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ROUNDTABLE DISCUSSION ON MEDICARE PHYSICIAN PAYMENTS: UNDERSTANDING THE PAST SO WE CAN ENVISION THE FUTURE

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED TWELFTH CONGRESS

SECOND SESSION

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ROUNDTABLE DISCUSSION ON MEDICARE PHYSICIAN PAYMENTS: UNDERSTANDING THE PAST SO WE CAN ENVISION THE FUTURE

THURSDAY, MAY 10, 2012

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

The hearing was convened, pursuant to notice, at 10:14 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Max Baucus (chairman of the committee) presiding.

Present: Senators Bingaman, Kerry, Wyden, Stabenow, Cantwell, Carper, Cardin, Hatch, Grassley, Roberts, Coburn, and Thune.

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

Senator HATCH. Let us get this going. Senator Baucus has been detained down at the White House, and, as I understand it, he has asked me to get this moving.

And let me just use some of what he would say. As is apparent from the physical seating today, today's forum is not a traditional hearing. Senator Baucus and I agreed to try today as an experiment. We want to facilitate deeper discussion. If it works, we will try it again. If it does not, we will not.

I have no doubt that my colleagues will let us know what they think.

Now, this is Senator Baucus speaking. After the statements of our participants, we will dive into discussion. Any Senator may comment or ask a question, and any Senator or participant may follow up. There is no order of questioners. If you want to speak, signal that to the chairman or me, if I am doing it, and he will call on you as quickly as possible. Senator Baucus and I will do our best to make sure comments and questions come equally from our Democratic and Republican Senators so that everybody is given a chance.

Now, I want to thank the chairman for convening—and it is a nice experiment here—today's roundtable on this important issue, one that affects our Nation's caregivers and patients.

Now this is, without question, a distinguished panel. I know each and every one of you, and we are very proud to have all of you here today, and it means a great deal to this committee to have you here.

It is an encouraging forum for promoting a bipartisan solution to the critical problems posed by Medicare physician reimbursement.

And, as many of you know, Chairman Baucus and I have both called for repeal of the flawed Sustainable Growth Rate payment formula. No one likes the annual end-of-the-year scramble to stop catastrophic payment cuts to physicians serving Medicare beneficiaries. Yet, while there is broad agreement that our current situation is not tenable, a solution has eluded the Congress up to this particular point.

The flawed SGR policy really is a 2-part problem. The issue that typically receives our attention is how we pay for a repeal or temporary fix of the formula. But the problem we hope to address today is more challenging. How do we move beyond the SGR? If we repeal the SGR or freeze physician payments for an extended period of time, we have only kicked the can down the road. We have not fixed the system, we have only left it for others to address. We need to move forward toward a permanent solution, one that makes real advancements in how we pay for and deliver care.

We need to provide a stable foundation for paying physicians today and tomorrow, not 5 or 10 years from now. And we must accept that many of these proposals advocated for today are, at best, years away from broad implementation and, quite possibly, will never work for many sole practitioners or small group practices treating Medicare beneficiaries.

Now, I want to thank the chairman again for convening this roundtable, and I personally look forward to hearing from our witnesses. My hope is that we will not get distracted by the budget issues with which we are all well-aware. Instead, I know both of us look forward to a fruitful discussion about the steps we must take to address this complex issue and encourage practical and realistic solutions. And I hope that this is the beginning of a meaningful discussion or set of discussions for our committee.

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

Senator HATCH. Now, I guess Senator Baucus is still not here.

Let me just say that I am pleased to welcome our participants for today's roundtable. All of them are former Administrators of CMS or its predecessor, the Health Care Financing Administration, known as HCFA.

Today we will hear from Gail Wilensky. Gail is a senior fellow at Project HOPE. Gail was Administrator at HCFA from 1990 to 1992. We are really pleased to have you here, Gail.

Next we will hear from Dr. Bruce Vladeck. Bruce was here last year to testify before the committee, and I am happy that you were willing to come back. Bruce is a senior advisor at Nexera and served as Administrator of HCFA from 1993 to 1997.

After that, we are going to hear from Mr. Thomas Scully. Thomas is senior counsel at Alston and Bird. He was Administrator of CMS from 2001 to 2004.

Finally, we are going to hear from Dr. Mark McClellan. Mark is the director of the Engelberg Center for Health Reform at the Brookings Institution. Mark was the Administrator of CMS from 2004 to 2006.

As a reminder, your written statements will be included in the record. And so we will begin with you, Ms. Wilensky, and go from there.

STATEMENT OF HON. GAIL WILENSKY, Ph.D., SENIOR FELLOW, PROJECT HOPE, BETHESDA, MD

Ms. WILENSKY. Thank you very much, Senator Hatch and members of the Finance Committee. Thank you for inviting me here to participate in this roundtable on Medicare physician payment reform.

As you have just indicated, Senator Hatch, I have had the honor and privilege of directing the Medicare and Medicaid programs, as have my colleagues to my left. I served as the Administrator of what was then called the Health Care Financing Administration from 1990 to 1992. I chaired the Physician Payment Review Commission for 2 years after that, and I chaired the Medicare Payment Advisory Commission from 1997 to 2001.

I am going to use my time to review a little bit the background as to what we had before we had the Relative Value Scale and how we have gotten to the position where we are, in order to give some thoughts about what we need to do next.

As you know, for most services, Medicare uses a bundled payment service now. It started in 1983 when we moved hospital inpatient reimbursement to a prospective payment system. It has been expanded to the capital payments, to outpatient hospitals, to home care, and to nursing homes. When those types of bundled payments have been used, we have updated the amount paid using an inflation measure and made an adjustment for productivity.

Physician payments continue to be and have always been very different from the bundled payment strategy that we use elsewhere in Medicare. There are some 7,000 or more Current Procedural Terminology codes that are used to bill. The updates were done by a top-down strategy initially, after the 1989 legislation, with the Volume Performance Standard, now the SGR and, also, adjustments for the Medicare Economic Index that is adjusted by these expenditure targets. The initial period for physician payment was from 1965 to 1984.

Senator Baucus, welcome.

The fees during that period were based on a historical charge basis. And what was seen using historical charges was that charges went up and volume of spending also went up.

We had a second period starting in 1984 through 1991, right before the Resource-Based Relative Value Scale, or RBRVS, was implemented, when the increase was based on the Medicare Economic Index. Basically, we tried to measure the cost for physicians. What we saw there was also rapid growth in fees and rapid growth in spending.

Looking at that period as a whole, it became clear that controlling only fees was not a very effective way to control spending. During the period of the 1980s, spending for physician services grew more rapidly than spending even for other services in Medicare.

At the very end of 1989, the Congress had passed the Relative Value Scale. That was a very different way to try to have this very disaggregated fee schedule used. Rather than basing it on historically based charges, there was a calculation of work effort, practice expense, and liability. There was a limitation for the liability that beneficiaries would face. There was a deliberate intention to shift

some of the reimbursement away from proceduralists and toward primary care services, and away from urban and toward rural areas.

At the same time, a volume control strategy was introduced to try to limit spending under this very disaggregated fee schedule. Initially, the Volume Performance Standard looked back 2 years and tied the increase not only to costs adjusted for changes in statute, but also looked at actual expenditures versus what the specified expenditures had been and made an adjustment either up or down based on whether expenditures were lower or higher than had been expected.

There were some problems with it. It was an unstable way to make the adjustment, and it was replaced in the Balanced Budget Act with the Sustainable Growth Rate. You have had a lot of experience now with the Sustainable Growth Rate. It is basically tied to the growth in real GDP per capita. You are now using, since 2003, a 10-year moving average rather than a single point in time, and it is used to update the Medicare Economic Index.

There is good news and bad news with the change. The use of the Relative Value Scale was an attempt to get away from some of the biases historically that were regarded as being in the fee schedule, and the SGR was more stable than the Volume Performance Standard. But when you look at the incentives that are involved, they are just awful. There is no reward for efficiency. There is no reward for quality. There is, worst of all, no link to how any individual physician or the physician's practice behaves, which is a very bad set of incentives. It makes it very hard to drive accountability or responsibility, basically because of the use of the 7,000-plus codes, combined with the SGR.

To my mind, there are really two strategies that you can use in its place. One is, you could try to refine the Relative Value Scale. A number of people have made suggestions about how to do it to make it more accurate than it is now, using better data. And most importantly, you could set the Sustainable Growth Rate close to the physician's own practice so there would be a direct link between the update and the actual behavior of the physician and the physician's group.

What I think is a better strategy is to try to move toward more bundled payments for physicians, as you have everywhere else in Medicare. You can start with chronic diseases, with or without ancillary services being provided. You can look at the high cost/high volume interventions. There are already some pilots that are moving in that direction, the ACE pilots.

Believe it or not, 20 years ago, when I was the Administrator, we had the bypass demonstration that did precisely that. Bruce also had a chance to oversee that. It went on for 10 years. And you can begin to move to more accountable units in that way.

The bad news is, there are no quick fixes on the horizon. To me, removing the SGR and not making any other changes in physician payment is simply not a solution. We know what will happen. Expenditures for physician services will grow more rapidly than other areas.

Unfortunately, because not enough work has been done over the last decade or two, despite many of us commenting on the need for it, there is no alternative ready for prime time right now.

What we need to do is make sure the pilots get started as quickly as possible. And for me, I do not want to only see them bundled with hospital payment. I think it is a very serious mistake to push all physicians or to think all physicians will be employed by hospitals or are part of hospitals.

We need to have a better way to pay physicians directly. I think that will continue to be an important part of the landscape in the future.

Thank you.

[The prepared statement of Ms. Wilensky appears in the appendix.]

The CHAIRMAN. Thanks, Gail, very much. I apologize for being late. I was down at the White House.

Bruce, go ahead. And thanks, all of you, for coming. I really appreciate it, Bruce, Tom, Mark, all of you.

STATEMENT OF HON. BRUCE VLADECK, Ph.D., SENIOR ADVISOR, NEXERA, INC., NEW YORK, NY

Mr. VLADECK. Thank you, Senator.

This is such a distinguished group of people who have been through some similar experiences as I. I really want to make just a few points about these issues very quickly.

I think there is a tendency, certainly, on the part of the policy community and a lot of our former colleagues, in the quest for something that is theoretically consistent or something that fits with people's ideas of how the world ought to work, to make things more complicated than they really need to be.

In fact, it is a very diverse health care system out there. It is a very heterogeneous system. It is very different from one community to another.

I think we have learned in physician payment in the Medicare program over the last 40-some years that one size cannot possibly fit all and does not fit all. And I think defining the future directions forward in terms of one sort of cure-all or one particular solution or one easy and elegant kind of fix is not going to be successful over time.

I very much agree with some of the comments that Gail has just made and some of the comments in Mark's statement, in particular, about the importance of experimenting with bundled payments, of thinking about new units and different units of paying for physician services.

We have done that, sort of in evolutionary terms, in some parts of the medical system over the years in the way we pay some surgeons, for example, and there are a lot of different ways. Further experimentation in other kinds of models, I think, is already underway.

I think some of us are being reminded, watching the travails of our friends at the Centers for Medicare and Medicaid Innovation, that actually doing these experiments is often more complicated than one would hope. But there is an awful lot of ferment and an

awful lot of activity going on out there, and I think it is really a good thing.

Just a couple of other sort of general points I would make. The notion that expenditures on physician services in the Medicare program are at risk of growing more quickly than other categories of expenditures and that that should be a particular problem, it is not clear to me that that is true.

I think there is an underlying policy direction where we are trying to get services out of institutional settings, away from expensive institutional control, into outpatient and community-based settings. And, if you do that, you, over time, should spend less money on hospitals, you should spend less money on other kinds of health care facilities, and more money on physician services.

So, depending on what you are getting for that increase in dollars over time, we might be better off if the share of physician services in the Medicare program increases. And I think that is just another example of how the application of uniform policies can produce undesirable sorts of results.

I do think, however, that is imperative that we fix the RBRVS and that we address some of the problems inherent in its construction, many of them having to do with practice expense, and some of the problems inherent in the way it has evolved over the years.

No matter how quickly we can move Medicare to other kinds of bundles or other kinds of payment methods, there is going to be an awful lot of fee-for-service payment in the American health care system for years to come. And part of the problem is that RBRVS not only sets relative Medicare payments, it is used by almost everybody else in the health care system as a way of evaluating the relative worth of physician services.

And, to the extent that it continues to over-reward procedural, interventional, and technologically intensive services and to under-reward basic primary care services, it exacerbates the already serious and worsening problem we have in our health care system of just having not enough primary care physicians and too many specialists.

It is very difficult in many communities in the United States today for people coming out of primary care training programs to make enough money to pay off their student indebtedness, and it is very difficult even for well-insured, sophisticated consumers, like my children, who have recently relocated to major metropolitan areas, to find capable primary care doctors.

So there are many components to that issue, but income is central to the problem, and the RBRVS is central to the income problem of primary care physicians. And there are a number of ways to address that or fix it, but I think we ought to decide, as a matter of policy, just to do something direct, possibly relatively arbitrary in the short-term, as part of a broader process of resetting these relative values.

I think when we adopted the SGR as part of the Balanced Budget Act in 1997, I think the Congress made a mistake. It was not the only mistake we made in the Balanced Budget Act. And, as I have been thinking about the history of these events in preparation for today, I am reminded that, among other things, both the CBO and OMB badly misestimated the impacts on providers of most of

the major changes in payment systems in the Balanced Budget Act. And partially, as a result, Congress, in 1989 and then again in 1999 and then again in 2001, significantly amended the legislation to change many of the payment formulas that had been authored by the Balanced Budget Act.

One of the things that the Congress did not address at the time was the SGR, because it had not really kicked in yet and its effects had not yet really been seen.

But, in fact, the way in which the SGR is written and the way it has been defined and interpreted by CBO creates this—what I strongly believe is this largely artificial, enormously large number that is identified with the cost of fixing it, which is an artifact not, as far as I can tell, of any underlying economic reality. It is an artifact of the way the formula was written and the way the projections are made. And so it has become a major deterrent for the Congress or for the executive branch to fixing a mistake that was made, along with many other mistakes in the history of legislation, about payment systems under the Medicare program.

And I am hopeful that some combination of the need to address overall deficit reduction strategies more generally and a different kind of political climate in the relatively near future will create the opportunity for people to say, "We made a mistake in 1997. We created a formula that produces irrational and counterintuitive results, and we are just going to abolish it and start all over again in terms of some kind of cap on Part B payments."

That is the only way we are ever going to sort of get out of this morass. And I can tell you with some confidence that, while it will appear as a major crisis in terms of overall budgetary strategy, in the real world of how we pay physicians and how the government of the United States operates, it will have almost no visible effect whatsoever.

So that is the political and psychological hurdle that needs to be surmounted if we are going to fix this very serious problem.

Again, thank you very much for the opportunity to be here today.

[The prepared statement of Mr. Vladeck appears in the appendix.]

The CHAIRMAN. Thank you, Bruce.

Tom, let us hear your wisdom here.

STATEMENT OF HON. THOMAS SCULLY, J.D., SENIOR COUNSEL, ALSTON AND BIRD, LLP, WASHINGTON, DC

Mr. SCULLY. Thank you, Mr. Chairman. Thanks for having us.

I would just note, first, for the four of us, believe it or not, even though we disagree on the policy, we are all pretty good friends and have talked among each other for years, along with Nancy-Ann Min DeParle, who was Administrator, and Bill Roper and Leonard Schaeffer and the other, I guess, confirmed CMS or HCFA Administrators. And we have a very civil, friendly discourse regularly and keep up regularly, and it is a very nice thing. And I appreciate you having us here today.

I have been very involved with this. As I noted in my testimony, I was one of the White House guys and the staff person, along with Bill Roper, in 1989 who got to push this thing through. So, sorry,

but at the time, it seemed like a good idea. And I still think it was a lot better than we had in 1988, and it was well-intentioned.

It caused a lot of chaos. I think it, obviously, needs to be fixed. It was then called the RBRVS system. It was invented, at least conceptually, by Dr. Hsiao, a professor at Harvard.

And what needs to be fixed is the SGR, and I went through some of the history of that, about why that happened in 1997. It was a swap. We needed to save money in 1997, and the physicians volunteered that as their saver. The hospitals took big hits, though, and the health guys took big hits, the skilled nursing facilities took big hits, and the physicians came in and said, instead of taking big cuts, let us just swap a formula change, and it was a big score from CBO, and that is why it was done.

So, obviously, it did not work and needs to be fixed. But the intention and what happened with RBRVS was to basically come up with something, as Bruce said, a global system of figuring out, when you will go from 6,000 codes to 7,000 codes, as we have in the last 10 years—you have to add some—somehow it has to come out and be paid for, even if you do not have the SGR. So keeping some sense of budget discipline in this is very important.

I think, in the long run, as Gail mentioned, the move to capitation is where the world is going, and I think the ACE program is a great example of that. I think the Accountable Care Organizations, while there are some flaws—and I agree with Gail's concern about pushing people too quickly to a hospital-based system—but the concept is it is basically a physician-based concept, and it is the right direction to go.

When I got to HCFA—I guess I am the only one who was both HCFA and CMS Administrator—we had 4 percent of people with Medicare Advantage. It is now 25 percent. I think that trend will continue to grow. But you still have 75 percent of people on Medicare fee-for-service, and we need to make sure that system works.

So, regardless of how we drop the SGR, I think you need to make the continuing RBRVS/SGR system work. And one of the things I mention in my testimony is, I think one of the biggest mistakes we made was—it is not their fault, as I mentioned—we took the RUC, which was a big system of the U.N. for health care back in 1992, and gave it to the AMA.

So when you sit around and decide who gets paid what, a surgeon versus a primary care doc, it is a system that is run through the AMA. It is not their fault, but it is very, very politicized. I think that was a big mistake, and I have said that in my testimony.

I think that, when you go back to restructuring this, you should try to make it less political and more independent, because it is $75 billion a year or more at this point that gets redistributed, and it is very, very intense between physicians, and it is something that most people are not aware of. But it is very sensitive and I think we made a big mistake in the way it was done in 1992, and others may opine on that.

The final thing I would say is, it may not be popular, but CMS is a great institution. There are a lot of great people. It spends $1 trillion a year. It is bigger than the Defense Department by quite a bit.

Some of the staff may remember, the first thing I did when I became CMS Administrator is I took the entire Finance Committee on a bus to Baltimore to see CMS. And I know that Senator Cardin, who is not here, has been there a bunch, because it is his State.

But it is a great place. They are doing a great job. They spend an awful lot of taxpayer dollars. And I think understanding how these systems work, including the RUC, including how the physician payment system works and the details, is extremely important, and Congress spends not a lot of time on it.

So I am thrilled that you are spending time on it today, and we are all happy to be here, and we will have input in helping you as you reshape it. But there is no doubt SGR is not working. There is no doubt it has to be fixed. But there is also, I think, no doubt in my mind, the sense of budget discipline—that was not there before 1989—needs to be retained.

Thank you.

[The prepared statement of Mr. Scully appears in the appendix.]

The CHAIRMAN. Your last sentence again.

Mr. SCULLY. Before 1989, there was no discipline at all in Part B, and, while the SGR system is flawed, some semblance of budgetary control, which RBRVS was, obviously, needs to be retained.

Thank you, Mr. Chairman.

The CHAIRMAN. Thanks, Tom.

Mark?

STATEMENT OF HON. MARK McCLELLAN, M.D., Ph.D., SENIOR FELLOW, BROOKINGS INSTITUTION, WASHINGTON, DC

Dr. MCCLELLAN. Mr. Chairman, Senator Hatch, all of you, thanks for the opportunity to join you.

The CHAIRMAN. I want to remind everybody here, we are going to try a different approach, kind of like the Supreme Court. We have 12 on this court. So when you finish, then we are just going to all ask questions and each respect each other. All of you respect all of us, we will respect you, nobody monopolize and anybody jump in, each speaks for himself or herself, in every sense of the term.

Go ahead, Mark.

Dr. MCCLELLAN. Thank you. I would like to get right to that discussion, but I did also want to highlight how important this issue is for health care reform.

It is the physicians and the health professionals who work with them that are the linchpin of our health care system. They are the ones who make the decisions that influence how all the dollars are spent, make the decisions that influence what happens to patients, and how they are paid has a big impact on what they are able to do and the kind of care that they are able to support.

You already heard from the rest of this distinguished panel about a lot of the details on where the RBRVS and SGR came from. So I am not going to recap that either.

I do want to note just how much legislative effort ends up being devoted year after year to stopgap measures to plug or patch the SGR. And, as a result, both physician organizations and Congress have a lot less opportunity than they would otherwise to focus on real physician-led improvements in care that could reduce long-

term costs. And this gets harder and harder as the SGR target gets farther and farther away from where we are.

By the time I got to be Administrator in 2004, in fact, we were all having hearings about how to reform the SGR and how to address these changes in payment that appear to be getting unsustainable. And you all may remember that we had a lot of discussions then about some of the ideas that you have already heard on this panel: moving away from fee-for-service payments toward more bundled payments or other efforts that would try to provide better support for improving care and lowering health care costs.

What has happened since then is that both the opportunities for doing that have become clearer and the pressures for doing it have become clearer, as well. And, while Bruce is right that there is no easy, one-size-fits-all solution, I think it is very clear at this point that we cannot just do another patch or we should not just do another patch.

And I want to thank you again for your leadership in making this year different, maybe the year when some real alternatives to the SGR actually emerge and can be sustained. In my written statement, I talked about what I think is the most important factor for that to actually happen, and that is some real leadership from the physician community.

I think the good news there is that a lot of physician groups around the country—in their own practices and working with private payers and working through communities and working with Medicare on not just pilot programs, but now integral parts of Medicare, like the accountable care organization program—are asking the key question, which is, where are the best opportunities to improve care and avoid unnecessary costs for Medicare beneficiaries, and then how do we actually get the support we need, the financial support we need, which is not necessarily there in fee-for-service payments, to make it happen?

These include ideas like relying more on nurse practitioners to help with managing care for chronically ill patients and for identifying patients who could benefit from preventive services who are not getting them, to spending more time being available for consultations with patients and reviewing with them what their treatment options are, what the evidence says, and being available if they are having complications, maybe heading off a visit to the emergency room, maybe heading off some unnecessary treatments and procedures. But it is very hard to do that with current fee-for-service payments, because a lot of those kinds of services that I just described either are not reimbursed at all or are reimbursed in a very limited way.

So what these actual reforms are doing is not just hoping we can make things better, but shifting the way that the physicians receive payments from traditional fee-for-service and RBRVS towards either a bundle around caring for a patient overall within their specialty or coordinating care with other specialties.

In my testimony, I give you a lot of examples of how that is happening in oncology, in cardiology, nephrology, surgery, radiology, pathology. Lots of specialties are moving in this direction, and there is also a lot of leadership taking place in primary care, where you can see the move towards medical home payments—which are

for coordinating care for a patient, managing their overall care—and away from fee-for-service payments is making a difference already for primary care physicians and giving them more opportunities to lead in these real reforms in health care delivery.

In fact, in an ACO learning network that we support at Brookings, along with Dartmouth, there are many organizations in the private sector that have added accountability for overall costs and for overall health improvements to the medical home payments that they are giving to primary care physicians.

As Tom was saying a minute ago, that is kind of the physician-oriented version of accountable care organizations, which is really expanding right now, not only in the private sector, but also now in the Medicare program as well.

So I think this is a very important time for physician leadership. That needs to be matched by the kind of attention that you all are providing today by starting earlier, not waiting until the last minute, despite everything else that is going on, despite the presidential election, to turn these good ideas and positive steps that are taking place in the private sector and, to some extent, in Medicare already, into at least the start of a systematic change away from the SGR.

So thank you again for the opportunity to help you address these issues and, hopefully, to help make these needed reforms happen.

The CHAIRMAN. Thanks, Mark.

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

The CHAIRMAN. I will just ask the first question.

First of all, the current SGR drives us all crazy. I think it especially drives this committee crazy. We have to figure out a way to pay for it every year. As you have said, it takes way too much time that could be devoted to other more important, longer-term issues.

The drift I am picking up is this: let us get rid of this thing, but let us move sensitively and reasonably, appropriately, to a different sort of either bundled payment or ACO, medical home, or some kind of pilot project.

I assume that is the drift among most, although, Bruce, you wonder about that a little bit. So we have a heterogeneous system. Maybe we should go that way a little bit.

Anyway, my question is, which of these different areas tends to be most promising? How do we prioritize? How do we transition to whatever it is we are transitioning to?

Sometimes the grass is always greener. We have to be careful where we are going. But whether it is the cardiologists—are they doing some of this? And orthopedists are doing some of this too, I guess.

Why are some areas doing better than others, and where do we go? Anybody, just jump into it. Anybody. Anybody jump in here.

Gail?

Ms. WILENSKY. I would start where the money is. I would pick the procedures that are the high cost/high volume, and get those bundled.

As I have said, we started when I was Administrator with a bypass demonstration, where all of the physicians who are involved in providing a bypass with the hospital came in, had a combined

payment, were monitored for quality and clinical outcomes—as best we were doing it in the 1990s—and patient satisfaction.

The areas are chronic disease and the high cost/high volume procedures. And trying pilots right away that are—some that are wrapped with the hospital, which would match what the innovation center is trying to pilot. I would strongly urge some that do not include the hospital in an attempt to try to promote multi-specialty surgeon practices and more physician leadership.

I agree very much with Mark's statement: they drive the health care system.

The CHAIRMAN. Bruce or anybody else, jump in anytime you want.

Go ahead, Bruce.

Mr. VLADECK. I would suggest that there are possible approaches that are less directive on the part of the government, and I would push to find more ways to open alternative paths so that different physician groups or different other kinds of provider groups could come up with their own ideas.

And I would just suggest, for example, that if you take any sets of codes in the RBRVS that now have individual prices to them and you had a bunch of physicians in some community say, "We'll provide services for the following 38 codes"—which is not dissimilar from what Mark was talking about—"and we have a formula that I think you could do that says, pay us 95 percent of what you would pay for the existing kinds of cases that you see," whether they are high volume/high cost cases or they are just those that are particularly appropriate for new kinds of approaches or new kinds of incentives, you would get all kinds of interesting things.

I think what we need to do is, rather than doing one experiment at a time, try to find formulas by which Medicare says to the physician community, "You can get paid item-by-item or we will encourage the bundling of different kinds of items, and here is a general methodology or formula for doing so, and, if you can put together a package, we will try it."

The CHAIRMAN. That would be similar to, for example, dual-eligibles. CMS is trying to figure out pilot projects designed to manage duals. But they have two basic approaches as they try to coordinate it, instead of just, everybody comes up with his own way.

Should that happen here too, as we move, and say to providers, docs, here are two or three basic approaches, or not?

Mr. VLADECK. I think that would be definitely worth exploring. I think that is what we should do. You can get paid on a shared savings basis, or you can get paid an upfront 95 percent of what this set of codes would ordinarily pay in your geographic area, or then you could get paid fee-for-service.

I think that is doable, and I think—to get to a separate digressive hobbyhorse of mine, you probably would have to increase the contractor budgets a bit out of appropriated funds in order to manage that.

But I think with existing—I think private payers that have better computer capability than the Medicare contractors are playing around with this kind of stuff already. So I do not see any sort of technical or logical objection to doing it.

It would take you a while to figure out what the formulas ought to be, but you could do that.

The CHAIRMAN. Just jump in. Anybody, just jump in.

Senator STABENOW. Mr. Chairman, can I just follow-up? Because we are talking about alternatives and creative approaches. And we appreciate all of you being here.

In health reform, we passed a number of options. I wonder if you could speak to that. We now have the pioneer accountable care organizations. They just announced a number of those. I am very pleased that Michigan was designated on three of those, and one is physician control and others. And then there has also been the multi-payer plan, multi-payer demonstration that is being put forward that is with private sector and hospitals and so on.

We have bundled payments. We have a number of different things that we have done. So we are moving. The accountable care organizations right now are moving. There are demonstration projects.

I am wondering how each of you would see these ramping up. What needs to happen at CMS to be able to really move forward with those in the process? And how could we do more of the multi-payer opportunities? Because it seems like we gave the structure. They are now designating hospitals and provider groups to do these things.

So, is it not more of just doing the things that we have already put in place structurally and trying to get them up and going and getting the results as quickly as we could?

Mr. SCULLY. I think everything that is going on in the ACOs is great. As Gail alluded to, you have to be able to be a little careful—and I had this debate with Don Berwick in the *Wall Street Journal*.

But the goal of ACOs was to drive doctors' control of behavior, as Dr. Coburn knows. Doctors take care of patients, and the goal of ACOs was to empower doctors, to give them risk to keep people out of hospitals.

And I used to run a big hospital association. I love hospitals. But the goal was to keep people out of hospitals and to pay the physicians for behavior to keep hospital beds empty.

What has happened, which is a little dangerous, in the last 5 years is that more and more of the ACOs are hospital-based. The number of physicians who were working independently and now work for hospitals has gone from 40 percent of physicians to 60 percent in the last couple of years.

So I love hospitals and I love the ACO movement and I love the capitation movement, and all this is a move in the right direction. You have to be a little careful that you do not make it so hospital facility-based, because the reality is, every hospital in the country has a crane in front of it, and they are very expensive. And the more you get into the hospital-based system, the costs go up, not down.

And I love physicians, but this is all about financial incentives and——

Dr. MCCLELLAN. I do think this is why you need to make changes in the SGR. It is much harder for physicians to lead in these efforts when they are spending so much of their time lobbying about a short-term SGR patch and trying to make ends meet

with this kind of reform care. That is what we would like to see. But they are not getting paid in a way that supports it in their foundational payment system.

So I am all for the pilots that move toward bundles and things like that, but when you have an underlying base system that is the core of physician reimbursement which does not support that kind of leadership, we are in the wrong place.

Senator STABENOW. And if I could just quickly follow up on that, and I know that Tom wants to speak.

I could not agree more about SGR and that we have to look at multiple things. I guess what I wanted to emphasize is that it seems like, through the Affordable Care Act, we have laid out some options, and it sounds like you guys are all talking about those kinds of options.

And I know at least with the Detroit Medical Center, it is physician-based. It is one of the new ACOs. And so, Tom, if you are saying we need to do more that is physician-based, does that mean we need to be doing more around the ACOs to be able to model that or to be able to show that as pilots? Because it seems like we have put in place some steps right now that address what you are talking about.

So is it a question of ramping it up or how fast we could do multiple models?

Mr. VLADECK. Let me respond to that, if I may, very quickly. I think it is this committee that is responsible for the existence of the Medicare and Medicaid Innovation Center in the Affordable Care Act, and I think it is one of the most productive and important things in the law, and I think they are doing a wonderful job.—

But they are still, by and large—even with all the efforts you made in the statute to streamline it—constrained by the definition of what they are doing as demonstrations, which means they have to have open public competition, which means they have to have a very elaborate system for evaluating competing applications, which means that OMB gets into everybody's underwear throughout the entire process, and so on and so forth.

And I think we are going to get wonderful results from that, but at the same time, I really think there ought to be a way to say, within the existing program structure, let us come up with some formulas or some templates for different payment models for physician services that are not demonstrators, that are just alternative ways to operate under the existing program.

And you are in a different organizational and legal process that is much more accessible, much less formal, much less difficult to get people to participate in, and that is what I think is the next step or a supplemental step.

Senator COBURN. Let me jump in here, if I may.

CBO just published a review of 15 years of demonstration projects that showed not $1 was saved as a result——

The CHAIRMAN. I just want to ask, are those——

Senator COBURN [continuing]. Of the demonstration projects.

The CHAIRMAN. Of the demonstrations in?

Senator COBURN. Run by CMS.

The CHAIRMAN. Run by CMS.

Senator COBURN. Over the last 15 years. We have a system, and we are not going to fix that system where we, in our country, we think somebody is paying the bill.

So, rather than use the stick approach, which was what the SGR did, why don't we use the carrot approach? Why don't we evaluate physicians?

First of all, every insurance company knows how either efficient or inefficient I am in my practice. They have the numbers on me. They know. And I will just tell you a little about an experience we had as a group of physicians.

A new insurer came to town, and we refused to take them because their prices were too low. And so they bought from Blue Cross/Blue Shield our numbers, and they came back and offered us more than they did everybody else in town, because they wanted us to be in there, because it actually costs less for us to give the same care.

Why could we not have a system that incentivizes the physicians positively rather than negatively? Because, if you think about the SGR program, the first year that we did a cut is when you got this, wow, you cannot do this ever again. But the point is that we blinked, because, if physicians really knew that if they were inefficient with the spending of dollars for their patients and that they were going to get a cut the next year, that incentive would have worked.

What was intended by SGR was a good idea, but we blinked, because we did not change behaviors in terms of physicians. So what I would throw out to think about is, how do we design something that positively incentivizes physicians to be more efficient, to do things positively, so you can compare them in their region by what they do?

It is nothing but a computer program, and you could say, at the end of the year, "My goodness, your average patient with diabetes had fewer complications in terms of the codes associated with that. You saved Medicare this compared to the standard in your area. We are going to give you a bonus. And, everybody else, next year, if you do not, we are actually going to cut you."

So where you could say in my region—Oklahoma, Texas, Kansas, Arkansas, and Louisiana—you can say, "Well, here is what the standard cost for this should be and, by the way, this group of physicians was well below that," not based on geographic cost difference, but actual physician practices, and let us reward it.

We tried the stick, and we do not have the guts to hold a stick. Why don't we try an incentive?

Ms. WILENSKY. Well, if you had the Sustainable Growth Rate or any kind of desired spending at the physician practice level, as the Blues plan did for you, that is fine. The problem that exists now is that you are penalized because you are a physician, and, collectively, physicians spent more than was desired under the Sustainable Growth Rate.

It is similar as long as what it is you are being judged by has nothing to do with either your individual behavior or your practice's behavior. If you want to have the judgment of your practice's behavior, where you, as a practice, can control what you do, that is fine. When you start doing it at a metropolitan level, at a State

level, all orthopedic surgeons, no individual group can influence what happens, and that is both unfair and leads to bad behavior.

So that is definitely one of the options, which is to have the tradeoff be at the physician's practice level. That would be much fairer and would have at least good incentives.

Senator WYDEN. On that point, I think Dr. Coburn raises an important point, because he is touching on this question of regional variation. And the fact is, out of the gate, regardless of value, you see—I am looking at my friend from Iowa, Senator Grassley, Senator Hatch, myself, Senator Cantwell, four States that are low-cost States, consistently have done exactly the kind of stuff you all are talking about, integrating health services. And again and again, we have been penalized for it.

I have sat here for an hour listening to four people I admire very much and am still kind of baffled about what do we do around the proposition that not all States are created equal.

The fact is that in some high-cost States, when the senior shows up, they get a higher payment, and this is baked into the SGR as of now. As of now, it is baked in to have these penalties for low-cost States that are giving value, that are doing what Dr. Coburn is talking about.

What do you all think? Since we are talking about the future of health care providers, what can we do to start moving away from this kind of built-in disadvantage for people to hold costs down and deliver value? Because even after health reform, I had the hospitals of Oregon come in yesterday, and they were scratching their heads, and they said, "We all were working on this during health reform. We were all talking about trying to pay for value, get the incentives right, lift the penalties for low-cost States." They said, "We haven't seen much happen as of now."

So now we have a chance to get this right with doctors. And what do you all recommend to change the baked-in penalty for Senator Hatch's constituents, Senator Grassley's constituents, Senator Cantwell's constituents, mine, others who are from these low-cost States and want to support exactly what you are talking about, these incentives for quality, incentives for value?

But right now we are already taking a shellacking, and it looks to us like we are going to get clobbered once more.

Senator ROBERTS. On that point, could I just add something to pile on here in regard to your questions, since you left me out? [Laughter.]

Senator WYDEN. You are a low-cost State. You are in.

Senator ROBERTS. I am in.

Senator WYDEN. And Mike is in, too.

Senator ROBERTS. I have the privilege of representing 83 critical access hospitals. Montana is in the same boat. And the chairman and I feel very strongly that the original cut that we did to providers to provide—it used to be called PPACA. What do we call it now? Well, whatever. Anyway, the health care plan. I know what I call it, but we are not going to go there.

But my main concern is that the rural health care delivery system, when I go out and have health care summits in Hays, KS or Dodge City or Abilene or, for that matter, Topeka, it is all the same. And here you have the SGR. You have three RVUs—I love

these acronyms—Relative Value Units, that really represent 7,000 codes—7,000 codes. I have the top 20 right here.

I went to the doctor this morning and found out I have a cracked kneecap. I wonder what code I am under? I have no idea.

Dr. Coburn would say, put ice on it, put your leg up, and just forget about it, and I would not even have to go to a doctor.

At any rate, something has to be done, it seems to me, because you have—the physician work and practice expense contribute to most of the determination of the ultimate payment. The physician work is 52 percent. Practice expense contributes 44 percent. Now, that is the administrative cost. That is all the nurses, and that is all the people who have gone through CMS Regs. 101, 102, and that is all they have so far in the universities to have people who will understand the codes with CMS.

I have no confidence in CMS. I have no confidence in IPAB when they finally get organized. Something has to be done with the SGR. I know we tried.

I really credit the chairman for holding this roundtable. We need something where we can come together in a bipartisan way and get traction, because we all know that this thing is not working. It tanked when the economy tanked.

And so I wonder if some model could be worked out that would at least consider the regulations. In my last visit to the Dodge City Medical Center, which has expanded, we have people running the ACOs who are private contractors, and they come in and they try to find where there is a Medicare reimbursement that basically does not fit the criteria over 3 years.

We lost two doctors, we gained one. I mean, the doctors are not even there yet. We have a new hospital administrator. We have an addition to the hospital.

Now they want to do it for 10 years. I asked the hospital administrator, "How much does this cost?" He said $50,000 a month.

Now we have something called face-to-face. That means when Mildred in Cimarron, KS, 32 miles away, wants her prescription, and the nurse clinician cannot fulfill it with the local pharmacist, who is about to go out of business, but that is beside the point, then this doctor has to take 1 day off and go out to Cimarron and see Mildred.

"Hi, Mildred." "Hi, Doc." "Are you still using your prescriptions?" "Yes." "Are you following what you should do?" "Yes." That is a whole day. What the hell is that? I just do not understand it.

Now they want to even go back 10 years, and that is just two of—I could list you regulation after regulation after regulation. We sent 34 of them to Kathleen at HHS and then boiled it down to seven later on and still have not had much of a response.

Something has to be done to figure out this number, 44 percent, in regards to practice expense, because it is just not right. And then I am really worried about whatever SGR we come up with or whatever—I do not know if it is in the SGR. We ought to rename it and call it something else. But at any rate, will it take into consideration rural areas, critical access, unique kinds of circumstances?

There is a great thing here about medical home demonstrations that CMS is now trying to implement, and physicians who manage

patients with chronic disease would receive a payment to compensate them coordinating and communicating among specialists, social workers, case managers, patients, so on and so forth.

We do not have those in rural areas. We have the hospital, we have a specialty hospital, and we have nurse clinicians.

I know a lady who just went through this who apparently had a stroke, but the person who gives her exercise once every few days was called because she could not get in the emergency room, and a few days later she died.

Now, I do not know if she got into the emergency room or if they had accepted her in the emergency room, but one of the situations was they did not think that she would fit under the circumstances. And she died.

Now, I am rambling, Mr. Chairman, but I really think whatever we come up with—I worry about this global thing, and it is a numbers game in regard to CMS. We must be aware of different States, different regions, and, more especially, the rural health care system. And you know that. You have been a champion of the rural health care system for a long time.

I am sorry for the rant. I did not get into oxygen tanks. I am learning. [Laughter.]

The CHAIRMAN. You are saving that one.

Mr. SCULLY. Unfortunately, Mr. Chairman, regionally, it is very different. So I think in Oregon you are probably up to 35 percent of people on Medicare Advantage. Change happens slowly. I will bet there is probably less than 5 percent in Kansas.

So every geographical—every part of the country is different. But I think the thing that we roughly all agree on is that we still have 75 percent of people on Medicare fee-for-service. So you are still going to be dealing with—the fact is, one of the seminal problems in Medicare, in my view, is the Federal Government, through CMS, pays every doctor the same thing.

So, if you are first in your class at Harvard or whatever, or last in your class at University of Western Guatemala, you get paid the same thing. And changing that variation over the years is important, and that is one of the reasons I am a fan of Medicare Advantage.

But short of the world going from 4 percent on Medicare+Choice to 25 percent on Medicare Advantage, which I think is a good development, we still have this massive program that is still on fee-for-service. And, if you are going to deal with those docs on fee-for-service, you have to find the right incentives.

And incentivizing doctors is the key, and I think we all agree on that. How do you provide—to say it is not the money is wrong. It is the money. Physicians are trying to do the right thing, but they follow financial incentives, and finding the right way to generate ACOs that are physician-driven, not necessarily hospital-driven, is key.

One of the problems that I think Gail was alluding to is—and I love a lot of the hospital-based ACOs—physicians do not have the $20 million in a region, in Portland, to go out and start an ACO. Finding a way to create the capital pools for physicians, to cover physician-run groups, not hospital-run groups, that are going to go out and drive this——

Senator WYDEN. But, Tom, the reason they are going out and creating ACOs in Medicare Advantage is because a lot of seniors cannot see a doctor in the fee-for-service system in Oregon.

They go out and make 6 to 10 calls, they have a heart condition, they have high blood pressure, nobody will see them, and then all of a sudden you get what you characterize in your testimony—and I think it is appropriate—the ultimate bundle.

But even in a place like Oregon, we are now at 41 percent Medicare Advantage, and it is good Medicare Advantage, the Medicare Advantage of high quality, guaranteed issue, community rating, that sort of thing, but we still have well over half in traditional Medicare.

And, if you all could just tell us what you think ought to be done to deal with the fact—and I was glad that the chairman piped in that his is a low-cost State, too, because a big chunk of us on this committee have what amounts to millions of seniors going to see doctors, and there is a baked-in disadvantage under the reimbursement system for treating those people.

And we thought it was going to get taken care of in the Affordable Care Act, and, as of yesterday, a big group of providers came in and said, "We sure haven't seen much happen."

So what would you tell us to advocate for to try to get the incentives that you correctly identify? Every one of the incentives, and the paying for value that you have talked about, I am for.

It is just, as of today, for a lot of us—those three up there at the top of the dais, and Senator Cantwell and myself—it sure does not look very good, because it just looks like we are getting another hit from what already is a system that discriminates against us.

So let us start with you, Mark, and just tell us what you would do to make sure that all States can get the fruits of this new approach that rewards incentives and value.

Dr. MCCLELLAN. Well, so long as Medicare fee-for-service is paying doctors on the basis of volume and intensity, which the current SGR program does, your physicians are not going to get ahead.

And I would say for Senator Roberts, too, I have been to some of his critical access hospitals in Kansas, and the way that they want to deliver care, the way that they need to deliver care, involves things like tele-health, it involves relying on nurse clinicians and other health providers instead of physicians.

And those things, as you heard from him, are not covered under—even though we have 10,000 codes, they do not squarely fit within any of them.

What will help is a move away from fee-for-service towards the payments that are more tied to what each patient really needs. And so that is what I talked about in my testimony, what Bruce and others on the panel have referred to as different kinds of bundling, but focusing specifically on physician services, and done, I think, not as a pilot—I think we are past that stage—but building this into the Medicare program systematically.

Maybe it could be done as an option so that people could stay in the traditional fee-for-service system or opt into this more bundled approach. But I think we are at the stage now where there are enough good ideas out there—and you have seen them in Oregon. Your State is trying to do this. The State has made a real effort

to move away from fee-for-service, and it is Medicaid and employee plans and the like, and that can be reinforced in Medicare and can be reinforced in every single specialty and primary care.

The ideas are out there among the physician groups. I think it is up to this committee and leaders in Congress to give the physicians an opportunity to say how they would make those moves now.

Senator WYDEN. They are good ideas. I am just not sure they work for those three States and mine unless we take away this baked-in disadvantage.

Dr. MCCLELLAN. That is what you would do. You would be taking some of the payments that are baked in, the fee-for-service volume and intensity, and shift them to something else.

If what is working in Oregon is things like a primary care physician or a cardiologist spending more time working together to track what a patient's medication needs are, making sure they are on the latest evidence-based treatments, and spending time with them to prevent complications, the way to do that is to take what is currently in their fee-for-service payments that does not support that—maybe extra payments for the additional imaging procedures or lab tests or things like that—and convert some of those to a payment that would go to keeping the patient's needs met.

And there are good measures for that. That is what Dr. Coburn was talking about. It is not easy to do in many cases, especially in small practices, especially in practices that are treating vulnerable patients, but we do not have to make a wholesale change right now overnight to make this much easier for the doctors in your States. We can start getting that.

The CHAIRMAN. I think what the Senator is getting at is, he is a little concerned that discrimination, if you will, will be baked in, and I think that that is his concern. If you go to bundling, that discrimination is going to still be baked in for low-cost areas. We are not dealing with the disparities in different parts of the country.

Bruce?

Mr. VLADECK. As a New Yorker, I probably ought to be the one to respond to this issue, and Senator Wyden and I have talked about it in the past. And Mark hit on one piece of this issue that is very critical if we are going to address these issues appropriately, and that is, until we can adjust adequately in the data about utilization patterns and outcomes for the characteristics and the differences in the characteristics of the patients being served from one community to another, we cannot fairly say that one place is more efficient than another.

And, in fact, if you contrast some of the 3- and 4- and 5-year-old Dartmouth rankings of relative metropolitan areas on their relative efficiency, with some of the more recent work done by MedPAC or by CMS, which has the appropriate data adjustments, you get very different rankings, and you find out that most of the difference in per capita Medicare expenditures from one region of the United States to the other is, in fact, associated with home care and durable medical equipment, not with differences in utilization patterns, because, when you adjust for the characteristics of the patients, the differences are not as dramatic as has long been described.

Now, I think we have two sets of problems here. One problem, which is very real and which Senator Roberts talked about and Senator Coburn talked about, is I am increasingly convinced that, when it comes to physician payment and physician incentives, we probably just need to have a separate system for rural communities than we use for urban communities, because all of these new bundles and systems of care people are talking about require a degree of infrastructure and a critical mass that, as Senator Roberts said, is not realistic in smaller communities.

The CHAIRMAN. Kind of like accountable care organizations. Like critical access hospitals, for example, just reimburse differently than——

Mr. VLADECK. And I think we have a model, and we sort of gave up in the hospital sector. We said for hospitals below a certain size serving certain kinds of communities, the Prospective Payment System is never going to work equitably for them, because the numbers just do not work. And so we created a critical access category, and I think there is no logical reason why we should not apply the same logic to paying physicians in rural communities and figure out what it takes.

The most important variable with the physician in a rural community is not how high quality he is or how efficient he is, but whether he is there or not in the first place. So that is less of a problem on the Island of Manhattan. So we should not try to develop a 1-size-fits-all formula for these very different issues.

On the other hand, I think we know less than we believe we do about the causes of variations in Medicare expenditures between the high-cost States and the low-cost States, as is evidenced by the fact, again, that the most recent data shows very different rankings of high-cost and low-cost than the Dartmouth atlas has been showing. And the IOM is in the middle of a study which you commissioned to try to look at these issues and disentangle them.

I think we need to get some better information about these issues, and it is in the process of being developed.

The CHAIRMAN. Could you explain to everybody what IOM is?

Mr. SCULLY. The Institute of Medicine. I will not pick on the New York guys.

Dr. MCCLELLAN. I am actually on that panel—as is Gail—and it is going to develop some better information. I am not sure it is going to completely resolve all the issues.

Mr. SCULLY. But there are huge differences, and, if you carved out Dade County and Louisiana and pushed them out in the Atlantic Ocean, you would save a hell of a lot of money. [Laughter.]

Can I give you two ideas that are a little different? And I agree with what Bruce is saying.

In rural areas—Oregon is different than Kansas, and you are probably not going to have Medicare Advantage plans at 41 percent ever in Kansas. It is just not going to happen.

But there are a couple of old programs that have been floating around. I know it is still on the books, Medicare Select, which I think may only exist in parts of Alabama, but it is basically a Part B capitation, where the doctors get capitated, they can take full capitation. All the Part A costs are passed through.

It is kind of half a loaf of Medicare Advantage. And, in a rural area where you only have hospitals and you are trying to give the docs the ability to go together and organize themselves—it actually started to take off. For a lot of reasons, it blew up under the 1997 bill, which I can get into, if you like. But there are ways where you can create the right incentives for doctors to do more.

One of the reasons I was such a big fan of creating Medicare Advantage—I think I made that name up one day—was because I hated Medigap plans, as Senator Wyden knows. We worked on that 25–30 years ago when he was in the House. He was the original Medigap reformer.

One of the worst incentives in the program is Medigap, which is private insurance, first-dollar coverage, which has 60-percent medical loss ratios; it is horrible insurance. You could go out in the rural areas, and, if somebody agrees to sign up to Medigap with a $250 deductible——

The CHAIRMAN. I worked on that with Senator Pepper.

Mr. SCULLY. Yes.

The CHAIRMAN. Senator Pepper.

Mr. SCULLY. It is horrible. It is terrible.

The CHAIRMAN. The medical loss ratios were just outrageous.

Mr. SCULLY. And, if you gave people higher deductibles and said, if I were in rural Montana and you agreed to do Medigap with a higher deductible, then you get the good one. The ACO gets paid more.

There is money in the system to create the right incentives for doctors, and there are existing programs around to do that, and I think we just need to find places to push more money for doctors to be incented to do the right thing.

Ms. WILENSKY. It has come up a couple of times. The alternative to the current RBRVS fee-for-service system is not necessarily Medicare Advantage. That is an alternative. That is the ultimate in a bundle.

Everyplace else in Medicare, you have directed the agency to move to a more bundled payment. So rather than focus on all of the little items that used to go on in the hospital, Medicare pays on the basis of a discharge, the diagnosis at discharge. And what happens during that whole experience is not Medicare's problem, it is the hospital's problem.

My argument is that, if you want to have that same kind of refocus, you have to get away from billing 7,000–8,000 different codes, taking care of people, and get to a type of a bundle that is appropriate for physicians.

If we see capitated systems growing, if we see premium support, if we see a very different world, that is fine. That is the ultimate bundle. You get around a lot of issues that you have to face otherwise.

You still worry about volume with prospective payment. That is why you have a readmission penalty now being imposed. It does not necessarily pay for quality, but it could pay differentially for quality.

But even in the rural areas, physicians who are taking care of people with single or multiple chronic diseases—congestive heart failure, congestive heart failure and diabetes, congestive heart fail-

ure, diabetes, and hypertension—all of those tend to go together, but are not always together.

Paying somebody, a physician, an amount to take care of a person with one or more chronic diseases for a year would be a very different mentality than billing them for every single service every time they walk into the hospital, and would allow them to focus in a different way.

Those are the kind of adjustments you actually can do in terms of how you pay physicians so that you just get away from this very micro-level mentality that has had so much distraction in terms of the gaming that people do and the fact that they do not have a good reward when they are practicing conservatively and getting good clinical outcomes.

It is just a question of how many times they bill and whether they bill for the expensive stuff or not.

The CHAIRMAN. I do not know. Tom has been trying to——

Senator CARPER. Thanks, Mr. Chairman. Thank you all for coming and for your continued service to our country.

Sometimes when people ask me what I think we ought to do in tax reform, I talk a fair amount about Bowles-Simpson, and I think they have a pretty good roadmap there. But I also talk about the underlying principles that I think we should adhere to as we follow tax reform.

I use this as an example to lead to my question. I say tax reform, among the things it ought to do, should simplify the tax code, not make it more complex. It should stimulate economic growth, not diminish it. It should help us reduce the deficit, not increase it. It should make the tax code, arguably, fair, maybe more fair than before.

Those are really underlying principles. We have talked about a lot of different directions for government specifically, and so forth.

What would be most helpful for me is to hear each of you just share maybe one underlying principle; that is, where you try to fix this problem, address this problem, to make sure we get better health care outcomes for less money, or the same amount of money.

Just give us a takeaway, an underlying principle that we, when we work toward solving this problem at the end of this year, should try to adhere to. For each of you, just one underlying principle we ought to adhere to, that would be helpful for me and maybe for my colleagues.

Ms. WILENSKY. For me, rewarding the kind of behavior we want to see.

The CHAIRMAN. Which is?

Ms. WILENSKY. Producing good outcomes, focusing on the outcomes, and then, on all the inputs on what you do, shifting that focus. And, by the way, I would not mind extending that to the patient as well.

Senator CARPER. What do you mean by "extending"?

Ms. WILENSKY. Rewarding the kind of behavior we would like to see, engaging in good health practices, encouraging that, discouraging or penalizing some who do not.

Senator CARPER. We actually try to do that in our bill by allowing employers to provide premium discounts of as much as 30 percent for folks who take better care of themselves.

Ms. WILENSKY. Exactly. That is exactly what I was thinking.

Senator CARPER. Thank you. Just one principle from each person, if you do not mind.

Mr. VLADECK. I am going to be the outlier in this group and the deviant, which will not be the first time. I think the basic underlying principle that the principal goal of the payment system is to pay providers and to try to change the world through fine-tuning payment systems makes life more complicated and more difficult.

So I think there are real issues of quality in the health care system that need to be addressed, but you can address them without dealing with how you pay people.

There are real issues of creating incentives for more efficient care. Every time you write a check to a physician group, you do not have to have that incentive contained in it.

The sort of "keep it simple, stupid" principle, I think, especially applies to both the tax code and to the Medicare program, because everybody from every interest, every stakeholder and every member, has some particular refinement that they want to put on it to move a particular agenda.

So I would say, do not expect too much out of a payment system. Make sure that it is auditable, it is reliable, it is understandable by the providers and the beneficiaries, as well as by the government, and that you are clear about what you are paying for and what you are not paying for.

You start from that and then you can adjust around the edges. If you are paying too much, you reduce the payments, et cetera.

Senator CARPER. Thank you.

Tom?

Mr. SCULLY. Since I do not have to run for anything, I am an unabashed fan of the Healthy Americans Act. So I will not get into that. But if you could reinvent the world, that is what I would do, but I will not get into that with Senator Wyden.

But if you had one thing to do this year, and I think Senator Baucus tried to start it, which was incredibly admirable—I am a huge fan of a tax cap—I would say, if you are really trying to change behavior, limit tax deductible excludability of health care to a very basic standard option and Blue Cross benefit, because you tried to do that a little bit in the ACA, and there was a lot of opposition to it.

The tax policy drives a lot of behavior, and there are a lot of places to go, but if you put in a tough tax cap, you change behavior, you raise revenue for other things, you close the deficit, and that is absolutely the right thing to do, and I admire you for trying.

Senator CARPER. Thank you.

Mark?

Dr. MCCLELLAN. I agree with the points about engaging consumers and helping people be healthier. I think that is probably the biggest, most important way to get to better health and lower costs.

With respect to physician payment reform and trying to apply a pretty simple principle or, I would say, a pretty simple test, I think at the end of this process, if you can ask providers, and each specialty tells you that these reforms will improve care, that is a good first part of the test.

The second part on accountability is, is there a way to show that competently, to measure that this is getting the better care, it is getting to lower costs, as Dr. Coburn suggested. And I think, while that does mean we need to move away from our already complex system—I guess Bruce was saying the expectations for payment systems do not need to be that high, certainly not that high for improving quality in current fee-for-service—I think we can do better than that.

I think these two principles, asking the providers themselves, the physicians themselves, are these changes that we have adopted going to improve quality, and, if they are confident about it, is there a measurable way to show it, would get us into a better place, and I think we can get there this year.

Senator CARPER. Thank you all.

Senator HATCH. Let me get into this to a degree, too. Some have suggested that the fee schedule will never separately work as long as the relative value of services is largely dictated by the AMA.

What do they call it, the RUC? Historically, as I understand it, CMS has accepted about 90 percent of their recommendations, except this last year, when it was about 60 percent. I think that is about right.

Now, I have three questions. One is this. Do you think this is a sea change in how CMS views the physician community recommendations, and do you view this as a positive or negative outcome to achieve greater stability in the fee schedule? That is number one.

Number two is, I am having a rough time figuring out how you really effectively bundle, which a number of you have mentioned in your remarks in various ways.

And, number three, what effect does—as a former medical liability defense lawyer, although it was a long time ago, I remember we used to tell them once they did away with the standard of practice in the community and opted for an open process that would take every case to the jury, we used to tell them, the doctors, "Look, you better make sure of your history. You can no longer rely on the standard of practice in the community. You better make sure your history has every possible consideration of their medical condition," even though a number of those tests really are not necessary. In other words, it led to unnecessary defensive medicine, which, from my standpoint, knowing what I did, about 95 percent of the cases that we saw coming through the office were frivolous cases brought to get the defense costs, which were considerable.

So those three things I am a little bit concerned about. Can we ever address the costs without addressing unnecessary defensive medicine and the terrible situation we have with the medical liability litigation in our society today?

So number one is, should we rely on the AMA or on this RUC, and is that 60 percent a valid thing compared to the 90–95 percent in the past? And then the other two questions as well.

Ms. WILENSKY. The adoption by the agency started between our two periods. It happened innocently enough. Once you had the Relative Value Scale in place, you needed to have a way to update relative values and to allow for a change.

The AMA, as best we can tell—Bruce and I have had this conversation, trying to piece together exactly what happened. Sometime after I left to go to the White House, before he was sworn in, when there was a lot going on, it was implemented. But, in its first year, the AMA approached the agency about whether it would allow it or like to have the AMA be the convener that would include all physician groups and make some recommendations, which initially were very minor adjustments that hardly affected the RBRVS at all. The agency accepted the offer.

It is important, and you have really indicated this by your mention of 90 to 60, the agency does not have to accept the recommendations by the RUC. It needs to have an outside convener. The question has been raised about whether the AMA is necessarily the best, although it is a big umbrella organization.

You want to include physicians, but the agency has the right to reject any of the recommendations it feels inclined to and occasionally has done so, and apparently used to do so in a bigger way. I do not know what caused the difference.

So it has the ability to take this on, but it would be very difficult for the agency internally to do this. It would want to contract with someone, and the question can be if this is the best group.

I would like to do one quick response to your liability question. I have been trying to encourage people to think about a quid pro quo for physicians. I do think that it is unreasonable to ask clinicians and institutions to practice in conservative ways, try to push them that way financially without giving them some protection if they are, in fact, providing good evidence-based care, and that is really the key.

And for me, it would be physicians who adopt the clinical guidelines of their own medical specialties—or you could convene special groups if you do not think they are always well enough developed—and follow a set of patient safety measures, which the Institute of Medicine has already developed. But, again, it could be reviewed to see if these are the best, but unless there is a case of criminal negligence, which occasionally can happen, these institutions and clinicians should be protected against liability.

There is a lot of debate among policy analysts about how much this drives cost and how much it drives defensive medicine. But, until you take it off the table in a way that seems fair, giving something in exchange for the patient, which is better reliance on evidence-based medicine and patient safety in return for protecting the institutions and clinicians, it will be there hanging over their head and be very unhelpful.

So, those would be the two things, I think.

Mr. SCULLY. Senator, in my testimony, I congratulated—I think the reason is Jon Blum who is a former staffer for Senator Baucus and the Finance Committee, runs Medicare, and it is voluntary. CMS has a very small staff. The lead doc who did this for 10 years at CMS left last year, and, traditionally, they took 95 percent of the recommendations because they do not have a lot of information.

I talked to Jon about it. I congratulate him. He has pushed back more in the past year than anybody else has, and I think that is very healthy.

So that does not mean the AMA is not doing the right thing. I just think it is—I have watched the RUC for years. It is incredibly political, and it just human nature. When you get the U.N. of docs together, of specialists who spend more money and more time and have a bigger impact, and they sit around a table—I have been to the RUC a couple times when I was the Administrator in Chicago. I can tell you war stories, if you all want to hear them, about trying to get pediatricians paid more. Magically, there are not any pediatricians on the RUC.

I had problems with them with immunizations years ago. So really it is all about political representation, and the AMA does a good job given where they are, but they are a political body of specialty groups, and they are just not, in my opinion, objective enough.

So, when you look at the history of it, CMS is starting to push back more, which is a good thing. I think it would be much better to have an arm's-length transaction where the physician groups have a little more of an objective approach to it. And that is the infrastructure of $80 billion a year in spending. It is not a small matter. It is huge.

Senator HATCH. Bruce?

Mr. VLADECK. Gail and I were talking about this issue of the RUC and the AMA a little bit before the session began, and we agreed that there needs to be some body outside of CMS to deal with these issues and look at the issues of changing the codes and technical updates and so forth.

The AMA is probably—even if they did the most objective professional job in the world, the appearance of conflict associated with it would over time, I think, be a problem.

I suggested to Gail that we contract it to Project HOPE, and she demurred. So I think we ought to give it to the Engelberg Center at Brookings to do. I think they could probably do a very good job of it.

But it is one of the pieces. We have to fix the RBRVS mechanism, and having a better way of updating it that is more transparent is a very important part of that subject.

On your other two issues, I, again, find myself in the uncomfortable position of largely agreeing with Gail on both the importance of liability reform and——

Senator HATCH. See how good we are for you?

Mr. VLADECK [continuing]. Its relationship to the development of quality standards and the development of safety standards and so forth. And there definitely ought to be a tradeoff. If we have professionally accepted standards and people meet them, that ought to be a defense against liability.

I do also want to respond to your third point very quickly, and, again, it is back to the suggestion I made about not prescribing bundles, but prescribing a generic methodology by which you could take a subset of the 7,000 codes, if you are a physician or a physician group, and say, "Okay, we are going to do management of knee sprains; we are going take a single price for the following 14 codes or 16 codes or 18 codes."

And the more sophisticated practices already have in their computers the bundles of codes they give for particular diagnoses. They

know what it costs them to produce. They know what they get paid for it.

If you had some general formulas and templates, they could go to their Medicare contractor and say, "Instead of paying us under the existing system for sprained knees, how about a fee of $714. That is 95 percent of what you are now paying, and we can make money at that."

That is, I think, the kind of bundling we are talking about, and I think you can leave it up to the individual physician practices. Again, it is very hard for a solo practitioner to do this, but once you have four or five or six guys or gals together, you can really do all sorts of neat stuff. And I would just say, let us have a formula by which you can do it and see what happens.

The CHAIRMAN. We are going to have to wrap up pretty soon here.

Anybody else?

Dr. MCCLELLAN. I was just going to add a couple more comments on Senator Hatch's questions. The point about bundling is right. You do not want to create yet another bureaucratic system for physicians. You want a system that will help physicians do what they think is the right thing for their patients. And Bruce and I think the rest of the panel have suggested some ways to do that.

And I want to commend you, Senator, and your staff for engaging the physician groups themselves, both at the national level and those in actual practice, including in Utah, for thinking about how to do this.

Small practitioners do not have a whole lot of technical infrastructure. There are some pretty clear ways, if you look closely at each specialty, in which they could get paid better through steps like what we have talked about today, and I think we will certainly hope to continue to work closely with you all to find the best way to do that.

I would add too that, to the extent that you do that, you take some of the pressure and power out of the RUC structure. And the RUC has taken a lot of criticisms for being too political, but let us face it: anytime you have a fixed pie and you are dividing it up between a bunch of different medical specialties, it is going to get political.

I think the nice thing about some of these reforms is that it moves the status away from being a fight among medical specialties to rather a unified effort across physician groups, different specialties, to get overall costs down through improvements in quality.

Now, all these debates are really focused on this 12 percent of Medicare spending that goes to physicians, when, if you would improve the way that physicians get financial support, you could do something about the 80 percent of health care spending that they influence. And even a small effect on those overall health care costs could do a lot to take the political pressure off this RBRVS process.

And I also agree with the points about liability reforms. It seems like there is unanimity here that that should be addressed too, to help physicians deliver care better.

The CHAIRMAN. John?

Senator THUNE. Thank you, Mr. Chairman.

I am just curious about how, since the 1997 SGR was created, there has been sort of the advent of physician-owned hospitals. You have also seen in some areas of the country more systems where you have physicians who are sort of working at hospitals, and how that has influenced utilization, those two different types of models.

And in a system-type approach, could you come up with a way in which you would sort of integrate the hospital and physician so you are not treating them differently in terms of reimbursement, so there is sort of an equality incentive for the entire system?

I realize that is probably a hard thing to answer because you have different ways in which these models are constructed out there, but, clearly, there is a question about—there is always a question, I think, about utilization and how that is shaped by various incentives that might be achieved in different types of models.

This is a sort of broad question. I know it is not an easy one to answer. But is there a way where you could get in a system-based approach where you would have sort of an integrated payment that would be incentivized based upon quality outcome, et cetera, where you would not have these sort of competing interests between hospitals and doctors?

Mr. VLADECK. We have, Senator, 12 hospitals in New Jersey at this minute operating under a system where, for all their Medicare cases, there is a permitted gain-sharing incentive with their physicians that essentially bundles the payment for in-hospital services for the physicians with that for the hospital, and the so-called Model 1 under the bundled payment demonstration that CMMI is conducting follows on that model.

Gail described earlier the cardiac bypass demonstration which began during her tenure, which was enormously successful, and we have been working on these ever since.

What happened was, we were ready to go with the next generation of them in the early 1990s, and then the Stark law was passed and the anti-kickback law became more aggressive. So the Inspector General got a seat at the table and decided they did not like this kind of common incentive, and it took 10 years to figure out how to put together projects that addressed their concerns, and so forth.

And the interesting thing is that the critical step in resolving the concerns of the program integrity people about having common incentives for physicians and hospitals was having robust quality measures and insisting on meeting the robust quality standards before anybody could get any incentive payments.

And so as I say, there are experiments in this regard going on at the moment. The preliminary results are extremely encouraging, and I hope we are going to see a lot more of them very soon.

Ms. WILENSKY. It is, of course, the purpose of the accountable care organizations to allow physicians and hospitals who have not been formally integrated to work together, show quality metrics, have auditable results, so that they can demonstrate savings, so that they would not then be subject to the Stark regulations.

So it has been an attempt—starting with the gain-sharing that Bruce talked about that has taken a long time, and now the accountable care organizations—to allow that.

The CHAIRMAN. This has been very helpful, more helpful than I think many other gatherings/hearings, and I deeply appreciate it.

I think the four of you should come up with some suggestions, short-term and long-term. That is, what do we do about physician payment reimbursement for this year, because we are going to be facing it, because the SGR is going to come up for a pay-for at the end of the year; and then, also, longer-term, how do we reform the physician payment system over the next several years?

If you could maybe let us know within a month. And I have not figured out yet in what form you are going to let us know, but let us keep that open for the time being.

But you have a lot of expertise. You have a lot of smarts and experience, a lot, and know a lot more about all of this than we do.

So I know that is a bit of an imposition. I sprung that on you and did not give you advanced notice, but I am doing it anyway. It would be great if, within about a month from now, we get together one way or another and see what you come up with. We will work with you. We really want to work with you. This is teamwork.

A lot of points came up here, and I know you will take them all into consideration and handle them in the appropriate way.

Thank you very much. The hearing is adjourned.

[Whereupon, at 11:48 a.m., the hearing was concluded.]

APPENDIX

Additional Material Submitted for the Record

Roundtable Statement of Senator Max Baucus (D-Mont.)
Regarding the Medicare Physician Payment System
As prepared for delivery

American historian and author Stephen Ambrose once said, "The past is a source of knowledge, and the future is a source of hope."

Today we begin the first in a series of roundtables about the Medicare physician payment system. This first discussion will focus on where things stand now and how we got here. We're joined by four former heads of Medicare who will share their expertise.

Congress enacted the sustainable growth rate, or SGR, in an effort to control overall physician spending and rein in Medicare costs.

But it hasn't worked as planned. The SGR called for cuts over the last decade, and Congress had to override them.

The cuts the SGR prescribed grew each time, and as a result, the problem has snowballed.

Under current law, a steep 27 percent cut to physician payments is slated to occur in January.

A cut that deep would put seniors at risk. It could mean they lose access to their doctors. We can – and we must – fix this problem. But we also have to keep working to restrain costs.

In the short-term, we need to guarantee seniors' access to their doctors. Over the long term, we need to find a solution that protects Medicare for future generations of seniors.

Today we'll look at the past as a source of knowledge. We want to understand the original purpose of the SGR. We'll consider the lessons we've learned and the path we're on now.

Our ultimate goal is to pay physicians in a way that results in high quality, affordable care for seniors. That's our hope for the future.

So let's take this opportunity to have a productive discussion. There's a lot we can learn from our guests, so I encourage them to speak frankly and be direct.

STATEMENT OF HON. ORRIN G. HATCH, RANKING MEMBER U.S. SENATE COMMITTEE ON FINANCE HEARING OF MAY 10, 2012 ROUNDTABLE DISCUSSION ON MEDICARE PHYSICIAN PAYMENTS: UNDERSTANDING THE PAST SO WE CAN ENVISION THE FUTURE

WASHINGTON – U.S. Senator Orrin Hatch (R-Utah), Ranking Member of the Senate Finance Committee, today delivered the following remarks at a committee roundtable discussion on the sustainable growth rate (SGR) formula within the Medicare physician fee schedule:

Chairman Baucus, thank you for convening today's roundtable on this important issue — one that affects our nation's caregivers and patients. This is a distinguished panel and an encouraging forum for promoting a bipartisan solution to the critical problem posed by Medicare physician reimbursement.

As many of you know, Chairman Baucus and I have both called for repeal of the flawed SGR payment formula. No one likes the annual end-of-year scramble to stop catastrophic payment cuts to physicians serving Medicare beneficiaries.

Yet, while there is broad agreement that our current situation is not tenable, a solution has eluded the Congress to date.

The flawed SGR policy really is a two part problem. The issue that typically receives our attention is how we pay for a repeal, or temporary fix, of the formula.

But the problem we hope to address today is more challenging.

How do we move beyond the SGR?

If we repeal the SGR or *freeze* physician payments for an extended period of time, we have only kicked the can down the road.

We have not fixed the system. We have only left it for others to address.

We must work toward a more permanent solution, one that makes real advancements in how we pay for and deliver care.

We must provide a stable foundation for paying physicians today and tomorrow, not five or ten years from now.

And we must accept that many of the proposals advocated for today are, at best, years away from broad implementation and, quite possibly, will never work for many sole practitioners or small group practices treating Medicare beneficiaries.

Chairman Baucus, thank you again for convening this roundtable. I look forward to hearing from our witnesses. My hope is that we will not get distracted by the budget issues with which we are all well aware. Instead, I look forward to a fruitful discussion about the steps we must take to address this complex issue and encourage practical and realistic solutions. I hope this is the beginning of a meaningful discussion for our Committee.

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Prepared Statement for the Senate Finance Committee, Roundtable on Medicare Physician Payment

Medicare Physician Payments: Understanding the Past So We Can Envision the Future

May 10, 2012

Mark McClellan, MD, PhD

Thank you for the opportunity to participate in this roundtable on the critical issue of Medicare physician payment – how we got here, and where we can go from here. This is centrally important for real health care reform, because physicians and the health professionals who work with them are the linchpin of our health care system. The support they receive influences everything – how and how well they are able to meet patients' needs, the quality of care, and the overall costs of health care.

Two previous bipartisan legislative efforts form the foundation of the current SGR problem. The first, legislation creating the Resource Based Relative Value Scale (RBRVS), was enacted in 1989. It led to the development of "relative value units" for each of the physician-related services paid for in the traditional Medicare program. This in turn led to an extensive regulatory process, initially to develop RVU weights and subsequently to keep them up to date, for over ten thousand specific activities. The goal of this effort was for the (relative) payments made by Medicare to accurately reflect the value of services. Not surprisingly, this system has always been marked by differences in views about how different kinds of services should be valued (for example, "cognitive" services like spending time diagnosing and advising a patient, versus technical services like performing a procedure or a scan). It is also difficult to keep all these relative values up to date as medical technology advances and expands. Perhaps most importantly, new services such as email consultations and new approaches to care such as nurse-

or pharmacist-led care management teams may not be included at all in the list of covered services. Or services may not be paid in proportion to their value. For example, a new diagnostic procedure that enables a physician to determine which patients will benefit from a costly drug or major operation will be "valued" at the cost of tests with similar inputs or measured effort, even though the value of this test to the patient who receives it may be far higher. RBRVS also assigns the same value to a service regardless of whether it is of lifesaving value for a patient, or little or no value at all. This matters as we head into an era of more personalized medicine, where the right treatment at the right time for each patient is increasingly individualized- where some patients with heart disease may benefit from a certain imaging procedure but others may not, and where some patients with breast cancer may benefit from a combination of chemotherapy treatments and others may do much better with other regimens. So, it's not really a "relative value" system so much as a "relative estimated average cost" system.

With the goal of controlling costs more effectively, the 1997 Balanced Budget Act linked the conversion of the relative value units to actual physician payment each year based on a national target growth rate – the "sustainable growth rate" or SGR. The SGR was intended to keep the growth in Medicare physician-related spending per beneficiary in line with growth in the nation's gross domestic product (GDP). In the early years of the SGR, when spending growth was lower than the GDP growth target, payment rates for physician services increased. But starting with the recession in 2002, spending growth per beneficiary began to exceed GDP growth. In 2002, payment rates were reduced accordingly, by 4.8 percent.

Every year since then, the SGR payment rate reductions have not taken full effect. Instead, because of concerns about access to care and the sufficiency of payments, Congress has headed off the full payment reductions on a short-term basis. Typically, this has involved offsetting at

least some of the budgetary costs with payment reductions affecting other Medicare providers. And these short-term patches have not kept up with inflation: between 2000 and 2010, the total cumulative increase in physician payment rates in the Physician Fee Schedule was 8%, while the "market basket" for physician services (the Medicare Economic Index) rose 22%.

Setting aside the problems for access and quality of care, one might argue that so long as Congress offsets these short-term fixes, at least there is no adverse budgetary impact. But because so much legislative effort ends up being devoted year after year to these stopgap measures, both physician organizations and Congress have much less opportunity to focus on reforms that could support real, physician-led improvements in care that reduce long-term costs. With each patch, actual Medicare physician spending moves farther and farther from the SGR target. Prior to a series of patches in 2011, the SGR projected payment decrease was 25%. In 2012, the payment rate reduction would have been 27.4% and in 2013, it is projected to be 27%. It's taking more and more money and more and more effort to do the short-term patches.

Medicare spending accounts for roughly 3.5 percent of GDP. Even with the scheduled SGR reductions and reductions in market basket updates for other types of Medicare providers enacted in the Affordable Care Act, Medicare expenditures are projected to surpass 5% of GDP by 2030. Medicare physician spending is only 12% of these costs, yet physician decisions influence over 80% of health care spending. Instead of trying to achieve overall cost savings by disproportionately squeezing physician rates, or by increasingly trying to "spread the cuts" across other providers facing tighter and tighter payment rates, this legislative effort might be better devoted to identifying changes in how physicians are paid in Medicare – focusing on opportunities for improving care – that could lead to overall cost savings by promoting needed changes in how health care is delivered.

As you know, the goal of changing how physicians are paid in Medicare and getting out of the cycle of SGR patching has long been a bipartisan goal in Congress. I had the privilege of testifying on this topic six years ago, when I was CMS Administrator. I noted that if Medicare could implement physician payment reforms that better align payments with the care that physicians know can lead to better quality and lower overall costs, we could both relieve the financial pressure on physicians and get some of the savings needed to make the overall Medicare program more sustainable. Since then, two things have happened. The need to reform the SGR in a way that helps achieve overall Medicare cost savings has vastly increased. And the opportunities for doing so have become clearer. Thanks to the early attention and leadership from the Finance Committee and other members of Congress from both political parties, this year may be different; it may be the year when real alternatives to the SGR system emerge.

I believe that several steps are needed for that to happen. The first critical step is leadership from the physician community. Needed physician payment reform should support real health care reform, and no one knows better than physicians and other clinicians about how to answer the key question: where are the best opportunities to improve care and avoid unnecessary costs for their Medicare patients that are not well supported by Medicare's current payment systems? Every day, physicians and health care professionals see opportunities to improve the value of care, but the way that Medicare pays often works against them. They know best which services are reimbursed that may be of little value to particular patients; and they see the services that aren't reimbursed much if at all that may be tremendously valuable in preventing costly complications. Despite knowing this from their practices, clinicians can't implement the changes in care needed to improve quality while lowering costs, while still making ends meet in their practice. Or at the very least, it's becoming increasingly difficult to do so with tighter and tighter

regulated payments. So by saying that clinical leadership is needed to get out of this cycle, I mean physicians and other clinicians must identify ways that, in aggregate, could add up to meaningful system-wide savings.

The second step closely follows the first: translating the clinical opportunities for improving care into Medicare payment reforms that better support high-quality, patient-centered care. This means identifying the current payment rules in the fee-for-service/RBRVS system that, however well-meaning, don't do as much as they could to help promote the kind of efficient, high-quality care that physicians would like to provide – care that emphasizes prevention, getting the right treatment to the right patient the first time, and coordinating a patient's care more effectively.

As I noted, I think the opportunities for doing this are better than ever, thanks to the growing examples of clinical leadership that is using payment reform to support care improvements all over the country. At the Engelberg Center for Health Care Reform at Brookings, we have been working with a number of clinical groups and medical professional societies who are earnestly engaged in these types of real reform despite the obstacles.

For example, the American Society of Clinical Oncologists and many of their affiliated oncologists have been developing ideas on how to provide more time and resources for making sure that their cancer patients get the best care for their needs based on the latest medical evidence, and that complications leading to emergency room visits and hospitalizations are prevented, by shifting how they are reimbursed. Currently, oncologists treating Medicare patients have to cover a large part of practice costs using the margin between what it costs them to obtain chemotherapy drugs and what Medicare pays to administer them. At the same time, oncology practices get relatively little support for doing many of the things that their patients need, things

like spending time working out a treatment plan that meets each patient's individual needs; managing patient symptoms; and coordinating care across a diverse range of providers. The reform effort here involves identifying ways to shift some of the payments currently provided through the drug administration margin toward payments that are more directly tied to what the oncologists and their patients want – better evidenced-based care, more resources for managing individual patient needs and preventing complications. This might include extended nurse hours, greater availability to consult with patients who might otherwise progress to needing an emergency room or hospitalization, working out an individualized treatment plan with each patient, and many other areas. Several pilot payment reforms have been implemented, including bundled payments for chemotherapy episodes that are no longer tied to giving more intensive chemotherapy and increasing drug margins; instead, the bundled payment provides support for the treatment protocols that the physicians determine are most appropriate, and is tied to a set of quality measures that support oncologists in focusing more on getting their patients the care they most need.

As another example, cardiologists around the country and the American College of Cardiology are taking steps to identify and better support high-quality care for cardiovascular diseases. Clinically informed payment reforms involve both chronic conditions such as congestive heart failure, and aspects of care where cardiologists have identified unnecessary or inappropriate care. Payment reforms such as bundling a limited portion of the fee-for-service payments for these types of procedures could give cardiologists better financial support for setting up registries for tracking their patients, coordinating care, and avoiding the need for high-cost interventions as well as preventable complications. Cardiologists are also exploring care coordination models for patients with chronic cardiac conditions, where cardiologists and primary care doctors together

can share in the savings for coordinating the care, promoting shifts in care to lower-cost settings, the use of "tele-consults" and other electronically-supported consultations where appropriate, avoiding referrals that can be handled in primary care settings, avoiding unnecessary or redundant imaging, and promoting more rapid and efficient referral and treatment of higher-risk patients.

Many other medical specialties are also working on innovative approaches to payment reforms linked to opportunities to improve care in their clinical areas. Nephrology is actively working to build on bundled payments for ESRD, such as payment reforms that promote better vascular access with fewer complications, and exploring options for patients with chronic renal insufficiency. Surgeons are learning from and refining bundled payment reforms for common surgical procedures in ways that make it easier to implement reforms that prevent complications, improve transitions, and reduce readmissions. Radiologists and pathologists are working to better define their role in the provision of certain services in a range of clinical areas, doing much more than reading and interpreting tests, for example participating actively in coordinated-care teams to help patients get the right tests as quickly and efficiently as possible.

Along with these expanding efforts across a diverse and growing range of medical specialties, thanks to leadership in primary care, we also have a rapidly improving knowledge base for Medicare payment reforms affecting primary care services. Many "medical home" reforms have already started shifting primary care payments away from traditional fee-for-service payments, which have been squeezed to become less and less adequate to support managing each patient's needs. The medical homes are moving toward payments that are more related to higher-quality primary care and care coordination. For example, our Brookings-Dartmouth Accountable Care Organization Learning Network is working with a number of organizations who are linking

medical homes with accountability for achieving better population health and lower overall care costs. These reforms give primary care providers the kind of financial support that reflects their central role in achieving better outcomes for the population of patients that they serve; in these payment reforms, a one- or two- percentage-point savings in overall health care costs resulting from better primary care and care coordination translates into a much larger percentage improvement in the resources available to primary care providers to achieve the savings. That's the right kind of payment reform leverage: even limited changes in how physicians are paid can have a disproportionate impact on overall health care costs, because what physicians do is so important for overall health care costs.

Many of the most promising examples that we have seen in supporting better care with reformed physician payment share several common elements. First, they don't simply hope for savings to materialize: physicians involved in these payment reforms take some portion of payment out of the current fee-for-services structure and convert it to payments that they can more easily use to provide the care that their patients need. Within a clinical area, whether primary care or specialty care, this means moving at least a small piece of fee-for-service payments into a "case management" or per-patient payment related to the clinical goals of better quality and better outcomes. Case management payments allow flexibility for physicians to invest in clinical practices and infrastructure that maximizes their ability to treat patients in clinically appropriate ways while not reducing their income due to the reductions in billable procedures that would otherwise occur. Across different kinds of clinical care, some fee-for-service payments may also be moved into "care coordination" payments to better support the providers working together, for example primary care physicians and oncologists, or cardiologists and radiologists. Care coordination payments on the other hand allow for tighter collaboration and information sharing

between physicians and provider settings for complex patients with chronic and other complex conditions. Cancer patients, ESRD patients, CHF patients and patients with multiple chronic conditions require careful attention to coordination among the specialists providing their care in order to minimize costly complications, redundant or unnecessary tests, and other care breakdowns. A care coordination payment model that takes a portion of the existing fee-for-service payment to the different providers and redirects it to support this coordination makes it easier for providers to work together to improve care, and thus lower overall costs. By shifting physician payments in the directions that physicians have identified as having the most promise to improve care, both within their specialty and through better coordination across specialties, physicians can be protected financially while getting more support for doing what they think is most important for their patients.

Second, to the extent that these reforms in payment lead to improvements in care and resulting overall cost savings, total physician compensation can increase in an actuarially sound manner. Medicare and private payers are currently implementing many "shared savings" outside of the physician payment context that enable providers to get more financial support when they take steps that lower overall costs. Building on the work to date, the steps described here can give physicians the support they need to improve care. Under the fee-for-service SGR system today, physicians not only get little support for the improvements in care described here; instead, their payment rates get reduced no matter what they do. With these reforms, providers who take steps to improve care in conjunction with these payment reforms can get paid more.

I've been focusing on physician leadership in, first, identifying opportunities in their specialty and across specialties for improving care, and second, matching these opportunities to reforms in Medicare's physician payment system. That is the best foundation for improvements in care that

can help reduce cost pressures in Medicare. I want to conclude by thanking you for your leadership on addressing this challenge; this is also an essential step in reforming the SGR. By starting now, and by working on a bipartisan basis to avoid another cycle of short-term SGR patches, it is possible to turn these opportunities into real Medicare reform. Thank you for the opportunity to participate in today's roundtable, which is addressing one of the most important issues for effective health care reform.

Testimony Before the Senate Finance Committee

"Medicare Physician Payments: Understanding the Past So We Can Envision the Future"

Tom Scully, HCFA/CMS Administrator May 2001-January 2004

The Medicare Volume Performance Standards (MVPS) and its successor the Sustainable Growth Rate (SGR) have been: (a) a success in that it is the only legislative and regulatory attempt in the last 40 years to track and react to growing Part B physician related services; and (b) a disaster in that its worthy goals have proven unworkable for both Congress and CMS, and created an unfair burden for individual physicians who are subjected (unlike any other part of Medicare) to global caps driven by nationwide physician behavior that they have no ability to impact or control.

In the Administration of President George HW Bush I was intensely involved in the effort to pass the initial RBRVS/MVPS legislation in 1989. I still believe it was a worthy, but flawed, effort that was done with the best of policy intentions. I have attempted to give a brief historical overview before getting into policy issues.

Historical Points

1989- Passage of the Resource Based Relative Value Scale (RBRVS) was a very bipartisan affair. Medicare Part B spending was projected to grow at 15% a year (under the old "cost" payment system) as President George HW Bush began his Presidency, with a Congress that had large Democratic majorities in both the House and Senate. Part B reform topped the health care agenda, with a proposal from Harvard Professor William Hsiao (RBRVS) leading the debate around reforming and restricting physician payment.

In the House, Ways and Means Chairman Rostenkowski, and Health Subcommittee Chair Stark were in favor of reform, but wary. Subcommittee Ranking Member Gradison was a supporter, but the bulk of Republicans initially supported the AMA in opposing the RBRVS reforms.

In the Senate Democrats, including Finance Committee Chairman Bentsen, were also warily supportive, as were Minority Leader Dole, and Ranking Finance Republican Packwood. But the Senate bipartisan effort was really led by Finance Committee members Senator Rockefeller and Senator Durenberger.

The Administration team was Dr. Bill Roper (now Dean of the UNC Health System), also a former HCFA Administrator under President Reagan, and at that time Deputy Assistant to the President for Domestic Policy; and me -- then the Associate Director of OMB for

Human Resources, Veterans and Labor. Nick Calio, then in WH Legislative affairs, was also very involved in the Congressional effort.

The AMA and most other specialty groups aggressively opposed RBRVS from the start—deeming them "Expenditure Targets" and flooded the Capitol with "No ET" buttons—and consistent opposition all through the Spring. In March, Democrats were wary and most Republicans were fundamentally opposed. President Bush had good relations with the Democratic Congress—especially Chairman Rostenkowski, and they both wanted physician payment reform. The White House was told that Democrats would support RBRVS—if at least half the GOP members on each of Finance and Ways and Means supported it. We worked through months of hearings and markups, garnering the needed Republican support in both Committees. It passed, with considerable effort by leaders in both parties, over the very agitated opposition of America's doctors, in the summer of 1989. It was a model of legislative cooperation and compromise. If only the policy had been sound!

Still it was a considerable improvement over the prior, even more flawed system.

1992- Implementation. It was a complex piece of regulation, and HCFA at the time did not have the staff resources to evaluate and assign weights to various services and practice expenses. Additionally, the very capable HCFA Administrator—Gail Wilensky-- left HCFA in February 1992 to join the White House staff. As I remember it, the then Acting Administrator, a career HCFA regional director, understandably concerned about the complex assignment facing the agency, turned to the AMA for help.

As a result, from the beginning AMA's Resource Value Update Committee (RUC) took a central role from the start in assigning weights and making recommendations on payments in Medicare. Bruce Vladeck and Gail may remember it differently-- but by the time Bruce came to HCFA a year later, in 1993, the RUC was firmly imbedded in the process.

You can't blame the AMA. They were doing a good job for their members by taking over the process. But it was a fundamental error for HCFA to delegate that authority—because the RUC quickly became very powerful, very political and very responsive to the stronger specialty groups, and many believe it limited the ability of the RBRVS/SGR system to make appropriate changes.

1992-97- The MVPS system had its flaws, and relatively few teeth. From 1992-97 it worked reasonably well, and spending and performance generally stayed within the parameters of the system. Still the deficit grew, and pressure mounted for Medicare spending reductions.

1997- In another bipartisan budget deal, President Clinton and Congress made large "cuts" in Medicare spending. Hospitals, nursing homes and home health were hit particularly hard-- causing chaos in each sector. Congress spent much of the next 4 years

adding back funding to each of these sectors—and the '97 budget bill was the hardest in this generation on providers.

The AMA and physician groups, early in that process, offered to Congress that their "contribution" to deficit reduction would be tightening the RBRVS system (the resulting new formula was the Sustainable Growth Rate). They swapped long term reform—giving the SGR teeth—for avoiding the immediate cuts that hammered other providers. It looked like a great call at the time, but it directly caused the messy situation of the last 15 years. Of course service volume growth and GDP growth contributed mightily—but only physician spending was subject to the "spending target and automatic cut" mechanism.

2002- The SGR hits for the first time. Unfortunately, I was the Administrator at the time. There were many efforts to fix the formula in Congress, but none proceeded—so there actually was a 4.8% reduction in payments in 2002, as dictated by the SGR formula. The unhappiness created by that cut generated the pressure to defer all subsequent SGR cuts—and the budgetary hole the system now faces.

2010- Part B drug spending was taken out of the SGR administratively. It helped relieve the pressure a bit, but not much. I was always amazed at the structure HCFA adopted in 1992, that RBRVS/SGR measured drug spend—but penalized only physicians when the drug spend accelerated? Instead of removing drugs, one could argue that Part B drugs should have been subjected to some other restraint mechanism.

Regulatory Structure—AMA and the RUC

From its inception, HCFA delegated most of the relative value discussion to the RUC. Traditionally, 95% plus of the RUC suggestions were followed, simply because HCFA did not have the staff resources to replicate what the RUC process could do, and because the AMA and specialty groups became so vested in it. The RUC became far more than advisory. It has become very political, and the AMA's role has given it far too much leverage in the medical professions, and the power it wields has made any significant change difficult.

In a 2010 New England Journal article, Paul Ginsburg stated that:

> in the 2002 five year review, 900 codes were identified [of about 6500] as improperly valued. 750 were reviewed – and 477 went up, and only 28 went down.

This outcome is not shocking, in fact it is understandable. Doctors were stuck in a finite, budget neutral "shark tank." Every new code added, or procedure that was increased had

to come from the hide of another procedure or specialty. So increasing primary care values had to be offset from surgeons or radiologists, etc—not an easy thing to do in the UN of Medicare physician payment.

Changing or dropping the SGR is essential. Still, removing the structure of the SGR may also relieve any sense of Part B discipline if it is not replaced with some other structure. Unless the system is well designed, is every new code and procedure a new expense that is not offset? If a value goes up, must another go down? Retaining some sense of budget discipline in the system is critical, or inevitably there will be bigger and less surgical cuts to restrain volume and spending.

The RUC serves an essential purpose in evaluating services. But in any reformed system it should be removed from the AMA and operate as an independent body, likely through a contractor reporting to CMS directly. The current structure is far too political and the existing structure makes objective assessment and reallocation almost impossible.

Under the current administration, it appears that CMS is asserting itself more, especially through Jon Blum, the Deputy Administrator for Medicare, to make the RUC truly "advisory", and they should be congratulated for that effort. CMS and objectivity should be driving valuations, not physician politics.

Other Policy Suggestions

MedPAC recommendations here are hard to disagree with, though obviously any "fix" is painful to physicians due to future freezes and cuts—and costly due to the needed "offsets". As MedPAC itself said (March 2012. Pg 87):

> the Commission stressed that Medicare must ultimately implement payment policies that shift providers away from FFS and toward payment policies… that reward improvements in quality, efficiency and care coordination- particularly for chronic conditions. Accordingly the Commission recommended incentives in Medicare's accountable care organization program to accelerate this shift because new payment models- distinct from FFS and SGR- may have greater potential to slow volume growth while also improving care quality. Similarly, incentives for physicians and health professionals to participate in the newly established Medicare bundling pilot projects could also improve efficiency across sectors of care.

AMEN!

Clearly "bundling" of services is the future. Pure fee for service reimbursement simply can't be expected to change behavior or to drive better results. There are a few obvious courses to take that should be accelerated:

- Accountable Care Organizations, ACOs. Are a great idea, if designed properly, and they are already changing the market and the way physicians look at care delivery. Not just in Medicare, but in commercial markets, physicians are again organizing to take risk—and to look at comprehensive patient care. It may be a small step—but a good one. The model has been there in California and elsewhere for years—and it is the only obvious answer: get physicians invested in the entire care system.

- Acute Care Episode (ACE) program. This demo combines hospital and physician services in the acute care setting, bundling doctor and hospital payments. It clearly works, saves money for Medicare while increasing compensation for the doctors and margin for the hospitals. It should be rapidly expanded.

- Post-Acute Bundling. It is evolving with CMS demos, and it is inevitable that global capitation, or a post-acute DRGs are coming in the near future. For doctors, this must include folding Part B reimbursement into these bundles. This will align their incentives with their post-acute provider partners. These costs are predictable, and CMS should move away from physician FFS in these settings and toward global post-acute capitation.

- ESRD Bundling. Dialysis patients see a provider 3 times a week—for 3-4 hours. No other patients encounter providers as often. Bundling ALL services an ESRD patient gets, including physicians, into a capitated plan, makes complete sense, and it is the most readily available bundle there is.

Medicare Advantage—The Ultimate Bundle. If you: (a) bundle pre-acute care; (b) bundle acute care and (c) bundle post-acute care; and combine them all into one bundle—you get Medicare Advantage? This bundle travels under other names-- The Federal Employee Health Benefits Plan (FEHB) and TRICARE. Medicare Advantage has its flaws, but private insurers and systems, when (1) appropriately paid and (2) well regulated can coordinate care to reduce volume and drive better behavior and performance. As Senator Wyden has discussed, a well-structured Medicare exchange that assures appropriate benefits can indeed provide better value.

From a Medicare budgeting perspective, the essential concept is to provide the right incentives to deliver more efficient care at reduced costs. Medicare Part D has accomplished this—and it can also be done in the broader program.

Medicare FFS: Today only 25% of beneficiaries are in Medicare Advantage, and I know I will be long gone before Medicare FFS is? So, we must make Medicare FFS work as effectively as possible as the program modernizes. Thus, redesigning a new RBRVS/SGR system to "make the trains run on time" as we gradually move to bundling and capitation, is one the critical challenges facing Congress—and the doctors and patients you represent.

As a die-hard capitalist, I honestly believe that well regulated private plans and systems will deliver these benefits most efficiently. Yet, I care deeply about the Medicare program and the vulnerable beneficiaries that it protects. Therefore I am also concerned that the next generation of Medicare FFS be well designed to maximize the level of services available to the majority of beneficiaries that will remain in the traditional program for years to come.

STATEMENT BY BRUCE C. VLADECK, PH.D

Roundtable on "Medicare Physician Payments: Understanding the Past So We Can Envision the Future"

Committee on Finance
United States Senate
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Introduction

Mr. Chairman, members of the Committee, fellow members of the Administrators' Alumni Association, it is a privilege and an honor to have been invited to participate in this Roundtable today. I congratulate the Committee for its willingness to confront the difficult issues surrounding Medicare payments to physicians, and for its creative efforts to provide a novel forum in which to explore them.

I wrote a couple of years ago that the Sustainable Growth Rate (SGR) and other aspects of the Medicare Physician Fee Schedule (MPFS) presented an extraordinarily difficult knot of interconnected policy and political problems. The intrinsic difficulty of the issues is compounded by the current political environment, the pervasiveness of a variety of hidden agendas on the part of major stakeholders and decision-makers, and the desire of many members of the policy community for conceptual and technical elegance, occasionally at the expense of attainable progress. I fear that all of those forces make identification of practical, achievable solutions to the problems more difficult, if not impossible.

Any health care financing system must address, among many other issues, two basic questions: how to pay physicians, and how to limit the costs both of direct payments to physicians and the related behaviors such payments may encourage or deter. If we start from that basic point, I believe we can better explain some of the problems associated with the MPFS and the SGR. By applying a little common sense, and remaining skeptical of all-encompassing or overly sweeping approaches, I think we might also begin to see our way clear to a means of exiting the box in which we find ourselves. The case for proceeding incrementally and pragmatically is further reinforced, I would note, by the surprisingly poor quality of most of the data we have about physician practice, physician incomes, and physician practice expenses. Physician services are a $500 billion-a-year industry, frequently employing some of the world's most advanced technologies, but the system's fragmentation, proprietary interests, and

diffusion of accountability have left us with remarkably little information about some of its most important characteristics.

Paying Physicians

There are really only a few basic ways to pay physicians. You can pay them specific fees for specific services, as most American and Canadian physicians, and many physicians in the rest of the world, are paid. Those services can be highly fragmented and itemized, or highly bundled, as is the case for most obstetricians and other surgeons. You can supplement that system with bonuses or penalties tied to any number of performance parameters, from quality to group profitability. You can pay a salary – a flat amount for a defined period of work – although many salaried physicians in this country also receive incentive payments tied to the quantity of services they provide. Or you can pay physicians per patient, as primary care practitioners in the British National Health Service are paid; such payments can be designed to cover just the physician's income and practice expenses, or also include an at-risk provision for separately billable services the physician orders. Each of these approaches has advantages and shortcomings, and none is inherently more virtuous than the others. Rational policymaking will thus require efforts to maximize the system's advantages and counteract its shortcomings. But in a health care system like that of the United States, where we insist on multiple independent payors and a sharing of responsibility between public and private sectors, it's hard to escape fee-for-service in some form.

I know that much of the current conventional wisdom in American health policy discussions portrays fee-for-service payment of providers as somehow inherently evil, and the source of most of our problems with health care costs and quality. To put the matter as politely as I can, that view is logically powerful, but inconsistent with the facts. Health care systems in nations that provide higher quality care at lower cost than the United States pay their physicians fee for service, and many of the health

systems in the United States we most admire for their high quality and parsimonious resource use developed in a world of fee-for-service payment, and still derive a considerable share of their income from fee-for-service payments. Most capitated health plans pay physicians fee-for-service, either directly or through sub-capitation to large physician groups which in term allocate the funds at least partially on the basis of volume. In other words, the payor may perceive that it is making capitated or bundled payments, but the individual physicians are paid fee-for-service, or some amalgam of salary and fee-for-service-based incentives. The proportion of physicians paid on a fee-for-service basis in low-cost, high quality Medicare service areas is not that dissimilar from that in high-cost, low quality markets.

Fee-for-service systems do contain a built-in incentive to oversupply certain services. That's the problem the SGR was meant to solve, which I will discuss later. But salary systems contain the symmetrically opposite incentive – to underprovide services – a lesson many hospitals learned to their sorrow in the wave of physician hiring and practice purchases in the 1990s. And just as there is no absolutely "correct" way to pay physicians, there is no abstractly correct price for any particular service, or level for any particular salary. In the early years of the Medicare program, it sought to pay physicians the "market price" for their services, but that market was badly flawed and seriously distorted, and we have been struggling to come up with something better ever since.

From a policy perspective, what is important about a physician payment system is not only the absolute level of prices, but the relative levels. The pre-MPFS market, it was widely believed, overpaid specialist services at the expense of primary care, and provided inadequate incentives for physicians to locate their practices in rural or low-income communities. The MPFS was designed to fix that. Through development and adoption of the Resource-Based Relative Value Scale, it was supposed to provide a "scientific" basis for the relative prices of different physician activities, which would have the expected

effect of narrowing the payment gap between "cognitive" and "procedural" services, thereby narrowing the gap between primary care and specialist incomes. Other components of the MPFS were designed to redress the imbalance between rural and inner-city practitioners, on the one hand, and those based in more affluent areas.

There is some data that suggests that, in the early years of the MPFS, the intended effect of transferring expenditures from procedural to cognitive services was achieved. By the late 1990s, however, the effects of the system began to swing in the opposite direction due, it is generally believed, to the process by which the Relative Value Scale is updated. Certainly, the income disparities between primary care physicians and specialists have continued to increase throughout the last decade. While not the sole cause, that widening gap is generally believed to contribute to the growing shortage of primary care physicians in many communities, which will substantially worsen if current trends in specialty choices among medical school graduates continue. Primary care residency slots go unfilled while some of the more lucrative specialties are oversubscribed.

It's important to emphasize that the misallocation of spending between primary care and specialist physicians is not just a Medicare problem. In the absence of alternative benchmarks, many private payors and organizations that employ physicians use the Relative Value Scale as the basic metric of physician services. Physician productivity is measured in Relative Value Units, and physician compensation systems – including many salaried systems in employment settings, group practices, and faculty practices – generally use RVU-based measures. Based the available data, the disparity between primary care and specialist payments is at least as severe in the private sector as it is in Medicare, although both private and public payors have taken steps in recent years, such as supplemental payments to Primary Care Medical Homes, to redress some of that imbalance.

If we're going to stanch the hemorrhaging of physician-provided primary care in many of our communities in the foreseeable future, we're going to have to find a way to substantially improve the income of primary care physicians, and because of its place in the market, Medicare will have to play its part, if not take a leading role. Of course under current budgetary constraints, not to mention the problems posed by the SGR, it may appear hard to identify where those funds might come from, although MedPAC and others have suggested that they might, over time, come at least in part from a reduction in the fees paid to certain specialists. Obviously, members of the specialist community object strenuously to such proposals. I note three things in this regard. First, by any standard of international comparison, American specialists are extremely well-compensated compared to their counterparts of similar training and experience elsewhere, both in absolute terms and relative to primary care physicians. Second, the concern that reductions in relative Medicare fees to certain specialties might create access problems for Medicare beneficiaries should be considered in light of the extent to which Medicare beneficiaries constitute a disproportionate share of all patients for many of the best-compensated specialties. On the other hand, I would restate the earlier point that there is no abstractly correct, Platonically precise means of determining either absolute or relative physician payments. In a badly flawed, imperfect market, the choice is ultimately social and political, and I don't envy you the responsibility of making it.

Controlling Costs

Regardless of payment system, payors need a method to determine updates, customarily applied annually, to reflect input price inflation, changes in technology, changes in utilization patterns, and policy objectives. Since the enactment of the Social Security Act Amendments of 1972, and more systematically since the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), the Congress and

successive Administrations have developed and applied prospective formulas with the primary objective of controlling the rate of increase in Medicare expenditures. Such policies or formulas apply to every category of Medicare fee-for-service coverage. Most are adjusted annually, or once every several years. Many are controversial, and not all of them work as well as policymakers might hope. But only the SGR creates the kinds of problems that have absorbed so much energy, and have created so much anxiety in the policy community, over the last decade.

The SGR has become such a problem, I would suggest, for two reasons. First, it is the only one of the formulas for annual Medicare payment updates that relies so heavily on a measure wholly outside the health system. Why the Congress chose in 1997 to cap the rate of growth in Medicare physician payments at the growth in real GDP per capita is unclear to me, but doing so was clearly a mistake. While limiting the growth in health care expenditures to the growth in the overall economy may be a laudable goal to shoot for over time, it is a far more stringent standard than payors, public or private, in the United States and elsewhere, have generally been able to meet in the absence of extraordinary circumstances. Further, to impose such an exogenous benchmark on one set of services, comprising less than one quarter of Medicare outlays, while using other update formulas for other services, makes policy distortions almost inevitable. In the case of physician fees, those distortions run directly counter to the broader policy goal of migrating an increasing share of Medicare services from institutional to office and home-based care. Still further, while it might be desirable, in the abstract and in general, to more closely link changes in Medicare outlays with changes in the broader economy, precisely one of the reasons why Medicare Parts A and B (along with Social Security) operate through Trust Funds is to dampen the short-term impact of macroeconomic fluctuations and ordinary workings of the business cycle on payment systems where some modicum of stability is critical to providers and patients alike. The experience of the last decade, in which real GDP per capita actually fell, was clearly not anticipated by the creators of the SGR, but has made that problem all the more acute.

The deficiencies of the SGR are compounded exponentially by its relationship to the processes required by the Congressional Budget Act. When Medicare mis-guesses about expenditure growth in non-physician services for any given year, as it also often does, it has a variety of mechanisms to compensate for those errors in future years. While those corrections sometimes generate some controversy –most recently on the issue of changes in hospital inpatient coding – they can generally be handled in the course of routine annual business. But the formula driving the SGR is cumulative, to the date of origin of the policy, so the difference that needs to be corrected grows every year. Further, because of the way the SGR is defined in the statute, the cumulative gap grows every year, compounded, throughout the budget projection period.

Thus, I was astonished to learn that, while the CBO estimates the cost of permanently "fixing" the SGR at something in excess of $250 billion, the actual differences, through the end of calendar 2011, between the targets the SGR formula produces and actual Medicare outlays since the enactment of the SGR are less than $13 billion, or roughly 1.2% of total outlays. I think I thoroughly understand the logic of budget projections and the difference between a current law baseline and a baseline adjusted for policy changes, but there is something fundamentally irrational about a formula that requires a fee reduction of 27% to recoup a difference of just over 1%. A similar logic applied to an ordinary commercial obligation would violate every anti-usury law I've ever seen.

In other words, we have been paralyzed on Medicare physician payment issues for the better part of the last decade because of the projected variance over ten years between two hypothetical lines, one projecting the SGR target and the other actual MPFS outlays. Replacing the SGR with something more sensible, and easier to adjust in the face of changing circumstances, would neither change any underlying economic facts nor have an overwhelming effect on the federal deficit or policies that are constructed to address it. But I fear that short-term political dynamics often frame the discussion in

ways that confuse the unavoidable arbitrary conventions of the budget process with some underlying reality.

And this is not just a theoretical problem, or one confined to discussion of Medicare physician payment policy. As was illustrated in this year's most recent "fix" to the draconian, SGR-mandated reductions in physician's fees, the Congress increasingly turns to other parts of the Medicare program for offsets, even though those other providers are already experiencing significant reductions in Medicare payments mandated by the Affordable Care Act, the Budget Control Act, and various other legislation. These incremental, piecemeal actions have tangible effects on hospitals and other health care providers already struggling to keep their economic heads above water, and they also make more systematic, comprehensive Medicare reform more difficult, not easier. It would actually be much more sensible, political considerations aside, for this or the next Congress to simply acknowledge that its predecessors made a mistake, repeal the SGR, and replace it with an update factor of the sort that is now employed for hospitals or ambulatory surgical centers or home care agencies. Even more elegant update formulas could also be designed, although I would suggest that simpler is generally better, especially because circumstances will inevitably change and the formula will probably have to be altered again in the next year or two.

Conclusion

In summary, I don't believe that what I'm proposing is that novel or unconventional; each part has been proposed by others more knowledgeable than I in recent years. We should create separate conversion factors for the Medicare Physician Fee Schedule that reward Evaluation and Management Services more highly than others, pending a thoroughgoing overhaul of the Resource-Based Relative Value Scale. And we should abolish the SGR and replace it with an alternative update factor similar to those which apply to other Medicare providers. This is not, at root, a conceptual problem, but a challenge to the

willingness of both Congress and the Administration to cut through political symbolism and inside-the-Beltway minutiae to permit the application of some common sense, no matter how fleetingly. The last decade does not provide much basis for optimism on that score, but I think you, Mr. Chairman, and your colleagues on this Committee, by your presence here today, reaffirm my confidence in your ability to accomplish that.

Again, I'm most grateful for the opportunity to appear before you today, and I look forward to participating in the discussion today and in the future.

Thank you very much.

Medicare Physician Payments: Where We've Been; Where We Need to Go

Presented to

Committee on Finance Round Table
United States Senate

By

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On

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Chairman Baucus, Senator Hatch and members of the Finance Committee. Thank you for inviting me here to participate in a roundtable on Medicare Physician Payment Reform. My name is Gail Wilensky and like the other members of the roundtable, I have had the honor and privilege of directing the Medicare and Medicaid programs. I served as the Administrator of what was then called the Health Care Financing Administration, now named the Centers for Medicare and Medicaid Services, from Jan. 1990 to March of 1992. I also chaired the Physician Payment Review Commission from 1995 to 1997 and chaired the Medicare Payment Advisory Commission from 1997 to 2001. I am currently a senior fellow at Project HOPE, an international health education foundation.

Because I was the administrator when the RBRVS was implemented and perhaps because of my experience with other Medicare commissions, as well, I've been asked to provide some historical background as to how we have gotten to the position that we are now in where there is a high level of dissatisfaction with the way physicians are currently reimbursed under Medicare but little agreement about what type of reimbursement system should take its place. There is also the not insignificant hurdle that moving away from the current system would cost more than $271 billion.

As the members of Congress know only too well, each year since 2003, Congress has felt forced to step in to prevent physicians who provide care to Medicare beneficiaries from experiencing a reduction in fees. Early on, the threatened

reduction was in the neighborhood of 4 to 5 percent. Next January, the threatened reduction in fees is 27 percent. Although it is difficult to imagine such a drastic cut occurring, given what it would likely do to beneficiary access, it is also not obvious what Congress is prepared to do to avoid this latest threat.

Medicare's Payment Origins

When Medicare began, it modeled its payment strategies on the way Blue Cross and Blue Shield, the dominant form of insurance in the mid-1960's, paid hospitals and physicians. Like the private payers of that period, Medicare based its reimbursements to both physicians and hospitals, on the amounts that had been historically charged for various health care services. In 1984, when the program adopted a prospective payment system for hospitals, moving away from a charge-based per diem rate, it introduced the use of the Medicare Economic Index (MEI)—a measure of the annual increase in physician practice costs—for updating physician reimbursement. This not only marked a divergence with charge-based reimbursement but it also marked the beginning of a divergence between Medicare's reimbursement for physicians compared to the way Medicare reimburses other providers.

For most services, Medicare has gradually moved to a bundled payment strategy. This began with Medicare's adoption of the prospective payment system for inpatient hospital expenses in 1983. The use of a per diem rate was replaced with a single, prospectively-determined payment which was to cover all of the costs during

the inpatient stay and which was based on the patient's diagnosis at discharge. Gradually the use of some type of bundled payment strategy has been extended to capital payments for hospital inpatient care, as well as to outpatient hospital care, renal care, home care and nursing home care. Updates for the bundled payments are based on inflation measures, adjustments for productivity increases and changes reflecting new legislation. The per capita payment made for Medicare Advantage can be viewed as the ultimate bundled payment since it covers all Medicare services.

Physician Payment History

Changes in physician payments have followed a different path. Although there was a time during the mid-1980's when Medicare (or at least the staff at HCFA) considered using physician DRG's, thus far there has been no serious move in that direction. Bundled payments are used to reimburse physicians in certain instances: surgeons receive a fixed payment that covers preoperative care, the procedure itself and some limited amount of post-operative care. I assume Medicare uses this type of bundled payment strategy for surgeons because it reflects the most common way surgeons are paid outside of Medicare.

In general, however, physicians are paid for providing discreet services according to a very disaggregated fee schedule that uses more than 7,000 different billing codes. A major change was made to how physician payments were constructed in 1989. Rather than being based on historical charges, the fee schedule was replaced with a Resource Based Relative Value Scale that attempted to assess the relative value of a

physician's work effort in providing a particular service, as well as the practice expenses and malpractice liability expenses involved. Among the many goals of the adoption of the RBRVS, was the intent to correct what had been perceived as an undervaluing of the services provided by primary care physicians and an overvaluing of at least some of the procedures done by specialists and also to correct differences between urban and rural payments that were regarded as larger than could be justified on the basis of differences in the cost of living or the costs of practicing medicine. There has been some debate about whether the RBRVS has succeeded in correcting these problems although payments for primary care services have increased faster than payments for all services.

Medicare's payment history has led to concerns about inappropriate volume increases whereby providers may seek to increase their income by inappropriately increasing volume for patients who don't really need services. It appears that the risk of inappropriate volume increases with more disaggregated and with charge-based billing systems although the penalties recently put in place for certain types of hospital readmissions indicates that concern can exist even with bundled payments.

Medicare's concern first arose when fees were based on historical charges from 1965 to 1984 and it was observed that charges and volumes of services increased rapidly. From 1984 (when PPS was introduced for hospitals), the growth in physician fees was limited by to the Medicare Economic Index but there was still a

rapid growth in spending because of volume changes. It became clear that controlling fees alone was not a very effective way to control spending, especially when a disaggregated fee schedule is being used as is the case for physician reimbursement.

Since the early 1990's and the adoption of the RBRVS fee schedule, some form of spending target has been used for physician payments. Initially the spending limit was set by a Volume Performance Standard (VPS) that tied the annual update to a target that was based on historical trends in physician costs, with a two-year lag between the adjustment and the data that was used for the adjustment. Because of the way the adjustment was calculated, it produced very unstable updates, with swings that were much greater than the changes in the underlying MEI. The variation in the MEI during its first 5 years was between 2% and 3.2% while the updates varied between 0.6% and 7.5%.

The VPS was replaced with the Sustainable Growth Rate (SGR) in the 1997 Balanced Budget Act. The SGR made several changes but also used a much more aggressive measure to control spending, tying the allowable increase in physician spending to the real GDP per capita growth rate. To increase its stability, a 10-year moving average of the GDP rather than a single year's GDP has been used since 2004. The update is the MEI adjusted by cumulative spending relative to the target. It's the cumulative spending feature combined with the way that Congress has bought itself

more time each year that has made the recent reductions implied by current legislation so large.

While the SGR has produced changes that are more stable than the preceding VPS, it has not been enforced since 2003 because of concerns by Congress about problems in access that would result. The concerns about the present system of physician payment reimbursement have occurred at least at two different levels. First, the use of a spending target for only one part of Medicare forces (if it were enforced) a rigid relationship between physician spending and the economy for only physician services. That led MedPAC, several years ago, to propose using expenditure targets throughout Medicare. While this might reduce some of the relative pressure on physician payments and would limit spending, if enforced, it doesn't consider the appropriateness of Medicare spending among the various components of the program that exist at a particular moment in time. Also, it does nothing to encourage quality improvements or any of the other goals Congress has set for Medicare.

Second, and of even more importance, the way the objectives of the SGR are inconsistent with the incentives it produces. The objective is to control total physician spending. However, the SGR neither affects nor is driven by spending by any individual physician or physician group, no matter how large that group is or how egregious their spending. If anything, individual physicians or physician groups are implicitly encouraged to increase spending, because nothing they can do

as individuals will affect overall spending but their fees will be affected by what other physicians do collectively, irrespective of their own behavior.

Future Options

There are a number of short-term patches, either to the SGR or to the RBRVS, which have been proposed. The changes to the SGR include the use of multiple SGRs to reflect the differential spending growth among some specialists, and the use of multi-specialty SGRs for multi-specialty physician groups to encourage more to develop. Among some of the changes to the RBRVS that have been proposed are changes to the relative values for services that have experience significant productivity increases, improving the data that is used for updating the relative value and improving the estimates of practice expenses.

However, none of these strategies addresses the "disconnect" between behavior at the level of the individual physician or the physicians' practice and the updates that are produced. What would fix the "disconnect," is to have the SGR set at the level of the physicians practice. This would link the physician's updates to the physician's own behavior. It is not so hard to imagine this being done for group practices of some size. It is harder to imagine for very small groups or individual practices because of the adjustments that would be needed to correct for patients who were atypical in any way. Furthermore, a billing system that is based on more than 7000 billing codes makes it very difficult to encourage greater accountability and or reward better outcomes. We will see if the "value-based modifier" that is part of the

Affordable Care Act has much effect but because it will represent such a small share of the physicians' reimbursement, it's hard to imagine that it will.

The other option is to begin developing a more aggregative payment. This will not be easy nor will it be done quickly but it is important to start as soon as possible. In the near term, payments could be developed that cover all of the services that a physician provides to a patient for the treatment of one or more chronic diseases. This is consistent with the work that CMS has been doing with medical homes but would also include the physician services and ancillary services. In addition, a bundled payment should be developed for the high cost, high volume interventions That would include all of the physicians' services involved in providing care to the patient for treating that procedure or DRG. The Innovation Center will include some pilots that bundle physician and hospital payments but it is important to develop payment systems that do not include payment to the hospital unless it is believed that all or almost all physicians will either be part of integrated delivery systems or employed by hospitals. Otherwise, this will be one more step that increases the power of hospitals at the expense of other providers and payers.

It is urgent that CMS devote more time than appears it has to redesigning how physicians are paid. It was disappointing to me that so little attention was paid to physicians in the ACA and it is even more disappointing that the early pilot studies from the Innovation Center are so focused on the hospital or are relatively limited in their scope. Physicians don't directly account for a large part of the health care

dollar but they have a disproportionate impact on how the health care dollar gets spent. It is hard for me to imagine reforming the health care delivery system until we figure out a better way to reimburse physicians—rewarding them for the kind of behavior we want to see.

There are no "quick fixes". No replacement system is ready for "prime time". Most importantly, removing the SGR and leaving in place the RBRVS, even an improved RBRVS, will only recreate the conditions that led to the development of a spending limit in the first place.

COMMUNICATIONS

Comments for the Record

United States Senate

Committee on Finance

Roundtable Discussion on "Medicare Physician Payments: Understanding the Past so We Can Envision the Future"

Thursday, May 10, 2012, 10:00 AM

215 Dirksen Senate Office Building

by Michael G. Bindner

The Center for Fiscal Equity

4 Canterbury Square, Suite 302

Alexandria, Virginia 22304

Chairman Baucus and Ranking Member Hatch, thank you for the opportunity to submit my comments on this topic. This topic is key to the question of the affordability of health care entitlements. It is useful to compare the impact of how provider limits have been dealt with between the Medicare and Medicaid programs.

Medicare provider cuts under current law have been suspended for over a decade, the consequence of which is adequate care. By way of comparison, Medicaid provider cuts have been strictly enforced, which has caused most providers to no longer see Medicaid patients, driving them to hospital emergency rooms and free clinics with long waiting periods to get care.

The Affordable Care Act works toward increasing funds for Medicaid providers, which is necessary to get people out of emergency rooms. The same act, however, counted on assuming that Medicare provider cuts would be implemented – a heroic assumption – in order to pass according to budget rules. Now that the Act is passed, however, the fiction that current law will be maintained can be dispensed with.

Parity between Medicare and Medicaid is desirable, although without mandatory sick leave, it will not keep poor people from having to use emergency room care, although it will benefit nursing home patients who will be able to see a doctor without hospitalization.

Separating Medicaid into a program for retirees and a program for the non-retired working and non-working poor will allow the retiree program to be fully federalized and managed with Medicare, rather than the separate management that occurs now under CMMS, which is part of the problem. That simple step will add clarity to this issue.

There are many ways of achieving parity, however great care must be used so that these don't constitute a race to the bottom. Cost shifting should not be used as a substitute for cost saving, especially if such shifting violates the tenants of social insurance.

The whole purpose of social insurance is to prevent the imposition of unearned costs and payment of unearned benefits by not only the beneficiaries, but also their families. Cuts which cause patients to pick up the slack favor richer patients, richer children and grand children, patients with larger families and families whose parents and grandparents are already deceased, given that the alternative is higher taxes on each working member. Such cuts would be an undue burden on poorer retirees without savings, poor families, small families with fewer children or with surviving parents, grandparents and (to add insult to injury) in-laws.

Recent history shows what happens when benefit levels are cut too drastically. Prior to the passage of Medicare Part D, provider cuts did take place in Medicare Advantage (as they have recently). Utilization went down until the act made providers whole and went a bit too far the other way by adding bonuses (which were reversed in the Affordable Care Act). There is a middle ground and the Subcommittee's job is to find it.

Resorting to premium support, along with the repeal of the ACA, have been suggested to save costs. Without the ACA pre-existing condition reforms, mandates and insurance exchanges, however, premium support will not work because people will have no assurance of affordable coverage. This, of course, assumes that private insurance survives the imposition of pre-existing condition reforms. If it does not, the question of both premium support and the adequacy of provider payments is moot, since if private insurance fails the only alternatives are single-payer insurance and a pre-emptive repeal of mandates and protections in favor of a subsidized public option. The funding of either single-payer or a public option subsidy will dwarf the requirement to fund adequate provider payments in Medicare and Medicaid.

Resorting to single-payer catastrophic insurance with health savings accounts would not work as advertised, as health care is not a normal good. People will obtain health care upon doctor recommendations, regardless of their ability to pay. Providers will then shoulder the burden of waiting for health savings account balances to accumulate – further encouraging provider consolidation. Existing trends toward provider consolidation will exacerbate these problems, because patients will lack options once they are in a network, giving funders little option other than paying up as demanded.

Shifting to more public funding of health care in response to future events is neither good nor bad. Rather, the success of such funding depends upon its adequacy and its impact on the quality of care – with inadequate funding and quality being related.

Ultimately, fixing health care reform will require more funding, probably some kind of employer payroll or net business receipts tax – which would also fund the shortfall in Medicare and Medicaid (and take over most of their public revenue funding).

We will now move to an analysis of funding options and their impact on patient care and cost control.

The committee well understands the ins and outs of increasing the payroll tax, so we will confine our remarks to a fuller explanation of Net Business Receipts Taxes (NBRT). Its base is similar to a Value Added Tax (VAT), but not identical.

Unlike a VAT, an NBRT would not be visible on receipts and should not be zero rated at the border – nor should it be applied to imports. While both collect from consumers, the unit of analysis for the NBRT should be the business rather than the transaction. As such, its application should be universal – covering both public companies who currently file business income taxes and private companies who currently file their business expenses on individual returns.

The key difference between the two taxes is that the NBRT should be the vehicle for distributing tax benefits for families, particularly the Child Tax Credit, the Dependent Care Credit and the Health Insurance Exclusion, as well as any recently enacted credits or subsidies under the ACA. In the event the ACA is reformed, any additional subsidies or taxes should be taken against this tax (to pay for a public option or provide for catastrophic care and Health Savings Accounts and/or Flexible Spending Accounts).

The NBRT can provide an incentive for cost savings if we allow employers to offer services privately to both employees and retirees in exchange for a substantial tax benefit, either by providing insurance or hiring health care workers directly and building their own facilities. Employers who fund catastrophic care or operate nursing care facilities would get an even higher benefit, with the proviso that any care so provided be superior to the care available through Medicaid. Making employers responsible for most costs and for all cost savings allows them to use some market power to get lower rates, but no so much that the free market is destroyed.

This proposal is probably the most promising way to arrest health care costs from their current upward spiral – as employers who would be financially responsible for this care through taxes would have a real incentive to limit spending in a way that individual taxpayers simply do not have the means or incentive to exercise. While not all employers would participate, those who do would dramatically alter the market. In addition, a kind of beneficiary exchange could be established so that participating employers might trade credits for the funding of former employees who retired elsewhere, so that no one must pay unduly for the medical costs of workers who spent the majority of their careers in the service of other employers.

The NBRT would replace disability insurance, hospital insurance, the employer contribution to OASI, the corporate income tax, business income taxation through the personal income tax and the mid range of personal income tax collection, effectively lowering personal income taxes by 25% in most brackets.

Note that collection of this tax would lead to a reduction of gross wages, but not necessarily net wages – although larger families would receive a large wage bump, while wealthier families and childless families would likely receive a somewhat lower net wage due to loss of some tax subsidies and because reductions in income to make up for an increased tax benefit for families will likely be skewed to higher incomes. For this reason, a higher minimum wage is necessary so that lower wage workers are compensated with more than just their child tax benefits.

Thank you for the opportunity to address the committee. We are, of course, available for direct testimony or to answer questions by members and staff.

Statement for the Record
to
The Senate Finance Committee
on
Medicare Physician Payments: Understanding the Past so We Can Envision the Future
May 10, 2012
by
The National Committee for Quality Assurance
1100 13th St. NW, Washington, DC 20005

Chairman Baucus, Ranking Member Hatch, distinguished Committee members, thank you for holding this hearing on Medicare physician payments.

The National Committee for Quality Assurance (NCQA) is a private, non-profit organization that for more than 20 years has worked to improve health care quality and value through measurement, transparency and accountability. One of the greatest impediments to higher quality care is misaligned payment incentives. Medicare has not paid clinicians to collaborate with patients, engage staff in a team-based approach or coordinate across the spectrum of health care. We believe it is essential for Congress to revise Medicare's physician payment system now to reward clinicians who do these critical things to deliver high quality, efficient care.

NCQA Patient-Centered Medical Homes

Our Patient-Centered Medical Home (PCMH) Recognition Program is by far the most successful tool for improving the quality and efficiency of primary care. In its first three years it has helped more than 20,250 clinicians at more than 4,220 sites transform their practices into what patients want primary care to be. That means:

- Patients have long-term partnerships with clinicians and enhanced access during and after office hours and through online communication, instead of a series of sporadic, hurried visits.
- Patients collaborate in their care, which makes care more patient-centered and sensitive to culture and language, and based on shared decisions about their care so they make more informed choices and get better results.

- Clinician-led teams coordinate care, with an emphasis on prevention and managing chronic conditions and across settings, including specialty clinicians', facilities such as hospitals and emergency departments, and community supports, as needed.

Many public and private insurers already use our PCMH program as a basis for rewarding physicians who deliver high quality, patient-centered and efficient care. We provide three levels of recognition based on how well practices meet our rigorous yet practical criteria. Many insurers pay additional fees based on the level of recognition, and some sponsor practices to become NCQA-Recognized.

Our program is practical, evidence based and built on solid research about how to provide the best primary care. It is flexible and applicable to a wide spectrum of practices regardless of size.

NCQA PCMH Practices by Size and Level as of 4/30/12

	1-2	3-7	8-9	10-19	20-50	50+	Total
Level 1	439	366	59	76	14	2	956
Level 2	108	109	9	15	5	0	246
Level 3	1111	1365	205	264	70	3	3018
Total	1658	1840	273	355	89	5	4220

Growing Evidence for PCMH Benefits

There is a growing body of evidence that this model saves more than it costs. PCMHs are especially good at reducing costly, preventable hospital and emergency department admissions. They also improve both patient and provider satisfaction. Specifically, we have seen that:

- North Carolina Medicaid has saved $1,000,000,000 through PCMHs.[1]
- Several other state Medicaid programs are seeing promising costs, quality and access trends.[2]
- A Level 3 (the highest level) NCQA PCMH in Texas helped Cigna reduce emergency department visits, increase evidence-based care, improve control of diabetes and reduce the plan's overall medical cost trend more than 2 percentage points better than the market.[3]
- PCMHs improve patient satisfaction and reduce provider burnout.[4]
- PCMHs also help low-income adults reduce access problems and gaps in care compared to higher-income populations, and be more satisfied with their care.[5]

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[1] Analysis of Community Care of North Carolina Cost Savings, Milliman, January 2012

[2] Reinventing Medicaid: State Innovations To Qualify And Pay For Patient-Centered Medical Homes Show Promising Results Takach, Health Affairs, July 2011

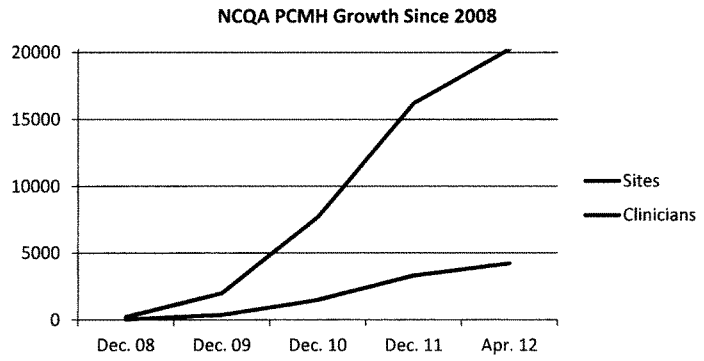
[3] Cigna's Collaborative Accountable Care Program with Medical Clinic of North Texas Shows Improved Quality, Lower Costs, August 2011 http://newsroom.cigna.com/NewsReleases/cigna-s-collaborative-accountable-care-program-with-medical-clinic-of-north-texas-shows-improved-quality--lower-costs.htm

[4] The Group Health Medical Home at Year Two: Cost Savings, Higher Patient Satisfaction and Less Burnout for Providers. Soman, Health Affairs, May 2010

[5] Achieving Better Quality of Care for Low-Income Populations: The Role of Health Insurance and the Medical Home for Reducing Health Inequities, Commonwealth Fund, May 2012

Growing Interest in PCMH Recognition

Because of these results, interest in our program is growing rapidly, with more than 150 additional practices applications each month. Most states have adopted policies and programs to advance PCMHs.[6] A growing number of private insurers, including United, Aetna, Cigna, Centene and more, also offer incentives or sponsor practices in their networks to obtain recognition.



Other parts of the federal government also are actively promoting PCMHs.

- The Department of Defense is helping its primary care practices become NCQA-Recognized PCMHs.
- The Health Resources Services Administration is helping 2,500 community health centers become PCMHs.
- The Centers for Medicare & Medicaid Services is rewarding up to 500 federally qualified health centers transform into PCMHs.
- The Center for Medicare & Medicaid Innovation also has two PCMH-related initiatives underway.

Options that public and private insurers use to promote NCQA PCMH Recognition include:

- Paying practices more based on Recognition levels.
- Sponsoring practices to become PCMH by covering Recognition costs.
- Educating members about PCMH benefits, featuring PCMHs in provider directories and lowering cost sharing when members get care at PCMHs.

In fact, many insurers are finding that this program so successful that they are expanding from pilots to full blown programs. Congress also should make PCHMs a permanent part of Medicare as it revises the physician payment system to get higher quality, efficient care.

[6] http://www.nashp.org/med-home-map

PCMH 2011: Raising the Bar

NCQA closely monitors all comments and suggestions about our PCMH program so that we can continually strengthen it. The PCMH 2011 program incorporates feedback and experience from 3 years of evaluating practices. It reflects greater clarity, specificity and challenging criteria. These changes "raised the bar" in several important respects:

- They make medical homes more responsive to patient needs by incorporating a PCMH-specific Consumer Assessment of Health Plans Survey and other information to engage patients and families.
- They emphasize language and culturally sensitive facets of care.
- They have a stronger focus on integrating care management and behavioral healthcare.
- They help pediatric practices by addressing such topics as parental decision-making, age-appropriate immunizations and teen privacy.

Deeming PCMHs for Meaningful Use

NCQA also carefully aligned the new standards with federal requirements for "meaningful use" of health information technology. This creates potential for deeming clinicians in NCQA-Recognized PCMHs as qualified for meaningful use bonus payments. There is a great deal of synergy between PCMHs and meaningful use, as both help improve quality and efficiency through better coordination and data sharing.

However, current statutory requirements for meaningful use bonuses are specific to individual providers, whereas NCQA PCMH Recognition is specific to clinical sites. We encourage Congress and CMS to allow deeming of all providers in a recognized PCMH as meeting meaningful use requirements. This would reduce burden on both providers and regulators and encourage more providers to transform into PCMHs.

Conclusion

NCQA strongly urges Congress to revise Medicare's physician payment system to actively promote and reward Recognized PCMHs. The evidence for PCMH success, substantial PCMH growth, and broad public and private insurer interest demonstrate that PCMHs are a powerful way to improve quality while reducing costs. Taxpayers who support Medicare and beneficiaries who rely on it deserve no less.

Thank you again for holding this important hearing. If you would like more information about NCQA PCMH Recognition or other NCQA programs, please contact our Vice President of Public Policy and Communications, Sarah Thomas, at Thomas@ncqa.org or at 202-955-1705.