions that you would normally expect that greater costs reach greater efficiencies. In fact, it may be exactly the oppo-

site of that. Let us then try to take what GAO looked at in the private sector with regard to what they do, and I presume these are PPOs, these are managed care organizations, and so forth, is that right?

Mr. STEINWALD. Yes, a wide range of organizations ranging from traditional insurers to some government-sponsored programs.

Mr. DEAL. OK. But if we are going to begin with these accountable care organizations, them being the umbrella organization that sort of manages and has responsibility for containing cost and insuring quality of care, are some of the principles that Mr. Steinwald said that the private sector is doing applicable to them, and the ones that sort of jumped out at me was giving the enrollees some financial incentive to see physicians in particular tiers that meet certain criteria. Now I don't know how you do that, but is that something that could be translated into this sector, Dr. Fisher? I suppose I will ask you.

Dr. FISHER. I believe it could. I would probably set it up if I were a health care czar so that you had several accountable care organizations within a community and patients would be given information about the quality and cost of care there which might influence both their part B premiums and might encourage them to choose the higher quality and lower cost systems.

Mr. DEAL. Incentivizing.

Dr. FISHER. Incentivize.

Mr. DEAL. If it is going to affect their premiums, is it going to affect their premiums in the aggregate which is the way we compute premiums now or are we going to approach the concept of premium allocations based on the efficiencies within an area.

Dr. FISHER. That is a question I probably can't answer. I can't think quickly enough to give you an intelligent answer.

Mr. DEAL. Mr. Steinwald.

Mr. STEINWALD. Well, the payers that we looked at were mostly tiering for co-payment purposes so the co-payment might be less when they go see a doctor that is gauged to be high on performance measures than if they saw other doctors.

Mr. DEAL. Could we make that work in a Medicare system?

Mr. STEINWALD. I think every idea ought to be on the table because the situation that you face is serious enough. It couldn't be done under current law but I think it could be considered. And let me add one thing. It is hard to find much good news in this discussion and from the previous panel as well, but one thing that Dr. Fisher pointed out that I think could be viewed that way is that quality and efficiency are not enemies. You can't have only one of them. His research and his organization has shown that very often good quality and efficient care go together. The question is how do we encourage more within our health care system.

Mr. DEAL. Let me take probably the most difficult of what the private sector does and ask if it could be applied to a reformed Medicare system and that was excluding inefficient physicians from the network. We have concentrated our concerns about doctors who are voluntarily leaving the system because the inadequacies and inequities of the current system put those pressures on the good doctors and many of them are the ones that are leaving. Can we make a system that basically puts the pressure in the opposite di-

rection like the private sector does of saying that if you don't meet certain criteria you don't qualify to serve Medicare patients.

Dr. FISHER. It seems to me there are two parts to that question. The technical part is that it is feasible to do it. With good measures it will be feasible to define those providers who could be limited and are restricted and not allowed to participate in the Medicare program. The second problem is a political problem and that would not be one that I could easily answer and that you would have to address.

Mr. DEAL. It also means that you got to make the Medicare program financially incentivized enough so that doctors want to stay in the system and it is something they want to participate in. Thank you, Mr. Chairman, for being lenient with me.

Mr. PALLONE. Thank you. Dr. Burgess.

Mr. BURGESS. Well, just very briefly, either Mr. Steinwald or Dr. Fisher, to carry Mr. Deal's logic a little bit further, is there a risk of driving out the good physicians if these types of principles are applied unevenly or in an non-even handed fashion where you only ended up with the poor performers?

Mr. STEINWALD. Well, you certainly want to have good, credible measures, and it is one thing to do a statistical analysis of the kind that we did, but if you were going to take that information and really apply it more stringently than the program currently does, I think you would want to supplement it with additional information at the individual physician level. So it is essential that the measures be good, credible, and fair.

Mr. BURGESS. Since I can't always count on the chairman giving me the extra minute that he gave Mr. Deal, let me go kind of quickly. Mr. Steinwald, you talked about insuring that the incentives applied to all providers. Were you speaking strictly of physician providers or were you talking about all parts of what should be an integrated Medicare system where hospitals, HMOs, part D pharmaceuticals would all be considered as part of that financial landscape?

Mr. STEINWALD. Our approach was different from the one that MedPAC adopted. What we were suggesting is that physicians be profiled but not just for services that they provide themselves but for a full range of services. Research generally has shown about 20 percent of spending is for physician services but they control something like 90 percent so it is their decisions to admit to the hospital and refer to other services accounts for that other spending.

Mr. BURGESS. Just briefly on the ACOs, Dr. Fisher, you said in some cases that may be a hospital in a medium size community. If you are going to use the ACO to help you with the technology platforms that are going to be available, how do you get around the star clause? We wrestled with that last time and never really got past go with that.

Dr. FISHER. There are a number of serious barriers to moving forward with ACOs, among them the legal barriers to collaboration among hospitals and physicians. Those would have to be addressed and Gayle Lewinsky has written a nice piece in Health Affairs about some of the challenges around addressing gain sharing, and the importance of doing so in order to improve care collaboration and care coordination. There are other barriers as well but obvi-

ously some legal changes would have to take place if you were to have independent physicians collaborating with hospitals under the current legal model.

Mr. BURGESS. If that were the model in a medium sized community where I practiced for over 25 years was a community of 60,000 with an HCA hospital right in the middle of, so presumably that by default would be looked to as the ACO. How is the accountability then governed?

Dr. FISHER. I think the challenges of defining the legal structures of the physician organization are substantial but there are models, physician hospital organization which emerged in the early 1990's and then quickly died as capitation was eliminated, independent practice association models where the physicians could——

Mr. BURGESS. And that was not without financial pain, let me just underscore.

Dr. FISHER. I understand. But the notion of trying to create some form of physician group accountability and shared opportunity to gain——

Mr. BURGESS. And that is exactly the point. Does that accountability derive from the HCA hospital in the middle of the community?

Dr. FISHER. There are models and some of them are discussed in our testimony and in the Health Affairs article, and I would be happy to provide those, where hospitals own physician groups, where physician groups——

Mr. BURGESS. I don't think you can do that in Texas, that we have a lot of corporate practice of medicine. But if the hospital is the notice of that accountability then the physicians surrounding the hospital while, yes, they make up the medical staff, and, yes, they are responsible for the bulk of the decisions about what medical services to utilize it is ultimately the hospital answerable to its owners and boards off site that is going to be the entity to which Medicare is responding for that accountability. That is, if a bonus is paid it is paid to the hospital, not necessarily to the physicians that surround the hospital if their network is so loose that there is not an identifiable physician's organization.

Now if there is an identifiable physician's organization we also get into some difficulty with the anti-trust statutes as they exist today because as you know we are not allowed to talk to each other about what we would or wouldn't accept as fair and reasonable compensation for a medical service or hauled up before the FTC downtown, and while we will eventually get off it costs us $250,000 in legal fees and we are all scared to death of taking that on. Is that something that you are looking at with the development of the ACO model?

Dr. FISHER. We are talking with a number of people about how to try to move it forward effectively, and there are lots of legal barriers, technical barriers and social and cultural barriers to moving it forward but our general sense is that among all of the strategies that are out there for improving both the quality and costs of care fostering better collaboration and coordination among physicians and between physicians and other providers within the community, not just hospitals but also nursing homes is an important one to consider.

Mr. PALLONE. Dr. Burgess, we are going to do a second round. We are going to come around again so one more time.

Mr. BURGESS. My minute over isn't up yet.

Mr. PALLONE. I know, but you will have another 5 minutes so let us move on. This will be the last round. We haven't asked you, Dr. Thames, too many questions so I want to ask you a question. You are aware CMS has embarked on a voluntary pay for performance system for physicians in Medicare, and this program asks all physicians to report on a number of measures intended to measure and improve quality. Of course, now we have the financial incentive to do so but this did exist, this system previously, and the results so far have been paltry due to lack of participation. That might change maybe with the financial incentive. But I wanted to ask from your perspective, are there certain modifications that AARP believe should be made to CMS' current pay for performance efforts with regard to how they are focused?

Dr. THAMES. Well, sir, we think that the measures that are going to be used ought to be vetted where particularly say vetted through the national quality forum because it not only has providers but it has purchasers and it has consumers so that the measures that you get are valid. Now we are going to have to see since it is a new program and I understand not starting very well now whether before the end of the year those incentives really get you the information that you need.

Mr. PALLONE. You want it changed and refocused, if you will, on these high cost, highly prevalent conditions for which you have the valid——

Dr. THAMES. Yes. We want it focused on those chronic diseases that cost the most money in order to get the information that is most valuable to us sooner.

Mr. PALLONE. OK. I was just going to ask him but I see you are kind of twitching there. Did you want to say something, Dr. Fisher?

Dr. FISHER. I am nodding my head saying I agree.

Mr. PALLONE. All right. Thank you. That is all I have. Mr. Deal.

Mr. DEAL. Let me revisit one of the other things that, Dr. Fisher, I think your research indicates, and that is that just as nature abhors a vacuum in the medical field empty beds abhor a vacuum, new imaging equipment abhors a vacuum when it is not being used, and specialists abhor a vacuum when their services are not being called on, so your high cost is in part attributable to those areas that have more bed space in the hospitals, more specialists in the community, and I presume if we were to branch it on out into the imaging more high cost imaging equipment in the community. All of that leads to an escalation of cost, is that correct?

Dr. FISHER. That is correct.

Mr. DEAL. OK. How do we get a handle on that part? I want to give you a specific example. My state has been a certificate of need state in Georgia. My legislature is in serious debate right now as to whether or not to repeal it in its entirety or at least partially, and I don't know how to predict what the outcome of that will be. In looking at the chart even though mine is a black and white chart, and the color coding I have a little bit of difficulty deciphering, I still think we are probably one of those high cost states even with out certificate of need law.

Now we allowed the moratorium on specialty hospitals to expire last year. I was not one of those who favored allowing that to happen because I think we will see this vacuum that I just alluded to probably increase as more specialty hospitals come on line. Do you have any of you have any suggestions as to how should we approach that? Should we take a hands-off approach, which now appears to be pretty much what we are in the posture of doing, and as we see more states do like mine of taking a hands-off approach too, aren't we going to see an escalation of this phenomenon?

Dr. FISHER. I believe you are. I think the challenge we face is that physician incomes and the incomes of providers within the current delivery system depend upon through put, depend upon staying busy, and as fees are cut whether it is in the private market or by Medicare the way to maintain your income is to increase the volume or adopt new practices such as a specialty on a hospital or an outpatient facility or an imaging device that the physician owns themselves. The key to the puzzle, I believe, is in fostering accountability for future costs. One of the advantages of a model that is either regional or ideally accountable so that the physicians have to stare at each other eyeball to eyeball when they are making their decisions the notion of an accountable care organization is that the best way with a shared savings model even under fee for service the most effective way to have your incomes be increased in the future is to reduce the recruitment of new physicians to avoid buying new technologies and perhaps to let physicians who are doing too much health services research to remain competent physicians to step down and stop practicing, as my colleagues have recommended to me.

But the notion of professional birth control is a future strategy for physicians to be able to maintain their incomes or for hospitals to control their future growth of services is the way even for the high cost areas to gain from a shared savings model and slow the growth of total health care spending.

Mr. DEAL. My concern is how do we put the adequate mechanism in place to allow that to happen because just as Dr. Burgess is concerned about the physician who may be in effect trapped by the hospital, I can see a situation where you have competing factions within this ACO in which somebody who is being responsible is being penalized because one component within the ACO is not being responsible. What kind of discipline measure do you have other than the discipline that we have got the problem with now of the good actor suffering with the bad? How do you differentiate even with an ACO even though you break it down into smaller components? You still have that human nature at play. How would you address that?

Dr. FISHER. Well, this is not a simple problem. We are in a complicated problem in the Medicare system right now and in health care in general in the United States. The strategy I think is clear of moving towards models of accountability for both quality and cost. A prospective payment system would be much more effective but it took us 5 years to design the DRG payment system and 6 years to do the RBRBS. The current examples from the physician group practice demonstration that was mentioned by Chairman Hackbarth this morning at least the preliminary data talking with

many of those groups is that they look as though they are doing the things that you would hope they would do to improve the quality and the cost of care because the potential gains from shared savings at the large group are quite substantial when you have large enough groups, so it depends a little bit on how the incentives and how they play out, so I can't predict the future but those would be my thoughts.

Mr. DEAL. On a related subject, does gain sharing in which a hospital would allow a gain sharing arrangement with a doctor or a doctor's group, does it have any liability in terms of minimizing these creative of maybe extraneous service components?

Dr. FISHER. I believe that well-designed gain sharing arrangements which could avoid the creation of a competing hospital, specialty hospital, and increase in local capacity could be very important.

Mr. DEAL. Mr. Chairman, I want to thank all of these gentlemen. They have been very helpful to us. Thank you.

Mr. PALLONE. And I also want to thank all of you. I thought this was very helpful today, and we appreciate your being here and sharing your thoughts with us. Thanks again. I would also remind members that you may submit additional questions for the record to be answered by the relevant witnesses so you may get additional questions, and those are submitted to the committee clerk within the next 10 days. And without objection, this meeting of the subcommittee is adjourned. Thank you.

[Whereupon, at 12:45 p.m., the subcommittee was adjourned.]

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